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# MALE CIRCUMCISION FOR HIV PREVENTION IN SOUTH AFRICA

## Addressing HIV and gender relations




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# Abstract

The thesis scrutinizes how gender relations and women's and men's control of sexual health are influenced by the intervention of male circumcision for HIV prevention in South Africa. The analytical framework combines the theory of therapeutic citizenship, post-development theory and gender theory.

We argue that the individual man's choice to circumcise is being challenged by international HIV prevention methods emphasizing men's responsibility in HIV prevention. In South Africa, current changes in HIV testing policies focus on health provider-initiated HIV testing. Health providers may play an active role in encouraging men to circumcise. As a consequence, men may be expected to get circumcised and the choice to decline circumcision is underemphasized. The South African campaign Brothers for Life is promoting a new and responsible man. The new man is encouraged to circumcise and adhere to international notions of addressing risky sexual behavior by abstinence, faithfulness, and condom use. We argue that Brothers for Life make rather essentialist representations of masculinity, which overlooks the complexity of South African identities. South African masculinities are uniquely constructed in a negotiation between modern and tradition values of masculinity. The campaign emphasizes men's paternalistic responsibilities as responsible for their own health, the health of women and their families. However, this may also reinforce men's dominance in sexual relations and contribute to gender inequality and weaken women's control over own sexual health. Female condoms are advocated for in South Africa, as a way women will be able to control their own sexual health, and not have to rely on men for HIV prevention. Female condoms may, however, have a counter effect and increase gender violence and gender inequality. We argue that HIV prevention programs may contribute to positive changes in gender relations if they do not focus exclusively on either men or women, but provides a

platform where men and women are equally playing active roles in HIV prevention. Finally we have argued that gender structures at the local level hamper individual behavior change in men. Therefore, if male circumcision for HIV prevention is to create fundamental changes in masculinity, its focus needs to go beyond individual men, and extend its focus to the structural level of gender relations.

## Acronyms

| | |
|---|---|
| ABC | Abstinence, be faithful, use condom |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| CAPRISA | Centre for the AIDS Programme of Research in South Africa |
| HCT | HIV Counseling and Testing |
| NSP | HIV and AIDS and STI National Strategic Plan for South Africa |
| NGO | Non Governmental Organization |
| SANAC | South African National AIDS Council |
| TVEP | Thohoyandou Victim Empowerment Programme |
| VCT | Voluntary Counseling and Testing |
| WHiPT | The Women's HIV Prevention Tracking Project |

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# 1. Introduction

## 1.1. Gender and HIV in South Africa

Despite a multitude of efforts to halt the HIV and AIDS epidemic in South Africa through numerous interventions by national governments, international donors and NGOs, the HIV infection rate in South Africa is still among the highest in the world[1]. Statistics from 2009 estimate that 17.8% of the South Africa population aged 15-49 is infected with HIV or AIDS. This accounts for 5.6 million[2] people out of approximately 50.4 million[3][4]. Prevention of HIV and AIDS remains a rising problem globally, and 'creative' approaches to preventing AIDS are being researched with the aim of creating alternative solutions. It is widely articulated and recognized that addressing gender issues is necessary in order to understand and to stop the spread of HIV (Boesten and Poku 2009, Jewkes and Morrell 2010, Susser 2009). There are a variety of ways to address gender-related risks in relation to HIV, such as improving women's legal and economic status and integrating gender-based violence prevention into HIV services. Gender based violence and HIV are among the most major societal problems in South Africa. Gender relations play a central role as an explanation for the rapid spread of HIV in South Africa. In those relations women have been seen as the weaker part and exposed to higher levels of HIV risk[5] due to men's sexual behavior (Jewkes and Morell 2010:2). HIV programs have sought to balance men's dominance over women and control of sexual relations by empowering women. This

[1] (USAID 2011)
[2] Based on estimates of 2008, approximately 3.2 million are women and 280,000 children (ages 0-14) out of the 5.7 million people infected with HIV. There is not any information providing how many men are infected with HIV. There is significant variation in HIV prevalence by province, ranging from 39.1% in KwaZulu-Natal to 15.1% in Western Cape (UNAIDS 2008).
[3] (USAID 2011)
[4] (UNAIDS 2009)
[5] Definition of "HIV risk": The probability that someone will contract HIV (Gupta et al. 2008, 765)

approach is still remains widely used. However, men's involvement in HIV prevention has become a major focus since the turn of the millennium. This approach is based on the assumption that women' situations will not change without the involvement of men, as they are in control of sexual relations. Furthermore men's risky sexual behavior is seen as a main driver of the spread of the HIV pandemic in South Africa (Akeroyd 2004, Kalichman, et al. 2009, Harrison, et al. 2006), and thus various programs seek to address and change male behaviors. The national South African campaign "Brothers for Life" focuses on these issues. The campaign was launched in August 2009 and targets mainly men aged 30 and over. The campaign encourages men to "do the right thing" such as avoiding concurrent and multiple partnerships, not engage in gender based violence and also addresses men's limited participation in fatherhood. Furthermore, it promotes HIV testing and condom use. Brothers for Life also promote messages on HIV prevention through male circumcision, which will be central to our analysis in this thesis.

The particular behaviors that the campaign seeks to address are behaviors that are linked to men's dominance over women in sexual relationships. Control in sexual relationships and control over gender relations are central components of manhood identity for many South African men (Lynch, Brouard and Visser 2010, Harrison, et al. 2006). Brothers for Life promote a new man whose identity is based on responsibility for the man's family. The 'new man' is faithful to one partner, uses condoms, and avoids alcohol and physical abuse[6]. The ideal 'new man' acts responsibility to prevent the spread of HIV. He does so via technical methods of HIV prevention such as condom use and circumcision. Circumcision is currently being scaled up[78] in South Africa as a HIV preventive measure.

[6] (Brothers for Life 2009) - see appendix C "Brothers for Life Manifesto"

[7]WHO definition of scale up: "Scaling up in the health sector means "doing something in a big way to improve some aspect of a population's health". It can be applied to scaling up inputs; outputs (access, scope, quality, efficiency); outcomes (coverage, utilization) or impact (reducing morbidity or mortality)." (WHO 2008)

The aim is to circumcise 80% of men aged 15-49, which approximately is 4.3 million South African men, by 2015[9]. Circumcision is recommended by WHO and UNAIDS as a way of averting the spread of HIV in South Africa, as well as bringing down the cost of HIV-related treatment[10].

## 1.2. Problem area

In 2007 UNAIDS and WHO recommended the implementation of male circumcision for HIV prevention in countries with high rates of HIV based on results from three randomized controlled trials. Trials were carried out in Uganda, Ghana and South Africa between 2005-2007 showed that male circumcision reduces female–to-male HIV transmission up to 60 percent , (Auvert, et al. 2005, Gray, et al. 2007, Williams, et al. 2006)[11]. A modeling study suggests that universal male circumcision in sub-Saharan Africa could prevent 5.7 million new cases of HIV infection and 3 million deaths from 2005-2025 (Williams et al. 2006, 1037).

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[8] "The Bophelo Pele" project in the township of Orange Farm in Johannesburg was already rolled-out in 2008. The project was made to serve as a model for a scale up of comprehensive circumcision services in rural and urban settings in Eastern and Southern Africa (Lissouba, et al. 2010).

[9] (South African Department of Health 2011)

[10] "Research indicates that circumcision is likely to be a relatively cost-effective way to prevent HIV infection in areas with high HIV prevalence. A review conducted by experts convened by the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization, and the South African Centre for Epidemiological Modelling, found that male circumcision was not only cost-effective, but also cost-saving. After reviewing six simulation models estimating the impact of male circumcision on HIV "it was concluded that one HIV infection could be prevented for every five to 15 men circumcised in settings with high levels of HIV and low rates of male circumcision, at a cost of US $150 to $900 per HIV infection averted over 10 years. By comparison, estimates of discounted lifetime treatment costs per HIV infection typically exceed US $7,000"(…) "a modelling study estimated that for every 1,000 circumcisions performed among men in South Africa's Gauteng Province, 308 new cases of HIV would be prevented, at a cost of US $181 per HIV infection averted. Assuming a lifetime cost of about $8,000 to treat each of those infections with antiretroviral drugs, the potential savings would be $2.4 million over 20 years" (Clearinghouse on Male Circumcision for HIV Prevention 2011a) (internet source 6)

[11] For more information on the random controlled trials:
(Clearinghouse on Male Circumcision for HIV Prevention 2011b) (internet source 8)

The public health benefit would be significant particularly in countries with hyper endemic or generalized epidemics[12], with a low prevalence of men circumcised and where HIV is predominantly spread through heterosexual relations (WHO and UNAIDS 2007, 7). These factors all apply to the AIDS pandemic in South Africa as it is generalized, and relatively few men are circumcised (Ramkissoon, et al. 2010, 4). Furthermore, about 85 percent of all HIV transmissions in South Africa are caused by heterosexual intercourse (South African Department of Health 2007, 85). Modeling studies show mass circumcision in South Africa may provide nine percent reduction in HIV rates over the next 10 years (Ramkissoon, et al. 2010, 4).

Based on the results of these modeling studies, there is optimism regarding the potential impact of circumcision, though critics are skeptical due to the social context of gender relations in South Africa. Gender is an important driver of the South African AIDS pandemic as social gender roles determine sexual relationships and encourage risky sexual behavior that increases the HIV risk of both men and women (Jewkes 2009, Harrison, et al. 2006, Peacock, et al. 2008). Men's sexual behavior is often seen as the main barrier to halt the spread of HIV in South Africa, due to identities of masculinity that are defined around sexual dominance over women (Higgins, Hoffmann and Dworkin 2010, 435). The circumcision intervention is a way of involving men in HIV prevention.

Men in South Africa are encouraged to circumcise to protect their own health and the health of others. What are the expectations to the South African man's contribution to HIV prevention? What are the means that are used to convince men to circumcise? Is the individual's right to decide not to become circumcised under pressure in the circumcision

12 An epidemic is considered 'generalized' when more than one per cent of the population is HIV-positive. (Unicef 2008) (internet source 21)

intervention? The South African National AIDS Council (SANAC)[13] and WHO emphasize that circumcision should not stand alone in preventing HIV. Rather it should be combined with other HIV prevention methods, where one component/method is to address men. This strategy mainly concerns risky male behavior that contributes to the spread of HIV by promoting ideals of a responsible man. How are the ideals of a responsible man constructed in relation to men's role in HIV prevention in South Africa through the circumcision intervention?

Circumcision only protects men and will not benefit women directly[14]. Women's rights organizations in South Africa are concerned that women's needs and rights for HIV protection will be overlooked by a scale up of male circumcision (Ramkissoon, et al. 2010, 38, Arnott og Kehler 2010, 9). Increased access to female condoms as a female-controlled prevention is seen by some women's rights organizations and women's health researchers as a way that women can, independently of their male partners, protect themselves from HIV transmission (Arnott og Kehler 2010, 8, Thohoyandou Victim Empowerment Programme 2008, Mantell, et al. 2006, Peters, Jansen og van Driel 2010, Kaler 2001). Similar to circumcision, the female condom is a technical solution to HIV but also has social gender implications. It is therefore relevant to ask; how are gender power relations impacted by female condoms? Can the promotion of female condoms alongside male circumcision cause an increase in gender equality?

13 The South African National AIDS Council (SANAC) was formed to strengthen the strong political leadership as well as to ensure inclusion of civil society in the overall response to HIV and AIDS. The Council is composed of both government and civil society organizations". (South African Department of Health 2009) (internet source 16)

[14]An indirect benefit is that women will be less like to encounter an HIV-positive partner, as longer terms HIV incidence in men will decrease due to circumcision programs (WHO 2007b)

Behavior change is major focus in HIV prevention interventions in South Africa (Cunha 2007, 213). Men's sexual behaviors are also addressed in the intervention of circumcision as these are seen as central drivers of the South African HIV epidemic. Is the focus on behavior change an effective way to stop the spread of HIV?

Based on the above considerations and questions, we pose the following problem formulation and research questions:

## 1.3. Problem Formulation

As a method that involves men in HIV prevention, how is male circumcision in South Africa influencing social gender relations and men's and women's control over sexual health?

### 1.3.1. Research Questions

In 2008 SANAC made four recommendations aiming to make circumcision a more effective HIV prevention method. We will focus on these four points in our analysis and final discussion in order to answer our problem formulation. The recommendations are summed up in the article "SOUTH AFRICA: Male circumcision: why the delay?" from PlusNews.org[15]:

> After lengthy consultations, SANAC issued a number of recommendations including that rollout costs should not divert funds from female condom distribution and other programmes directly benefiting women; the procedure should be offered as part of a comprehensive sexual health package, including

[15] Irin PlusNews: PlusNews is a global online HIV and AIDS news service of the United Nations Integrated Regional Information Networks (IRIN 2011)

> HIV counseling and testing; and communities should be informed that male circumcision was only partly effective in preventing HIV infection[16].

To analyze those four points and consequently answer our problem formulation we have set up four research questions:

1. What are the implications of an individual responsibility to circumcise wedded with public health targets of HIV prevention in the South African context of circumcision scale up?
2. Which masculinity representations are produced and reproduced in the scale up of the circumcision for HIV prevention intervention?
3. Can female condoms contribute to enhancing women's control of their bodies and gender equality?
4. What are the possibilities of creating more fundamental changes in masculinities and male behavior through the circumcision intervention in South Africa?

## 1.4. Project design

In the *first chapter* we presented the thesis' problem area, our problem formulation and four research questions.

In *chapter two*, we present the thesis' theoretical framework which is a combination of theoretical perspectives of therapeutic citizenship, post-development theory and gender and development theory.

Chapter tree outlines our methodology. The chapter contains an argumentation for our

[16] (PlusNews 2009)

choice of method and empirical material. The thesis' central concepts of "intervention" and "gender relations" are defined and we explain how the concepts are used analytically in our analysis. Finally we discuss the generalizability of our conclusions.

Chapter four contains two background sections; one on the medical explanation of how circumcision reduces HIV transmission and on the meaning of traditional circumcision in South Africa. Another section outlines the current policy context of HIV and AIDS strategies in South Africa.

The analysis consists of three chapters. *Chapter five* analyses how the circumcision intervention impacts individual men's choices over own sexual health.

*Chapter six* analyzes the masculinity notions that are being produced and reproduced in the circumcision campaign of Brothers for Life.

*Chapter seven* analyzes how increased access to female condoms may impact on women's control over sexual health and gender equality in a time of scale up of male circumcision for HIV prevention in South Africa.

C*hapter eight* is a discussion of the possibilities of creating more fundamental changes in masculinities and male behavior through the circumcision intervention in South Africa.

In *chapter nine* we present the conclusion of the thesis.

# 2. Theory

## 2.1. Introduction to theory

Our analytical framework for male circumcision for HIV prevention will be developed in this chapter.

Our focus is on the relations between national and international efforts to control the HIV epidemic and the expectations to the individual's contribution to HIV prevention. To understand this we use therapeutic citizenship as our overall analytical framework. The theory was originally developed in the setting of individuals adhering to ARV treatment. We have adapted the theory to our own purpose of analyzing circumcision for HIV prevention. Post-development and gender theory are the supporting theories utilized to emphasize our perspective on male circumcision as an intervention which has implications for gender relations in a South African setting.

We use the theoretical framework to understand better how individual responsibility for HIV prevention is being articulated and established through the intervention of circumcision for HIV prevention. Ideas of responsibility are aimed at meeting public health needs in HIV prevention. We will analyze how individual efforts wedded with collective initiatives shape therapeutic citizens and the gender relations they are part of.

## 2.2. Individual and/or collective 'choice' to prevent HIV: Therapeutic citizenship, gender and responsibility

This theory section addresses the notion of therapeutic citizenship regarding health priorities decided between individuals and state. For instance, we will elaborate on whose responsibility it is to prevent HIV, individuals or the state. As WHO and UNAIDS,

amongst others, collaborate on HIV prevention in less developed countries, male circumcision is a development intervention in South Africa to prevent HIV. Controlling HIV in South Africa through male circumcision both manage bodies due to a change of the genitals, but also manages behavioral notions of individuals through ABC messages[17]. Our theory introduces therapeutic citizenship to elaborate on decision-making between the state and individuals in regards to HIV prevention. Vinh-Kim Nguyen (2005, 2010) originally bases therapeutic citizenship on HIV treatment and the individual access to ARVs as provided by the state and health providers. We use the arguments from therapeutic citizenship concepts and apply to them male circumcision for HIV prevention. We theoretically address male circumcision for HIV prevention and the decision making, fluctuating between individuals and the state in South Africa.

We found the theory of therapeutic citizenship to be insufficient in exploring individual decision-making regarding HIV prevention. However, the introduction of Richey (Richey 2006) and Robins (Robins 2006) contextualizes individuals in South Africa in their social settings, and highlight possible barriers to individuals in given settings not able to make decisions about their conditions. Richey and Robins both base their research on South African health settings. Richey argues for the importance of *gendering* the therapeutic citizen, and Robins argues further on that priorities between individuals and the state is reduced to the individual being a *responsible citizen* who thus takes responsibility for his

[17] "On September 17, 2002, the U.S. Agency for International Development (USAID) hosted a technical meeting in Washington, D.C., to consider behavior change approaches to HIV/AIDS prevention, sometimes referred to as the "ABCs" of primary prevention. More than 130 HIV/AIDS and reproductive health experts shared research findings and lessons learned. The participants included representatives and researchers from UNAIDS, the World Health Organization, UNICEF, the United Nations Population Fund, the U.S. Centers for Disease Control and Prevention, the Bill & Melinda Gates Foundation, USAID cooperating agencies, and U.S. and European universities. As Connie Carrino, Director of USAID's Office of HIV/AIDS, noted in her opening remarks, analyzing sexual behaviors and behavioral changes — such as the "ABC" approaches of Abstinence/delay of sexual debut, being faithful/partner reduction, and Condom use — is key to understanding and combating sexual transmission of HIV."
(USAID 2002)

or hers condition. In regards to male circumcision, that could amount to the individual staying HIV negative by being circumcised and adhering to the behavioral notions emphasized in the national circumcision brochures, which we will analyze in chapters five and six.

### 2.2.1. The therapeutic citizenship

In the early years of international response to HIV and AIDS, the agenda shifted to an empowerment approach as it focused on human rights as well as improving social conditions for the most vulnerable living with HIV (Nguyen, et al. 2007). In that approach, it was stressed that people should disclose their HIV status in order to increase HIV prevention. Based on Western experiences, the arguments were that people seeing or knowing someone living with HIV could increase HIV prevention. A concept to define this kind of disclosure came to be known as 'self-help through disclosure' and in the mid-1990s triggered a wide variety of 'disclosure services' such as community and discussion groups. Nguyen (2005, 2010) argues that such groups in a context of poverty and minimal state services can provide individuals with social solidarity, in which the individuals can gain access to resources and medication.

Scarce HIV prevention resources meant prioritizing individuals more likely to adhere to the medical programs. Put in other terms, the people most likely to survive (in a rational sense) are also more likely to get access to resources, whereas those who have lessened prospects of survival do not get access. In terms of HIV and AIDS treatment, demand often outruns supply, and Nguyen argues that "those who were most charismatic and most able to deliver effective testimonials would be the best advocates for getting more drug donation" (Nguyen, et al. 2007, 33). That could take place by the individual disclosing a HIV positive status, which consequently places the individual in a vulnerable situation, to attempt to get access to resources from the state or NGOs. In social settings, such

disclosure of HIV status may have different implications in social relations. The technique of self-help through disclosure as Nguyen argues has contributed to produce activists, as the technique not only was self-transformative, but also changed social relations. These negotiations of treatment and social relations of people living with HIV in local and international landscapes is what Nguyen refers to as the *therapeutic citizenship*: "we have found therapeutic citizenship to be both a political claim to belonging to a global community that offers access to treatment for the ill, as well as a personal engagement that requires self-transformation" (Nguyen, et al. 2007, 34).

This merging between people's claims and global discourses of treatment is at the core of *therapeutic citizenship*, which Nguyen defines as "a form of stateless citizenship whereby claims are made on a global order on the basis of one's biomedical condition, and responsibilities worked out in the context of local moral economies" (V. Nguyen 2005, 142). Nguyen also defines therapeutic citizenship as a "biopolitical citizenship, a system of claims and ethical projects that arise out of the conjugation of techniques used to govern populations and manage individual bodies" (V. Nguyen 2005, 126). The citizen, i.e. the individual, is identified by its biomedical condition, which in regards to male circumcision is HIV status. In the arena of HIV prevention internationally and nationally the citizen is identified by an HIV status which determines the therapy he or she needs. When an individual discloses an HIV status in order to get access to treatment or prevention, private and individual matters become concerns of the therapeutic state. Richey (2006) emphasizes that "AIDS has represented a challenge to the central impulse of liberal individualism, forcing into the social realm matters that had come to be viewed as of no legitimate public concern" (Bayer 1990:179 in Richey 2006, 3). That an HIV status is of public concern may indicate that individual's decisions are prioritized less and the national and international efforts towards HIV prevention are at front in HIV prevention and treatment efforts. This we will elaborate on analysis chapter five.

### 2.2.2. Gendering the therapeutic citizen

Richey (2006) defines a therapeutic citizen as "The self on ARVs as linked to the geopolitical realm of AIDS treatment both globally and locally has been termed the therapeutic citizen" (Nguyen 2004 in Richey 2006). However, Richey argues that gendered implications on the local level are not emphasized sufficiently by the notion of therapeutic citizenship. She argues that the therapeutic citizen needs to be gendered as local expectations to men and women influence the therapeutic citizen's choices in relation to ARV treatment. She bases her arguments on research from a South African clinic with women's reproductive health, where she considers the dilemma of reproductive decision making in an AIDS clinic as an individual right versus the priorities of the health providers. Richey defines a successful therapeutic citizen, but at the same time, emphasizes that success cannot be achieved without finding "a way to gender the therapeutic citizen in order to reintegrate the biopolitical struggle of ARVs with the 'social issues' percolating within the therapeutic state" (Richey 2006:1). Similar to Nguyen, Richey argues that what used to be private health issues contemporarily are unfolded in public health norms. In terms of male circumcision, an HIV status determining whether individuals can get circumcised is an example of individual and private matters being unfolded in public health conditions.

Richey underlines her argument of gendering the therapeutic citizen by pointing to the limitations of the therapeutic citizenship. Therapeutic citizenship alone could not account for reasons why HIV positive women became pregnant after being advised not to. When the HIV-positive women got healthier due to ARV treatment, they returned to leading sexual lives and would disappear from the ARV clinic, only to come back nine months later expecting a child. Women left the clinic because it was not allowed to become pregnant while being on ARV treatment, a condition they avoided in order to carry out local expectations of becoming mothers. The problems arose as demonstrated in the example

with the expectations of the clinic to women's adherence to ARVs and the local expectations of motherhood.

Another argument Richey makes in terms of gendering the therapeutic citizen is exemplified in her research with poor women in a South African HIV clinic, which concludes that "poor women on public ARV programmes are unlikely to be in a position to navigate the obstacles that stand in the path of exercising meaningful reproductive choices between the individual and the state" (Richey 2006, 5). This is why she points out the importance of gender and social issues in regards to understanding the issues of reproductive health and decision-making between the therapeutic state and individuals. When an ART appropriate HIV patient adherences to treatment it can be termed to be a 'successful therapeutic citizen', which will be elaborated and contextualized in a South African context later in this section. In Richey's research with South African women at township health clinics, she summarizes:

> Being a successful therapeutic citizen requires choice, commitment, spousal communication, and control of a woman's fertility. Implicitly, it is recognised that a health child could be the potential reward for a job well done. The meaning that ARV treatment provides to couples is that they can resume their lives, and in doing so, reproduction will mark success (Richey 2006, 22).

In terms of male circumcision, the commitment to ABC messages and control of individuals maintaining HIV-negative would be indicators of success to health providers. Richey continues: "The use of conditional language, 'if, then' implies a management strategy and a controllable outcome. If, both parties are able to manage their sexual encounters and their viruses, then they have the chance of achieving a healthy child" (Richey 2006, 23). The control of an individual is thus partly expressed as control over access to treatment, but also the conditions, which treatment is given under, and consequently determining a successful therapeutic citizen. Where Richey goes beyond

Nguyen's concept of therapeutic citizen is when she emphasizes that the social setting of the therapeutic citizen cannot be reduced to activist's claims about treatment. Furthermore, some individuals may not be able to negotiate HIV prevention due to social gender structures that prevent individual decision-making, which we elaborate on throughout our thesis. According to Richey, Nguyen considered this issue an "unexpected challenge" (Richey 2006, 8). In that view, Richey concludes that it seemingly appears like therapeutic citizens do not reproduce, which Richey explains is to overlook the 'gendered reality'. The therapeutic state, in which the therapeutic citizens navigate and make choices about their reproductive health, assumes that individuals are capable of making such decisions. Yet, decisions regarding sexual health within the therapeutic state are excluding important gendered realities of individuals, which impact their decision-making in regards to sexual health. . In the circumcision intervention, there are certain expectations to the individual man's contribution to HIV prevention. These expectations include avoiding risky sexual behavior that may contribute to HIV spread. In chapters six and eight we will discuss how gender structures influence the men's ability to live up to these expectations. In the next section, we will elaborate on the therapeutic citizen in regards to male circumcision in a South African context.

### 2.2.3. Male circumcision as a means of control to create 'responsible citizens'

Two circumcision brochures published by Brothers for Life in South Africa focus on circumcision both as a procedure that men have a right to, but also as a necessity required to protect the health of a nation. This is further elaborated in analysis chapters five and six. The cross section of circumcision being a 'voluntary procedure' wedded with the public health efforts to minimize HIV prevalence in South Africa exemplifies the decision-making regarding HIV prevention between the individual and the therapeutic state. Since circumcision cannot be performed without consent, it is forbidden to perform neonatal circumcision in a South African context, as the child cannot decide for itself according to

constitutional law. The choice of whether to become circumcised is therefore a choice made by the adult man. However, even though the choice itself is made by an adult, it can be questioned whether that also implies the choice being voluntary, which is one of the points we focus on in analysis chapter five. The next section will elaborate upon male circumcision as a marker of responsibility.

### 2.2.4. Male circumcision as a marker of an HIV status

Where Richey argues for the awareness of gendered realities of women, Steve Robins argues for the awareness of gendered realities of men. Robins is the author of *'Brothers are doing it for themselves': Remaking masculinities in South Africa* (Robins 2008). Another similarity to Richey emerges when Robins stresses that private sexual matters have entered the realm of public concerns, and points to AIDS as well as gay and gender activism as contributing to that transformation (Robins 2008). Robins emphasizes that South African men have a tendency to avoid public health clinics, not to mention HIV testing and support groups. Furthermore, Robins argue that men in the view of health professionals like nurses and counselors are seen as villains as they "are blamed for being irresponsible in their sexual lives, health, and lifestyles" (Robins 2008, 8). These are notions, which Robins argue are supported by HIV prevention and treatment messages that call attention to 'responsible' sex and lifestyles.

Therapeutic citizens living up to the global expectations of the therapeutic state are in Richey's terminology termed as successful therapeutic citizens. Similar to that notion, Robins argue that the concept of therapeutic citizen is defined by individual responsibility in living up to global expectations, why Robins introduce the concept of a responsible citizen. A responsible citizen is characterized by "political claims and demands based on individual responsibility, self-help, and 'caring for the self'" (Foucault 1997 and Nguyen 2005 in Robins 2008).

The article *From "Rights" to "Ritual": AIDS activism in South Africa* by Steven Robins (2006) goes further into depth with the concept of a 'responsible citizen', and emphasizes that 'responsible citizens' are produced in a balance between "the rights of individuals and the public health needs of society" (Robins 2006, 312). The concepts of therapeutic citizen and 'responsible' citizen underline negotiations between individuals and social expectations about sexual health and the therapeutic state and global expectations about sexual health. Due to the biological condition of an HIV status coupled with a 'social' mark of men being irresponsible and drivers of the HIV epidemic, Robins argues that the therapeutic state conditions individual access to HIV remedies or prevention, which really comes down to the individual being a responsible citizen. Robins exemplifies the notion of social triage with research made with HIV positive men who seek treatment and must meet several criteria in order to access ART[18] . Robins refers to a selection method of access to ARV treatment by men's responsibility. Men with social problems (such as drug and alcohol abuse) are more likely to be excluded as they will be perceived to be less likely to adhere to ART, due to their irresponsible behavior. Whereas Nguyen et al. (2007) refers to triage as a selection method of who is more likely to adhere to ARV treatment, Robins focuses on predominantly social selections methods where the most vulnerable are excluded. The most vulnerable excluded in male circumcision for HIV prevention are men with HIV. The combination of a positive HIV status and not being circumcised may have impact on social relations, which we will investigate further in chapter five. Therefore, we use the concept of triage in regards to male circumcision, as a combination of both Nguyen's concept of triage, where individuals are marked by their HIV status, but also Robins' version of social triage, to elaborate on the impact of an HIV status on social relations. Male circumcision might both be a biological marker of an HIV-negative status, but also a social 'mark'. WHO recommends male circumcision to HIV-negative men and not to HIV-positive men, as male circumcision has not the same effect. Similar to Robins'

[18] Antiretroviral Therapy

concept of social triage in relation to ARV treatment, HIV positive men are excluded from the HIV prevention service of circumcision. In addition, this can lead to exclusion in sexual relations, as non-circumcised men will indicate an HIV-positive status. We will elaborate upon that further in chapter five.

### 2.2.5. Sum up

In conclusion, therapeutic citizenship has been addressed at multiple levels. Nguyen (2005, 2010) points attention to the concept as a merging of biopolitical and social issues, which are to be understood as individual claims and activists' adherence to ART programs. Some keyword highlights are confessional techniques and triage. Richey takes the concept of therapeutic citizen further by questioning the implicit claim that anyone is in a position to negotiate ARV treatment without considering social implications influencing reproductive decision-making in the therapeutic state. Richey in particular focuses on women in South Africa, and their negotiation of living up to global expectations of ARV treatment wedded with social expectations to motherhood. Robins focuses on masculinities and their negotiations for ART in local settings and introduces the concept of responsible citizen. Nguyen's notions of triage and Robins' notion of social triage may both indicate circumcision as a biological and social mark of responsibility, defined by an HIV-negative status. Both Richey and Robins emphasize that gendered realities are to be considered in the negotiations between individuals and the therapeutic state. The therapeutic citizen or responsible citizen, as Robins puts it, also has connections to the gender issues men, for example being 'blamed' for the spread of HIV due to their irresponsible behavior.

Therapeutic citizenship forms the foundation of the analytical framework we utilize while analyzing male circumcision for HIV prevention as a gendered intervention. We utilize

therapeutic citizenship within the perspective of male circumcision for HIV prevention and its effect on women's and men's HIV risk and gender roles to analyze circumcision as a means of control of the therapeutic state to individuals. In these negotiations, we investigate the actions of the government as well as international actors and the negotiations of the individual to be a 'responsible citizen'. In terms of male circumcision, individuals changing their body for the greater good of the population (Robins 2006) emphasizes responsible social behavior for HIV prevention in the therapeutic state. Circumcision is thus viewed as having public health benefits since the WHO argues that "The greatest potential public health impact will be in settings where HIV is hyperendemic (HIV prevalence in the general population exceeds 15%), spread predominantly through heterosexual transmission, and where a substantial proportion of men (more than 80%) are not circumcised"[19].

The next theoretical section outlines post-development critiques of development. We use this perspective to engage in a critique of the therapeutic citizen and the relationship between "development" and individual responsibility.

## 2.3. Post-development theory

The purpose of our focus on post-development theory is to present critical views on development interventions like male circumcision. Post-development theory criticizes development interventions for being overly technical in their approach to develop settings, in which the problems are not technical in nature, and thereby neglecting political and social issues. Post-development theory critiques development interventions for being standardized and applicable to any setting disregarding social and political context. Post development theorists James Ferguson (Ferguson 1990) and Cooper and

[19] (WHO and UNAIDS 2007a)

Packard (Cooper og Packard 1997) argue that in "development" the focus is on the transition from undeveloped to developed.

In the following sections, we will utilize post-development theory to theoretically reflect upon male circumcision in South Africa as a development intervention. A central issue will be the distinction between developed and underdeveloped in the context of male circumcision for HIV prevention.

### 2.3.1. Development interventions as a means of control and surveillance

Development approaches have changed throughout history. Internationals organizations, like the World Bank and UN organizations were established in the late 1940s and early 1950s and were shaped by the notion of developing nations through technical assistance (Cooper og Packard 1997, 8-9). Led by Harry Truman[20] development frameworks became a part of international politics, as priorities changed from market-driven development to the mobilization of technical knowledge to assist underdeveloped nations.

Cooper and Packard argue that development interventions after World War II became a means to control and monitor target settings. Initially, the process of creating new persons was downplayed as colonial governments realized how little control they had over such process. So, in approaches to development in the 1940s, development became a means through which "colonial regimes tried to respond to challenges and reassert control and legitimacy" (Cooper and Packard 1997, 18).

[20] Thirty-third President of the United States, 1945-1953 (The White House 2011) (internet source 18)

### 2.3.2. The post-development critique of development

Post-development theory has come forth as a criticism of the conceptual framework of development initiated in the 1940s. It is essential to post-development theory that development is seen as an apparatus of control and surveillance, as it functions merely as one of a series of "controlling discourses and controlling practices – a 'knowledge-power regime'" shaped by institutions and structures in which economic action occurs typically located in the "West" (Cooper and Packard 1997,3).

The new conceptual development framework of the 1940s and 1950s also relied on the notion of development as a relationship between industrialized, developed nations and poorer, underdeveloped nations (Cooper and Packard 1997, 1). Since the 1940s, Cooper and Packard refer to the emerging of a "development orthodoxy". This is defined as a number of measures such as foreign aid and investment, promotion of health and education, as well as economic planning to lead poorer, underdeveloped countries to "become "normal" market economies" (Cooper and Packard 1997, 2). Development is consequently defined by a relationship between Western and developed nations compared to non-Western and underdeveloped nations (ibid). Defining Western and non-Western is closely related to "development" perspectives on tradition and modernity. Modernization theory was founded in the 1950s and resembles the view on development as a transition from underdeveloped to developed.

### 2.3.3. Modernization theory: transition from 'traditional' to 'modern'

In the 1950s and 1960s modernization theory emerged. Within the theory, there is a focus on modernizing countries and people. This included an attempt to transform traditional people into modern people. However, this transition from tradition to modernity did not take place for all people, and the ones "left behind" were categorized as " the 'indigenous person', the 'traditional' person, the 'community', the 'village', the 'local'" (Pigg 1997 in

Cooper and Packard 1997, 18). Ivan Karp further elaborates that "certain kinds of societies can be defined as 'backward' and means devised from transforming an 'underdeveloped person' into a 'developed' one" (Cooper and Packard 1997, 19). Circumcision for HIV prevention can likewise be viewed as a way the South African man transitions into a modern man. We elaborate upon this later in this section.

In our analytical framework we will focus on the cultural and social context of individuals and the impact a technical HIV prevention method such as male circumcision may have on gender relations. The cultural and social context of gender relations may however also become a barrier that hinders the transition from "underdeveloped" to "developed". This perspective is challenging modernization theory which defines development as a linear process. According to Cooper and Packard (1997) and Ferguson (1990) interventions are tools for foreign agents to exercise their 'politically neutral' intervention together with the state in the country of implementation as the service provider. In the following section, the specific context of the South African state as an 'agent of modernity' will be discussed.

### 2.3.4. The state as a modern agent

In the above we have elaborated on the development agendas of institutions and a post-development critique of the conceptual framework of development. In this paragraph, we will focus particularly on the national level and the role of the state as a modern entity. The previous South African government and its approach to HIV prevention (AIDS denialism) questioned the relation between HIV and AIDS, may have implications for the current South African government and partially explain why it may be stressing to appear modern in its approach to HIV prevention. We will elaborate on this in chapter four. Ferguson elaborates on the role of the state in a less developed country in which an intervention takes place:

> The state in "less developed countries" and international agencies such as the World Bank each find a role by accepting each other's: the national government allocates development resources and portrays itself as the agent of modernity, while outside agencies legitimately intervene in sovereign states by defining their services as benevolent, technical, and politically neutral. Both are content with development as a process with depoliticizes and disempowers local populations … both are content with an expertise-driven structure of development (…)" (Ferguson 1990 in Cooper and Packard 1997, 3).

The approach of WHO, UNAIDS and the South African state to development through technical methods could, in the light of post-development, be criticized for depoliticizing and disempowering local populations. Technical methods, provided through a development intervention, may have the reverse outcome than what is intended due to the social context which the development intervention is implemented in. Gender relations are central to explain the spread of HIV in South Africa, and disregarding that may lead to disempowerment. An example could be providing women with the technical means such as female condom, which, due to gender imbalances, may have unintended outcomes such as increased gender violence. This will be further elaborated in chapter seven. To depoliticize development interventions is thus to disregard the context in which individuals, who are targets of the intervention, are situated. Recognizing the social and economic context is essential when intervening in less developed countries. In our analysis we focus on the social gender context in South Africa whereby we also point to how the intervention of circumcision might influence "local populations", in particular with regards to the influence on gender relations.

Technical approaches may appear apolitical, but post-development theorists argue that they are political in a specific way, which we will explore in the following paragraphs.

### 2.3.5. "Development" interventions as the problem, not the solution

Ferguson emphasizes that "'development' is the name not only for a value, but also for a dominant problematic or interpretive grid through which the impoverished regions of the world are known to us. Within this problematic, it appears self-evident that debtor Third World nation-states and starving peasants share a common "problem", that both lack a single "thing": "development"" (Ferguson 1990, xxxi). Not only does Ferguson state that there is a problematic, but he also elaborates on the effects of "development", and how it works in practice. Ferguson refers to development as an 'anti-politics machine', which is "depoliticizing everything it touches, everywhere whisking political realities out of sight, all the while performing, almost unnoticed, its own pre-eminently political operation of expanding bureaucratic state power" (Ferguson 1990, xv). An example of a development discourse that attempts to depoliticize development is when "'development' agencies present the country's economy and society as lying within the control of a neutral, unitary and effective national government", where the government merely is seen as a "machine for providing social services and engineering growth" (Ferguson and Lohmann 1994, 178).

Post-development theory is a critique of development and a critical perspective on institutional agents determining underdeveloped settings and justifying needs for intervention. Ferguson (1990) argues that development as a technical intervention is problematic, in that institutional agents define underdeveloped countries as having 'a problem' to which development agents have a solution. The solution that they hold fits the development problem that they themselves have defined. In this context, Ferguson (1990) argues that development and development agencies are using a standardized framework where a given country profile has minimal relation to the economic and social setting in which the intervention is implemented, in order to make countries suitable targets for intervention and thus legitimizes and justifies the program the development institutions execute (Ferguson 1990, 70).

According to the WHO recommendation, the effect of male circumcision will be most significant in countries with high rates of HIV and the low rates of circumcision (see problem area). This is applicable to South Africa, which justifies the intervention of male circumcision for HIV prevention. The technical approach also impacts the approach to addressing individuals who are targets of an intervention. This will be elaborated upon in the following paragraphs.

### 2.3.6. Development issues are not technical in nature

The construction of development agents and projects as politically neutral transforming economical and social sectors only, commonly termed technical solutions, is, according to Ferguson, an attempt to solve problems which are not technical in nature. The formulation of a project untied to any specific context makes the implementation possible in any setting without too many adjustments. Encouraging men to practice abstinence, faithfulness and condom use (ABC) is an HIV prevention approach, which is applied in many developing countries. It is also applied as a component of the circumcision intervention. In our analysis we will be critical towards this approach as we argue that male behavior in South Africa cannot be approached by a standard solution not adjusted to the South African context.

### 2.3.7. Individuals reduced to technicalities

Ferguson argues that linking the reduction of political and structural causes of poverty to individual attributes like values, attitudes, and motivation, often implies that structural changes are addressed through educating people (Ferguson 1990, 86). Ferguson is critical towards the efficiency of solving structural development problems through an individual focus. WHO and SANAC emphasize the need of educating individuals on the partial effect of circumcision, and the need to combine male circumcision with other HIV prevention

methods. Individuals are encouraged to follow these recommendations. Whether the emphasis on educating individuals is an effective approach to reach the targets of the circumcision intervention will be discussed in chapter eight.

### 2.3.8. Sum up

Institutionalizing development through international politics began in the 1940s when several international institutions were established. The way in which it became a conceptual framework influenced technical approaches to development interventions and still influences contemporary development agendas. Such an approach exemplifies the control development agencies have in regards to defining where to intervene and how to develop less developed countries. Post-development theory critiques development interventions for their technical approach to development problems and disregard of social structures. This critique is also applicable to HIV prevention interventions that do not address gender as gender is an essential social factor that contributes to the spread of HIV.

The focus on traditional versus modern in post-development theory contributes to an elaboration of the responsible and therapeutic citizen. Becoming a responsible therapeutic citizen by following the advice of the circumcision intervention can be phrased in the terms modernization theory as a transition from a traditional to a modern person. Circumcision indicates the transformation from an 'irresponsible' man with irresponsible sexual behaviors, to a man who takes responsibility for his sexual health and risky behavior and thus becomes responsible. A man who is circumcised and lowers the possibility of spreading HIV, exemplifies that he is 'doing the right thing' by taking responsibility for his health and behavior, and consequently being 'modern'.

In the next section of our theoretical framework we will develop our theoretical perspectives on gender and development, with a particular focus on gender and HIV.

## 2.4. Gender and Development Theory

Through our analytical framework, we aim at investigating how development is defined, and how HIV prevention as a development problem is addressed through circumcision in South Africa. Where post-development criticism provides a critical perspective on interventions, this section focuses on gender as an issue within development theory and practice. We will start by focusing male sexuality as this is central to constructions of masculinities in South Africa. This is also important in order to understand how masculinity notions influence on the spread of HIV in South Africa.

### 2.4.1. Male control over sexuality in South Africa

Wood and Jewkes (Wood og Jewkes 1997) argue that power relations between men and women in South Africa are unequal. Men dominate over women in that they control when and if a woman should conceive, whether condoms should be used, and when sexual intercourse should take place[21]. In addition Wood and Jewkes emphasize that power relations between women and men can have many forms, but in a South African context they commonly occur as sexual violence and assault (Wood og Jewkes 1997, 41-

[21] Similarly, Magrethe Silberschmidt (2004) argues that the socioeconomic changes have lead to disempowerment of men, which is linked to sexuality and the spread of HIV based on research in East Africa. Men are incapable of fulfilling social roles and expectations; hence masculinity is strengthened by multi-partnered relationships and sexually aggressive behavior (Silberschmidt 2004:234). Based on Silberschmidt's research demonstrating masculinity includes having control over women (Silberschmidt 2004:244). Due to the crisis of masculinity and men's disempowerment, Silberschmidt argues that men are not willing to let go of their previous position of power as e.g. the head of the household and providers. Men demonstrate that position by irresponsible sexual behavior and thus conform to hegemonic masculine values (Silberschmidt 2004, 245)

42). About 85 percent of all HIV transmissions in South Africa take place in heterosexual relations (South African National AIDS Council 2007, 85). Men's control in sexual relations plays a central role in the construction of masculinity in South Africa. Circumcision is an intervention that involves a bodily surgery on the genital male parts and therefore, in a very concrete way, enters the realm of sexuality by comprising a physical change. Masculinity and gender relations are therefore highly relevant for our study on a HIV prevention method aimed at men in South Africa. There is a growing body of literature on how constructions of masculinity contribute to the spread of HIV and AIDS in heterosexual relationships. We will now briefly describe some of the issues that have been studied on the interrelatedness of notions of masculinity and HIV infection in South Africa.

Patriarchal norms remain dominant in South Africa where control of sexual relationships and control over gender relations are central components of male identity for many South African men (Harrison et al. 2006). Furthermore, there is a belief that men must have a variety of sexual partners to attain sufficient sexual release (Lynch, Brouard and Visser 2010, 17). The practice of having multiple sexual partners is common. At the same time it is described as "high risk" sexual behavior in terms of spreading HIV. Notions of masculinity are used to explain the high risk sexual practice of non-condom use, which is common. Condom use is for many not compatible with being a real man; it is "unmasculine" (Lynch et al. 2010, 17, Foreman in Chant 2000).

Moreover, men are expected to be in control and invulnerable. On that basis illness is perceived as unmanly as it exposes vulnerability and a lack of control (Lynch et al. 2010, 16). In South Africa men are hesitant to visit health clinics and consequently remain unaware of their HIV status and uninformed of HIV prevention information. One explanation is that this is a result of an understanding of what it means to be a real man, which cannot be combined with seeking medical assistance and thereby showing

vulnerability (Peacock, et al. 2008, 1, Lynch, Brouard and Visser 2010, 16, Greig, et al. 2008, 35).

We will now continue with theoretical perspectives with a specific focus on the crisis of masculinity in South Africa. We draw on Robert Morrell in our theoretical framework on masculinities as he has done extensive work on masculinities in South Africa. We therefore see his perspectives on masculinities as applicable and relevant to our study on masculinities in an intervention taking place in South Africa.

### 2.4.2. 'The crisis of masculinity' in post-apartheid South Africa

After apartheid and the transfer of power from predominantly white, male, Afrikaans speaking elite to African male elite, the economic reality and political violence in South Africa has had deep implications for gender relations and male identity. After apartheid there was an expansion of the African middle class, but in proportion to the overall black population it was only a small percentage of blacks expanding as the middle class. Morrell emphasizes that the economy in South Africa is growing slowly[22] and has not managed to provide employment for people who have been unemployed their whole life (Morrell 2000, 109). Morrell argues that the South African reality is that "men no longer make decisions, no longer provide for the family" (Morrell 2000:109). In addition Morrell emphasizes that the absence of men in households not necessarily indicates a man's declined interest or influence in family affairs, but rather "the decline of authority and self-esteem among many men" (Morrell 2000, 109). The above notions of men having less authority and self-esteem in South Africa after apartheid have shaped gender relations and male identity in the country. Understanding the specific context of masculinities in South Africa is relevant in order to understand why we focus on gender and HIV as a

[22] Morrell refers to a growth on around 2 percent a year (Morrell 2004:109)

development issue. Men's declining authority comes from a decline in wealth in South Africa generally which, as already mentioned, has affected the man's position in the family. The next part of this chapter deals with gender and development theory and how it became concern of international agendas.

### 2.4.3. Historical background for focusing on gender in development

Gender relations' influence on the spread of HIV in South Africa has been a subject of interest to various scholars, and the theme is continuously being analyzed. The aim of the following paragraphs is to provide theoretical understandings and perspectives of the fields of Women in Development, Gender and Development and masculinity theory. We will draw from these theories in our analysis on circumcision for HIV prevention as a gendered intervention in South Africa in chapters six and seven. We will now give a historical introduction to gender approaches in development, which started with an exclusive focus on women. Both theoretically and in the practice of aid interventions, the issue of women and development has been characterized by its constant shift of approaches to understanding the role of women in development. The constant change is reflected in the strategies and goals of interventions targeting women (Richey 2000, 394).

The link between gender and development issues has been studied since the 1970s. In the early 1970s Esther Boserup published "Women's Role in Economic Development" in which she was the first to use gender systematically as a variable in academic analysis. Subsequently, the term 'Women in Development' came into use (Rathgeber 1990, 490).

In the 1970s, the first generation of gender sensitive approaches were simply called Women in Development (WID) and intended to add the specific consideration of women into development interventions (Richey 2000, 394, Chant 2000, 8). Through the emergence of WID, it was recognized that women's experiences of development differed

from that of men. Thus it became institutionalized and legitimate to focus on women's perceptions and experiences as a research topic. WID aimed at improving the integration of women into existing societal structures, such as the educational system and the labor market. New interventions or 'technical fixes' were seen as a solution that could improve women's situation and help them achieve better participation in education and the labor market. However, the notion of WID is criticized for several reasons of which we will highlight a few. Rathgeber argues that the WID approach is nonconfrontational and accepts existing social structures without critically addressing and questioning the underlying reasons for women's subordination and suppression (Rathgeber 1990, 491). In line with the nonconfrontational approach, WID is being criticized for its focus on individual women as a target group and thus making individuals responsible for their own development (Richey 2000, 399). This focus has distracted attention from the underlying reasons for women's underprivileged situation. The 'failure' of addressing women in their gendered context was approached differently with gender and development. Rather than a specific focus on women in development, the focus moved to gender relations.

## 2.5. Gender and Development

Following WID, the gender and development (GAD) approach was introduced in the 1980s and 1990s. Addressing how gender relations impacted gender inequalities was now put to the forefront. GAD, as a theoretical concept, is not concerned exclusively with women, which is the case in WID, but gender relations. More specifically it concerns itself with the social construction of gender that determines roles, responsibility and expectations to men and women respectively. GAD also calls on the state to promote women's emancipation (Rathgeber 1990, 494). GAD emphasizes the importance of gender perspectives at all levels of development planning processes and gender relations are placed in the centre, as opposed to the periphery, of development practice (Chant 2000, 8). The GAD approach is fundamentally different to the attempts of WID. It does not, like

WID, attempt to integrate women into existing structures through designing women-friendly interventions and affirmative action strategies. Instead GAD challenges social structures and institutions by requiring “structural change” and “power shifts” (Rathgeber 1990, 495).

A major critique of GAD is that in practice it still enforces the WID approach of primarily addressing women and thus translates gender into meaning “women” (Marchand 2009, 923) and women-only projects have continuously been the prevailing way of addressing gender issues in development (Richey 2000, 407). There are a number of problems related to excluding men from GAD of which we will highlight two here. Some examples are stereotyping men and women into categories of “good girls” and “bad boys” and emphasizing women’s vulnerability and inability to resist suppression from men. This is problematic as it establishes women and men as inherently in opposition to each other and also gives the impression that men’s power and position is unchangeable (Cornwall 2000, 20; White 1997 in Chant 2000, 10). According to Chant, it is problematic regarding men’s power and position as unchangeable, as gender and gender relations are negotiable and dynamic, as opposed to static. Moreover, addressing the problem of gender inequality by addressing women exclusively puts a great burden on women and Chant advocates for a shared responsibility by both men and women in dealing with gender relations (Chant 2000, 10).

Inspired by the critique of WID and GAD we will critically assess the ‘gender approach’ of two women’s rights initiatives which will be the focus in chapter seven. They are concerned that male circumcision for HIV prevention will potentially be implemented at the expense of women’s sexual and reproductive health, which will have consequences for gender equality in South Africa. To avoid this, the women’s rights initiatives advocate for an increased distribution of female condoms to women. In the next paragraph we look at “practical” and strategic gender needs which are two useful tools within GAD. We apply

them in chapter seven to analyze arguments for female condoms as a way of securing women's health and gender equality in a time of the scaling up of circumcision in South Africa.

### 2.5.1. Practical and strategic gender needs

GAD operates with a distinction between different types of gender needs and the interventions designed to meet them. These needs are "practical gender needs" and "strategic gender needs", which are concepts developed by Molyneux (Molyneux 1985 in Richey 2000, 403).

The terms "practical gender interests" and "strategic gender interests" from development literature are similar to the distinction between short and long term objectives (Baylies 2000, 18) and will be used synonymously in this thesis. First, we will explain the two concepts overall, then afterwards in the specific context of HIV and AIDS in order to elaborate on how we will use these concepts in our analysis in chapter seven.

The two concepts are based on notions of real and perceived power relations (Baylies 2000, 18). The needs are identified by men and women "within socially accepted roles in society" and arise from existing gender relations (Richey 2000, 403). Practical gender needs can be met through initiatives that relieve hardships that a gender is subject to, but they do not imply any fundamental change in prevailing patterns of gender relations (Baylies 2000, 18). The practical gender needs can be inadequate housing, water, health, employment, etcetera (Richey 2000, 403). In our case practical gender needs refer to needs related to HIV prevention options and access to these options. Practical gender interests can, however, challenge existing structures of power in some cases but also consolidate them or simply have a neutral impact (Baylies 2000, 18). On the other hand, responses to strategic gender needs challenge the existing gender power relations:

> Meeting strategic gender needs require policies to improve women's status, promote equity and remove biases against women in both the public and private spheres; they are clearly a challenge to the gender status quo (Richey 2000, 403).

Now we have sketched out the difference between the concept of practical gender needs and strategic gender needs, we will continue by looking at how the two concepts will be applied in our analysis of gender in a HIV prevention development intervention. The two concepts provide tools to discuss the probable consequences of an intervention (Baylies 2000, 18) where we, in chapter seven, focus on consequences for women in the scale up of circumcision for HIV prevention. They two concepts serve as tools to assess whether an intervention is consistent with perceived practical or strategic needs. The distinction between practical and strategic gender needs is, according to Baylies, "useful for examining how far short term interventions are consistent with and permit progress toward long term objectives" (Baylies 2000, 18). In chapter seven we examine how female condoms are assumed to impact long term objectives such as increased gender equality. Besides WID and GAD we will draw on perspectives and theoretical concepts of masculinity theory which we will present below.

### 2.5.2. Men's involvement in HIV prevention

As women do not control their sexuality and bodies independently of men, HIV prevention methods targeting men may be beneficial to both men and women. According to Rathgeber (1990), women's position will not change if men are not addressed in development efforts. Furthermore, she argues that the long-term sustainability of development processes is contingent on involvement of both men and women: "Planning for change in women's lives clearly entails changes for men, with structural shifts in male-female power relations being a necessary precondition for any development process with long-term sustainability" (Rathgeber 2005 in Chant 2000, 8). There are also arguments

specifically related to the necessity of men's involvement in of HIV prevention. Jewkes, who is a South African scholar, states that "changing men is clearly critical for HIV prevention in women" (Jewkes 2009, 37). Within the field of health men's involvement is in particular important based on the dominance of men in sexual relations. Wood and Jewkes (1997) argue that women do not autonomously govern their own bodies and thereby their own sexual health and hence men cannot be ignored when addressing women's needs (Wood og Jewkes 1997).

In GAD gender relations were scrutinized but, according to Cornwall, the focus was on women in relation to men. Men's identities and roles were not studied per se (Cornwall 2000, 18). In the following paragraph, we will elaborate on masculinity theory as a break away from the specific focus on women of the WID or the "women in relation to men" perspective in GAD, into a study of men specifically. Cornwall argues that masculinity theory provides a framework that can deepen the understanding of men's identities further than representations of men as oppressors of women (ibid).

### 2.5.3. Gender and hegemonic masculinity

We take point of departure in gender theory elaborated by Connell. Connell's research creates a base to analyze masculinities more in depth, and goes beyond only understanding men in opposition to and as oppressors of women. Second, we present perspectives on masculinity in South Africa by Robert Morrell, a South African scholar. In the following paragraphs a theoretical introduction of the notions of gender and masculinity will be presented. In the methodological chapter we will further elaborate on what these definitions mean to our analytical approach.

### 2.5.4. Gender - the feminist poststructuralist assumption

We rely on Connell's definition of gender. Connell bases her definition on a poststructuralist assumption where "nothing 'human' is outside discourse". Society is a world of meanings, and gender is an example of such meanings. A 'man' and a 'women' are embedded in tremendous systems of understandings. These understandings are shaped by social processes that are historically contingent (Connell 2009, 83).

In feminist post structuralism gender is discursively constituted through a historical process of old and new discourses that are produced and reproduced. Several discourses compete to define the social order and meaning and identities of different actors. This leads to the question of how institutions, identities and activities come into being articulated in certain ways inside historical contingent discourses. The distinction between biological gender and social/culturally constructed gender is dissolved as the meanings of bodies are discursively formed by the historically specific discourses (Stormhøj 2005, 480-481). In other words, gender is a dynamic system which is in a constant process of change, and is changed through a historical process (Connell 2009, 89-90). Therefore, gender is different from context to context depending on the power structures of the given context. Gender often appears unchanging, but in fact it is in a constant process of changing (Connell 2009, 11). As we base our approach on Connell's definition of gender, and its poststructuralist base, we do not analyze gender as a given present reality. In feminist empiricism gender is explained based on the biological gender (Stormhøj 2005, 488). We however, focus on gender as a social process. We will focus on how gender categories, especially masculinities, are negotiated and potentially undergo changes in South Africa due to the types of discourses and practices that the Brothers for Life campaign, among others, promotes. Concretely, this means that we are analyzing how the changing of men's bodies through circumcision for HIV prevention, together with the discourses of public health is forming new meanings for gender identities. Due to our

historically contingent definition of gender, the conclusions of this thesis regarding gender are context-specific, and would look different in another setting or other time in history.

In order to further analyze the negotiation of masculinities we will draw on the concept of hegemonic masculinity which we will now present. This notion plays a central role in the analysis in chapter six.

### 2.5.5. Hegemonic masculinity

Morrell (1998) bases his work on several theorists including Connell who then together with a group of scholars produced an approach to masculinity called the "New Sociology of Men". This approach rejected the essentialist, and at times biological, understanding of men and embraced a social constructivist approach where gender identities are created socially and historically, and negotiated through a continuous process. Therefore, there is not one universal masculinity, but several masculinities. Masculinities are forged as result of changes in society and simultaneously affect society. In every society there will be a variety of masculinities that are shaped by the races and classes present in the respective society. The dominant masculinity within a society can be termed the "hegemonic masculinity". This hegemonic masculinity both subordinates women and also silences and subordinates other types of masculinities, additionally it presents its own version of what a "real man" is. The real man is a normative cultural ideal or image of how a real man behaves or should behave (Morell 1998, 608). The South African hegemonic masculinity is characterized by many scholars by its control and dominance in heterosexual relations as described earlier in this chapter. The hegemonic masculinity is, due to the emphasis on fluidity and contestation of gender identities, not static but changed as it is challenged by rival representations of masculinity (Morell 1998, 606-608). Moreover, Morrell argues that the notion of hegemonic masculinity "provides a way of explaining that though a number of masculinities coexist, a particular version of masculinity holds sway, bestowing

power and privilege on men who espouse it and claim it as their own" (Morrell 1998, 607-608). The men who do not conform to the hegemonic masculine ideals consequently seem inadequate, as expressed by Caroline Sweetman (Sweetman 1997). She elaborates that "each man's has varying 'success' in conforming to the norms of hegemonic masculinity, depending on experience, upbringing, and external context" (Sweetman 1997, 3) and masculinities are thus subject to other competing masculinities as well as changing circumstances and surroundings. We will use the notion of hegemonic masculinity to analyze the 'new man' the Brothers for Life campaign is promoting. We analyze it by looking into modern and traditional notions of masculinity and how these are produced and reproduced in the campaign.

In a South African context, Morrell focuses on new and old African patriarchy where the latter is defined by notions of dominance and authority. In the analysis on men's involvement in HIV prevention, we focus on new patriarchy to a larger extent, which supports Connell's view on alternative masculinities. Similarly, new patriarchy is an alternative to old patriarchy. We have already explained notions of old patriarchy above by describing men in their dominant and patriarchal setting. Below, we focus on alternative roles of men in a South African setting.

### 2.5.6. New African patriarchy

Morrell emphasizes a new gender order which is characterized by non-abuse of women, respect, tolerance, justice and openness (Morrell 2000, 114). However, many men in South Africa are "assailed by the pressures of unemployment and political powerlessness, and still located in social structures that validate masculinity in terms of physical toughness, competitively proving themselves against other men" (Morrell 2000, 115). The new gender order might be emerging but masculinity is still very much defined around values of old patriarchy.

We will further elaborate on the connections between our overall theme of responsibility and the involvement of men in HIV prevention by exploring the views of Baylies and Bujra (Baylies and Bujra 2000) and Baylies (2000) in the following paragraphs. However, to address male behavior brings out questions as to how it should be done. In that regard, it is relevant to discuss whether to address men individually or collectively, and if women should be separated from the discussion or join in. This will be expanded in the following.

### 2.5.7. Involving men in HIV prevention – by appealing to paternalistic interests

Baylies (2000) emphasizes that greater attention should be placed on men in terms of halting the spread of HIV. However she is also concerned that this may happen at the expense of the mutuality of interests of both sexes (Baylies 2000, 21-23).

Mantell et al. (2006) highlight that men might be motivated to be involved in HIV efforts if the involvement appeals to men's paternalistic interests. If men play an active role in providing health care to their families, this could both be beneficial to himself and the health of their families. Simultaneously it could be a way to strengthen masculinity as the man is able to play a role as provider (Mantell et. al. 2006, 2005). This is relevant to a South African setting where men have lost self-esteem and authority in the family. Focus on men's responsibility may however also increase gender inequality if the emphasis on men's responsibility reinforces their dominance and the subordination of women (Baylies and Bujra 2000, 195-196, Mantell et al. 2006, 2005). Baylies and Bujra point to that it may be more beneficial to utilize strategies that "stresses equality aspirations for life, mutual respect between men and women, mutual responsibility and mutual benefit from intimate relations will have far more profound effect" (Baylies and Bujra 2000, 195-196).

### 2.5.8. Towards gender sensitivity: excluding one gender over the other?

Brothers for Life emphasizes men's responsibility in HIV prevention and do not address women. In chapters six and seven we analyze the outcomes of the initiatives addressing HIV prevention through focus on one gender alone, and excluding the other. The focus on one gender alone in HIV prevention is problematic whether it is on women alone as in WID, or concentrated on men.

Baylies argue that the mutual interest of both sexes should be at the center. In identifying men's self interest in gaining more authority in the family, "it is important that strategies of protection against HIV do not simply reinforce men's paternalistic role as responsible for – rather than *equally* responsible *with* – women" (Baylies 2000, 23, emphasis in original). In that regard, Baylies and Bujra emphasize that closer linkage between women's empowerment and male involvement need to be established (Baylies and Bujra 2000, 196).

# 3. Methodology

## 3.1. Methodological approach: A 'Vertical cut'

As mentioned in the introduction, we see our approach as a "vertical cut" top-down approach that analyzes circumcision for HIV prevention at three levels; the international level, the national level and the level of gender relations. At the international level we focus on the WHO and UNAIDS as they are the central multilateral organizations working with HIV in South Africa. They recommended the use of circumcision for HIV prevention after links between male circumcision and reduction in female to male HIV transmission was established by the three randomized controlled trials in South Africa, Kenya and Uganda. Therefore, the WHO and UNAIDS policy papers and recommendations will be part of our empirical material.

At the national level we focus on the South African government and South African civil society (NGOs). The Brothers for Life is a campaign carried out in collaboration between the South African Health Department and civil society organizations, as well as international development agencies. Our empirical data utilizes campaign material consisting of the brochures "Time to get wise – Circumcise!" (Brothers for Life 2010) and "Get circumcised. Know the facts" which will be the direct objects of analysis (The AIDS Helpline, The Department of Health KwaZulu-Natal, Brothers for Life, Sonke Gender Justice 2001). Furthermore, we analyze two reports by two women's rights initiatives advocating for female condoms. These women's right organizations are called The Women's HIV Prevention Tracking Project (WHiPT) (Arnott og Kehler 2010) and Thohoyandou Victim Empowerment Programme (TVEP) (Thohoyandou Victim Empowerment Programme 2008). They will be presented further in chapter seven. The

focus on male circumcision and female condoms will serve as a comparative focus, as both are technical measures in HIV prevention with gender implications.

On the national level we focus on how circumcision as a public health initiative changes individual bodies of men in the South African state and consequently change gender relations. This level will be illuminated and analyzed by drawing on scholarly literature on HIV and Gender in South Africa. Utilizing the "vertical cut" we will operate on different levels in the analysis. The main emphasis will however be on the impact of national and international actors' HIV prevention approaches on individual decision-making and gender relations.

We use empirical material derived from Brothers for Life, WHiPT, and TVEP, as they represent different perspectives on gender and HIV. However, the main focus of the study is on men and masculinity as men's involvement is the focus of our research. Masculinity in South Africa is to a large extent defined around sexual relations between men and women. According to Morrell, sexuality plays a central role in masculinity, and men's masculinities therefore cannot be seen in separation from their relationships to women (Morell 1998, 629). Furthermore, the theoretical gender approach of the thesis is relational. Hence none of the chapters focuses exclusively on one gender. More precisely we hence have chapters that *primarily* focus on one gender, but no chapter focuses exclusively on one gender.

## 3.2. Choice of method – in a new study field

Circumcision for HIV prevention is a very recent phenomenon. Hence the topic is still under-researched and social science research in the field of circumcision for HIV prevention is relatively limited. As said in the introduction of the thesis, WHO and UNAIDS first recommended circumcision in 2007 and circumcision for HIV intervention is now

starting to be implemented in several countries in Sub-Saharan Africa[23]. Hence this thesis is contributing to social science research on male circumcision for HIV prevention which is not yet, but most probably will become a subject of study as the scale up of circumcision takes place in South Africa and in more sub-Saharan countries over the next couple of years.

Conducting field work was a relevant option due to the limited amount of research and data on the topic of our thesis. It could however have been difficult to collect meaningful and enough data as circumcision for HIV is a relatively new initiative. There is plenty of scholarly literature of HIV and gender in South Africa. The very developed body of research on gender and HIV in South Africa has made it possible for us to access data from multiple sources in order to answer our problem formulation in a thorough manner. The existence of data which is directly linked with circumcision for HIV prevention and gender is, as already mentioned, very limited. Hence our empirical material consists of both text and literature that make links between issues of gender and circumcision and material on gender issues linked to *other* prevention methods. The latter are however still very relevant as they provide us with insights that point to tendencies and experiences from other HIV prevention methods that can give us indications of potential gendered implications of circumcision for HIV prevention.

Drawing on secondary data has been a major advantage as we have been able to access data from various sources in a short time which, from a pragmatic viewpoint, has been helpful considering the relatively short time span for writing the thesis.

[23] (Irin Plus News 2010)

## 3.3. Why focus on South Africa?

Here we want to highlight our motivation for choosing South Africa as our case. South Africa is one of the locations of the randomized clinical trials that established the relationship between medical circumcision of men and a reduced risk of female-male transmission. Due to South Africa's central role in the trials, the topic has, since the beginning of trials, received attention both in the public sphere and in research on HIV prevention in South Africa. Choosing South Africa or one of the other countries of the trials (Kenya and Uganda) seemed most relevant, as these have already been generating knowledge that we can build on. Moreover, we had already been acquainted with the subject of circumcision for HIV prevention while interning in South Africa in NGOs working with HIV and gender. Thus, choosing South Africa as our geographical area of interest was based on the established familiarity with the setting. While staying in South Africa we got to know the debates on gender violence and HIV through our work, the media and conversations with people. We encountered critique pointing to the possible counter effect that circumcision may have for women's HIV risk and position in gender relations. Our initial motivation to research on circumcision for HIV prevention was hence an interest in how circumcision for HIV prevention would impact on women. During our stay in South Africa we both worked in organizations working with human rights of vulnerable groups, with a great emphasis on women's rights. Men's involvement in development problems, such as HIV prevention had, if it had any, a peripheral position within the organizations. As we initiated our research on male circumcision, we encountered the Brothers for Life campaign. Their approach caught our attention, especially since previously in our work in South Africa we had not been presented to approaches that focused on men as a solution to HIV and AIDS. This shifted our initial focus on women into focusing primarily on men in HIV prevention. We were further motivated when reading more of the academic literature on the HIV reducing potential associated with men's involvement and the fact that the research on men's involvement in HIV prevention is a

growing research field. Our research focus on men's involvement through circumcision intervention is thus contributing to a very vibrant and relevant research field in today's research within the field of HIV prevention.

Furthermore, being familiarized with the South African context was helpful, especially in terms of pointing our attention to our research topic. It was also very helpful for us that we had personal contacts in South Africa who, especially in the initial phase of our research, could direct our attention to relevant empirical material.

## 3.4. The relationship between our theory and empirical case

Since the beginning, our research has been motivated by an interest in understanding the gendered implications of the empirical case of circumcision for HIV prevention in South Africa. The initial focus was, as described above, on women and thus we began to search for theory on women and development. As our interest shifted to men's involvement in HIV prevention our empirical change also informed a theoretical shift where we started to look into masculinity theory.

During our research we encountered the notion of the therapeutic citizen by Nguyen. The theory pointed to issues on the relationship between the state and the individual but in relation to ARV treatment. This concept inspired us to reflect on what the implications might be when the state asks individual men to change their bodies to improve the health of a country or in other words to solve a development problem such as HIV. As we read more on the therapeutic citizen we encountered Robins and Richey who both focus on the therapeutic citizen in a gendered perspective. Their expansion of the concept helped us to create a link between gender and individual perspective in the therapeutic state provided by the notion of therapeutic citizen. Robins' expansion of the therapeutic citizen to a "responsible citizen" broadened our perspective to the extensive emphasis on men's

responsibility in the circumcision campaign of Brothers for Life. In our further reading on masculinities we encountered specific literature on men's involvement in HIV prevention. Thereby we were able to get further understanding of possible gender implications when involving men in HIV prevention.

Besides gender theory we also looked for theories which could give us insights into circumcision as a development intervention. We chose to use post-development critique of development interventions as this could provide us with perspectives for a definition of development interventions and provide critical perspectives on development interventions. As we read post-development theory we encountered a critique of development as a transition of individuals from tradition to modern. Post-development theory critiques development for being controlling discourses and practices that are formulated and implemented by states and international development actors. This informed our initial interest in the relationship between the state and the individual to also include the international level of the WHO and UNAIDS that together with the South Africa state sets the development agenda in HIV prevention.

## 3.5. Gender definition

"Gender" and gender relations are central concepts in this thesis and will be defined here. We rely on Connell's (2002, 2009) definition of gender. She describes gender as "a matter of relations within which individuals and groups act" (Connell 2009, 10). Seeing gender as relational is in opposition to a focus on "differences" between men and women. A common way of defining gender is to explain cultural differences between men and women based on the biological division between men and women (Connell 2002, 8-9). Connell criticizes this view as simplistic as it explains social arrangements as mere results of bodily differences (Connell 2009, 11). Defining gender in terms of bodily difference represents a feminist empiricism approach where "men" and "women" are objective

realities that can be identified primarily by the anatomic differences in sex (Stormhøj 2005, 476). In Connell's definition, gender arrangements are reproduced socially and not biologically. This does not mean that biological differences and physical bodies do not matter. But explaining gender arrangements in a given society on the basis of reproductive difference between men and women does not suffice. Instead the process of gender is both related to bodies *and* social processes. This process is contained in the concept of the 'reproductive arena' in which bodies are brought into social processes where society addresses bodies and deals with reproductive differences. Connell uses the notion of the *reproductive arena* to solve what she calls "the paradox of difference" to define gender as: "the structure of social relations that centres on the reproductive arena, and the set of practices that bring reproductive distinctions between bodies into social processes" (Connell 2009, 11). Hence gender arrangements are not a result of bodily differences but bodily differences do play a central role in the constitution of gender as they are brought into social processes. Thus, the biological gender is central to the intervention of circumcision. Thereby, men are addressed due to their reproductive difference. The body is becoming part of a social process, where the physical change of the penis, leads to new meanings of gender. These meanings are connected to the poststructuralist base of Connell's concept of gender which was elaborated in our theoretical chapter two. In the following we present how our definition of gender shapes our analytical approach to circumcision as a gendered intervention.

## 3.6. Circumcision as a "gendered intervention"

Our thesis relies on the assumption that an intervention is not gender neutral. We work on the basis that foreign aid interacts with gendered power relations. Foreign aid can exacerbate gender inequality. As gender relations are based on the unequal distribution of different kinds of power, for example physical, social and economic power, interventions bringing in new resources causes changes in power balances (Richey 2000,

420). Our particular focus is on how the intervention of circumcision interacts with power balances in gender relations in South Africa. Our theoretical tools to analyze gender relations and men's and women's control over sexual health derive from WID, GAD and masculinity theory, which we already have introduced.

In feminist research there is no such thing as "gender neutrality" and a gender sensitive perspective is employed in an analysis of the "social" (Stormhøj 2005, 473). Hence, this thesis is a continuation of the tradition of feminist research and in line with the feminist post structuralism.

## 3.7. Circumcision influencing practices in sexual relations and discourses

Our gender definition is relational and is constituted through bodily and social processes where both gender structures and gender practices are influenced and changed by each other. Bodies are interconnected through social practice. In practices where bodies are involved social structures are formed and new practices emerge (Connell 2002, 47). Medical circumcision as a biological HIV prevention method only addresses men's bodies directly. Men's and women's bodies are however deeply interconnected in the practice of sexual relations. It is potentially in these relations that men and women transmit HIV to their sexual partner. Gender organizes social relations, which shapes opportunities and constraints surrounding sexual interactions between men and women (Mantell, et al. 2006, 1999). Therefore, we focus on the opportunities and constraints that circumcision and female condoms provide for women and men's control of their own sexual health. On a more concrete level, the control of men and women is analyzed by focusing on prevention options and the influence and power that men and women respectively have in decisions about HIV prevention in sexual relationships. Furthermore we analyze how

this control might enhance current power structures or lead to changes in current gender structures and identities.

As we have argued, gender and HIV are two notions closely connected in a South African context. During the time of the scale up of circumcision in South Africa, sexual behaviors or practices in sexual relationships are being addressed and potentially changed. This thesis seeks to analyze the discursive level of gender. Different discourses compete to define the order of the social world and its meanings, including identities of different actors (Stormhøj 2005, 480). The Brothers for Life campaign represents an attempt to introduce a new meaning of masculinity in South Africa. The analysis of discourse is however deeply linked to the level of practice, which we have explained above, as we focus on how practices of gender are shaped and potentially changed when identity discourses and ways of thinking about what it means to be a man changes.

## 3.8. Control and responsibility in a HIV prevention intervention

We rely on therapeutic citizenship as the overall framework that provides us with a way to think about the individual decision to undergo circumcision in relation to the broader needs of national and international actors to decrease HIV rates. Our focus is on how circumcision, when becoming subject to the broader interest of public health and the targets of development interventions, influence individual choices both related to the medical procedure of circumcision but also choices concerning social behaviors, which in turn leads to changes in gender relations.

The development intervention of circumcision is our focus area. We understand development interventions within the framework of Cooper and Packard's post-development critique of development as controlling discourses and practices (Cooper og Packard 1997, 3). Control is embedded in the power to define a development problem

and to define a solution to a development problem. In our case the WHO and UNAIDS suggest circumcision as an important method to reduce HIV transmission. Post-development theory critiques development discourses and practices. In connection with the critique of development presented by post-development theorists Cooper and Packard, as well as Ferguson, we rely on the definition of development as entities that transition from traditional to modern. This could both be individuals and states. Traditional, underdeveloped, and non-Western is typically defined in contrast to being modern, Western, and developed. The transition in focus is thus from an underdeveloped entity to a developed one. The transition from "irresponsible men" to "responsible men" is the overarching focus in the campaign which we elaborate on in the analysis.

We analyze how the solution that circumcision presents in HIV prevention is articulated in the Brothers for Life circumcision brochures. The campaign clearly communicates that the intervention requires men's collaboration; that men need to become responsible and act in a particular way subsequently to being circumcised. Our particular focus is on how these discourses define how 'responsible men' act and behave in HIV prevention. Due to our grounding in feminist theory we anticipate that gender relations change and are also impacted in the process of the circumcision intervention. We particularly focus on how hegemonic masculinity is sought to be challenged and changed through campaign discourses on what it means to be a 'responsible men' and how men ought to behave sexually. We also analyze how the perspectives of a 'responsible man' might affect the control of men and women over their own sexual health respectively as well as gender relations in the scale up of circumcision.

## 3.9. Generalizability

Gender patterns differ in different contexts (Connell 2002, 10). The apartheid history of the country has played a central role in the way gender relations in South Africa have

developed (Jewkes 2009). In that sense the gendered structures in South Africa are unique as they have emerged from a historical development that is specific to South Africa. Hence our findings are not directly applicable to other sub-Saharan countries where circumcision is being implemented.

But at the same time other countries in sub-Saharan Africa experience similar challenges related to HIV prevention and gender. Similar historical processes and developments are factors that can contribute to explain some similarities between South Africa and other countries in Sub-Saharan Africa. Colonization has restructured local gender orders (Connell 2009, 92-93). Silberschmidt (2004) has studied how socio-economic changes in East-Africa have affected men's lives. The colonial power's introduction of migrant work has played a central role. In that process men's role as providers has weakened and thus their position as the head of the household. She concludes that the socio-economic transformation has caused an escalation of gender antagonism and domestic violence. Men have attempted to hold on to their positions as the head of the household by demonstrating control over women, including using violence (Silberschmidt 2005, 236-244). In South Africa the trajectory of migrant work has likewise affected men's role in the family. Men's role as providers has weakened and the deterioration of men's authority as heads of the household has exacerbated sexual violence, as dominance over women in sexual relationships has been used as a compensation for lost power in other areas (cf. chapter two) Thus similar socio-economic developments and notions of masculinity that are common to many former colonies in sub-Saharan Africa means that this thesis' findings might very well also be relevant in other settings in sub-Sahara countries where circumcision is implemented as an intervention.

The practice of circumcision, either medical or traditional, varies in levels in the different countries where circumcision for HIV prevention is implemented. Circumcision for HIV prevention is both being introduced into non-circumcision communities and circumcising

communities. Consequently the acceptability will both depend on the willingness to introduce a new practice and the willingness to integrate new meanings into current meanings of the practice of circumcision. Also within South Africa the traditions of circumcision differ among ethnic groups. Our results can thus not be generalized to all provinces and ethnic groups of South Africa, as only some ethnic/religious groups are already practicing circumcision and attach different meanings to it, including meanings of masculinity. To generate knowledge on how circumcision can best be implemented in a very ethnically diverse South Africa would require in-depth geographically defined anthropological studies.

Due to our focus on the national level, our findings do not only apply to specific groups but produce knowledge on how gender categories are used on a national level and interact with discourses and practices that affect each other in a gendered context of circumcision. Moreover, due to our focus on the overall national level we operate with broad categories of “women” and “men”. This also means that our findings do not apply to all men and all women, as we acknowledge the existence of various sub-categories of men and women.

# 4. Background chapter

This chapter outlines the medical explanation of how male circumcision reduces HIV transmission followed by an in introduction to traditional circumcision. Afterwards we present the policy context in which the future circumcision strategy will be developed.

## 4.1. Reducing HIV through male circumcision - a medical explanation

We will briefly describe the biological facts that establish the relation between male circumcision and HIV prevention. In much of the literature we have encountered circumcision is presented as a controversial procedure, as the surgery alters the genitals of the individual and is an irreversible procedure, which many consider unnecessary, and not to be performed without the informed consent of the individual[24].

As male circumcision has been proven up to 60% safe in preventing HIV, several countries with high rates of HIV and low rates of circumcision are making effort to implement the strategy[25]. The biological facts about circumcision preventing HIV has to do with the foreskin of the penis. The foreskin contains a certain kind of cell, called Langerhans cells that are particularly susceptible to HIV. With the removal of the foreskin, the cells are also removed, and this particular susceptibility to HIV is then no longer present for men, thus

[24] Currently, boys are able to consent independently to circumcision only when they are 18 as the procedure is classified as an operation. In the future, when s12(8) of the Children's Act comes into operation, boys below age 16 can only be circumcised for 'religious' or 'medical reasons on the recommendation of a medical practitioner' (Strode, Slack and Essac 2010) whereas those above 16 may undergo circumcision for any reason. Boys over 16 must receive counseling prior to the circumcision, and they have the right to refuse circumcision" (Strode, Slack and Essac 2010)

[25] Several Sub-Saharan countries have implemented male circumcision for HIV prevention, which besides South Africa includes Botswana, Burundi, Kenya, Swaziland, Tanzania, Uganda and Zambia. (Clearinghouse on Male Circumcision for HIV Prevention 2011c) (internet source 7)

decreasing the risk of female-to male transmission. However after this procedure, women's susceptibility to HIV remains unchanged.

## 4.2. Traditional Circumcision and manhood in South Africa

In South Africa, the region of KwaZulu-Natal is implementing medical male circumcision, whereas the region of Eastern Cape performs traditional male circumcision[26]. Medical male circumcision is not seen as a 'real circumcision' to traditional healers and initiates who have been circumcised traditionally, and may lead to social exclusion[27]. Rather, amongst the amaXhosa[28] ethnic groups in the Eastern Cape, traditional male initiation rituals of male circumcision is part of a rite of passage, through which the initiate transitions from boyhood to manhood[29]. Male circumcision is thus intrinsically connected with ideas of manhood and defining a "real" man amongst the amaXhosa. A 'real man' is primarily defined by not showing weakness, and use of anesthetics and medical assistance/hospitalization during the initiation process is regarded as unmanly[30]**.** Similarly, men who are not circumcised traditionally are not 'real men'. Being a man is thus not defined by age, but by whether he has gone through initiation[31]**.** Men who have not been initiated in the amaXhosa circumcision rituals are legally still regarded as boys and not held responsible for their actions. They cannot own property or marry and thus do not have status in the community. Men who are not traditionally circumcised are considered irresponsible and the possible cause of things that go wrong in the community. These

[26] Kwa Zulu-Natal used to have circumcision rituals to "keep the Zulu warriors healthy". The Zulu King Goodwill Zwelithini has now called for the revival of the tradition of circumcision but to prevent HIV and… "keep the Zulu nation healthy" (Brothers for Life 2010).
[27] (WHO 2008a, 25)
[28] The amaXhosa is an ethnic group who lives predominantly in the Eastern Cape province of South Africa (WHO 2008a, 6)
[29] Not all Xhosa groups circumcise, as it is limited to the Tembu, Fingo and Bomvana groupings, and circumcision is traditionally not seen among the Bhaca, Mpondo, Xesibe or Ntlangwini (WHO 2008a, 10).
[30] (WHO 2008a, 15;45).
[31] Ibid:23

men experience social exclusion, name-calling and are likely to be the victims of violence[32].

Currently, the context in which male circumcision is implemented is unique for South Africa. This is due to patterns of gender and HIV, but also to traditional and cultural reasons for circumcision which has existed prior to male circumcision specifically for HIV prevention.

## 4.3. The policy context of HIV and AIDS strategies

### 4.3.1. Centralized versus broad-based HIV approach

Circumcision is being introduced in South Africa in the wake of a devastating HIV epidemic with 17.8 percent of the population aged 15-49 being HIV positive[33], a general poor state of the public health and a dysfunctional health sector. In economic terms South Africa is ranked as a middle-income country. Health indices are however lower than that of lower income countries. For example, life expectancy has been reduced by almost 20 years since 1994. Life expectancy is now 50 for men and 54 for women (Coovadia, et al. 2009, 817). The following quote sums up some of the factors that pose a challenge to combat HIV in South Africa:

> The combination of acute and chronic diseases spanning all age-groups and socioeconomic strata imposes a massive burden on an already weak and underdeveloped public health care delivery system, struggling to overcome poor administrative management, low morale, lack of funding and brain drain (Chopra, et al. 2009, 1023).

[32] Ibid: 24-25
[33] (UNAIDS 2009)

Not only is the health sector weak in the areas highlighted in the quote, the national approach to fighting HIV has, since 1994, been criticized for being ineffective. Historically AIDS programs in South Africa have been placed within the Department of Health and characterized by a top-down approach, centralized in the government:

> the government too often took sole responsibility for implementing policy (thus negating other potential role players) and too easily reverted to approaches that leaned narrowly towards a biomedical model, predominantly looking to the national and provincial Health Departments for implementation (Wouters, van Rensburg og Meulemans 2010, 180).

In South Africa HIV and AIDS has mainly been defined as a medical health issue and has also been addressed vertically by the Department of Health. Horizontal social factors, including economic, social and behavioral dimensions that drive the epidemic have not been addressed in the centralized approach (Wouters, van Rensburg og Meulemans 2010, 174-180). The unsuccessful attempt to break HIV rates in South Africa is often ascribed to a centralized approach in the national HIV strategy. Uganda, which is a low-income country, has been more successful than South Africa in its HIV efforts, which is ascribed to a multi-sectoral approach in national HIV work (Parkhurst og Lush 2004, 1921). It is argued that a sustained HIV reduction requires efforts that go beyond biomedical interventions and applies a multi-sectoral approach including interventions that address social determinants. In the South African context these are, for example domestic violence, changing the existing culture of men's behavior towards women and children, strengthening families, poverty reduction, etc. (Chopra et al. 2009, 1027). We will engage in this discussion in our analysis by looking at the interplay between circumcision as a medical intervention and the social issues of gender. Currently there seems to be a shift in the national HIV approach, which we will elaborate below.

### 4.3.2. The South African national HIV and AIDS strategy 2007-2011

The current national AIDS policy in South Africa, "HIV/AIDS and STI National Strategic Plan for South Africa 2007-2011" (National HIV and AIDS policy) focuses not only on the medical aspects but also socioeconomic and cultural dimensions of HIV and AIDS (Wouters, van Rensburg og Meulemans 2010, 171;179).

The policy has been getting positive attention; even by critics of the South African government at the time of the policy launch. It has, according to Wouters et al. been "announced as South Africa's most dynamic and comprehensive document yet on AIDS issues" (Wouters, van Rensburg og Meulemans 2010, 172;178). In addition, it has been praised internationally as an example of good policy (Coovadia et al. 2009, 828). The policy is praised for several reasons. First, it has been multi-sectoral in that several actors have been involved in the policy formation by consulting civil society, specifically the private sector and the government. Secondly, the plan is characterized as holistic and socio-medical and thus goes beyond the narrow medical approach of former governments (Wouters, van Rensburg og Meulemans 2010, 178-180).

To sum up, circumcision is being scaled up in a context of a devastating HIV epidemic and a generally strained public health sector. There has been a move from a centralized to a multi-sector approach in the national South African HIV and AIDS policies, which is articulated in the current national HIV and AIDS strategy. This also entails a focus beyond HIV and AIDS as a medical issue to social aspects that impact on the spread of HIV. However, in our analysis we point that circumcision for HIV prevention still in many ways has a narrow-based focus on the medical dimensions of HIV prevention.

Circumcision as an HIV prevention method has been discussed in South Africa since 2005 and below we will elaborate on the issues that have been raised by HIV stakeholders in South Africa regarding circumcision.

### 4.3.3. Implementation of male circumcision for HIV prevention in South Africa

Male circumcision is one of many HIV preventive strategies that have been introduced in South Africa. The area of HIV treatment and prevention is highly contested in South Africa (and internationally) due to for example ideology, religion, tradition, politics and social factors. We will look into some of the debates that circumcision has given rise to by focusing on the formation of a South African circumcision policy.

Critical voices have emphasized that the government has been too slow to implement a national circumcision strategy. The article titled "SA Male Circumcision Plan Almost There" (2010)[34] tracks the progress of several African countries in developing a national circumcision strategy. In the article it is stated that "South African stakeholders have been pushing since 2005 to have the government engage the issue of male circumcision" which in turn shows that there has been a close watch on the formation of a circumcision policy in South Africa.

Yet, six years after such statements have been made; there is yet not an official policy on circumcision in South Africa.

The article "Africa: Tracking the male circumcision rollout"[35] states that South Africa at this time had a draft policy, but no manual for training, quality assurance, or monitoring

[34] (Thorn 2009) (internet source 19)
[35] (Irin Plus News 2010) (internet source 11)

and evaluation. Another article titled "South Africa: Male circumcision: Why the delay?"[36] presents different reasons as to why a national circumcision policy has not been developed and concerns of different stakeholders. Professor Helen Rees, head of SANAC HIV prevention Committee as well as the executive director of the Reproductive Health and HIV Research Unit at University of Witwatersrand in Johannesburg, emphasizes that there was a possibility of providing circumcision in 2007, but it was not followed through, due to a lack of political will. This remark is referring to the Mbeki government, which we will elaborate later in this chapter. Furthermore, at the Social Aspects of HIV/AIDS Research Alliance (SAHARA) conference in December 2009 different civil society voices made their opinion on male circumcision. Moreover, women's advocacy groups were questioning the benefit of male circumcision for women. Traditional leaders practicing circumcision as a rite of passage for young men also expressed concerns that medical circumcision would interfere with the traditional circumcision. Social scientists in the afore-mentioned SAHARA Conference in December 2009, expressed their reluctance for a quick implementation of circumcision for HIV prevention, as they were emphasizing the importance of educating the target group on the effects and the limitations of the surgery prior to the roll out. This concern is based on data from other African countries where men who underwent circumcision as a preventive measure subsequently were acting in a high risk sexual manner based on the assumption that circumcision would keep them 100 percent safe from HIV infection[37]. Furthermore, the social scientists at the SAHARA conference emphasized the importance of a roll out that pays attention to underlying social and cultural factors and framing the roll out in the right way, in order to secure that the intervention will have the intended effect.

36 (Irin PlusNews 2009) (internet source 13)
[37] (Irin PlusNews 2009)

After consulting the representatives at the conference, SANAC presented several recommendations, which will be summed up below:

> After lengthy consultations, SANAC issued a number of recommendations including that rollout costs should not divert funds from female condom distribution and other programmes directly benefiting women; the procedure should be offered as part of a comprehensive sexual health package, including HIV counseling and testing; and communities should be informed that male circumcision was only partly effective in preventing HIV infection.38

The issues raised in the recommendations will, as already in the introduction of the thesis, be dealt with in our analysis. The next section of this chapter will present a view on the broader political context of HIV policies in South Africa and point to factors that seem to determine the political will to implement circumcision as an HIV preventive intervention. Our aim is to contextualize the policy context in which circumcision as HIV prevention is entering.

### 4.3.4. Responses to HIV and AIDS by South African governments

Since the first democratic election in 1994 South African governments have launched several national HIV and AIDS strategies which have been unsuccessful. Salim Abdool Karim, Director of the Centre for the AIDS Programme of Research in South Africa (CAPRISA) [39] states in a Lancet article that he coauthors that, "Until now the South African

[38] Ibid.

[39] "CAPRISA was created in 2001 and formally established in 2002 under the NIH-funded Comprehensive International Program of Research on AIDS (CIPRA) by five partner institutions; University of KwaZulu-Natal, University of Cape Town, University of Western Cape, National Institute for Communicable Diseases, and Columbia University in New York. CAPRISA is a designated UNAIDS Collaborating Centre for HIV Prevention Research.

Governments response to the disease [HIV] has been marked by denial, lack of political will and poor implementation of policies and programmes" (Abdool, et al. 2009, 921). We will now continue by looking at the HIV approach of the former government in order to understand the HIV legacy that the current government is working in continuation of.

### 4.3.5. AIDS denialism

The most reputed South African national approach to HIV and AIDS is that of the era of president Mbeki government (1999-2009). Mbeki's approach to HIV and AIDS has been known worldwide as a time of "AIDS denialism". During those years the national response to AIDS stagnated and reversed (Coovadia et al. 2009, 831). A disbelief in that HIV causes AIDS, asserting that anti-retroviral medicine were poisons and HIV tests were inaccurate were some of these denialist views (Leclerc-Madlala 2005, 849). The health minister of Mbeki's government, Manto Mabalala Msimang, became known for promoting traditional medicines to cure HIV (Richey 2008, 2). She also uttered her opposition to circumcision as HIV prevention and said that the information of the WHO guidelines regarding circumcision as a preventive measure were "incorrect and misleading" and that "Circumcision is a cultural practice and should not be used as a preventative measure in the fight against HIV-Aids". Furthermore, the health minister also addressed traditional leaders and healers by saying that cultural practices should not be used for "purposes other than those for which they [were] meant for at the beginning"[40].

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The main goal of CAPRISA is to undertake globally relevant and locally responsive research that contributes to understanding HIV pathogenesis, prevention and epidemiology as well as the links between tuberculosis and AIDS care." (CAPRISA 2008)

[40] (Health24 2008) (internet source 9)

However, denialism, including the outspoken mistrust in science, is no longer prevalent in South Africa. TAC (Treatment Action Campaign)[41] announced in an official newsletter in 2006 that the era of denialism had come to an end. The announcement succeeded a speech by the Deputy-President, Phumzile Mlambo-Ngucka who said that HIV causes AIDS and is a major cause of death in South Africa. The Deputy-President also met with AIDS specialists that the government had not wished to consult before and agreed on the importance of ARVs in fighting HIV and AIDS. In another Newsletter in May 2007, TAC presented the view that the National Strategic Plan for HIV and AIDS and STIs 2007-2011 was a "decisive break with AIDS denialism" and that they (TAC) now as an organization "operated in a different political and policy environment to the period 1998-2006" (Richey 2008, 19-20). TAC has been working politically to push the South African government for ARV treatment which means that they have followed the political development in South Africa closely. Their assessments we therefore hold to be a very reliable indicator on the South African HIV political environment. The election of 2009 also introduced a new era in South African HIV politics which we elaborate in the next section.

### 4.3.6. Post elections 2009

In May 2009 Jacob Zuma was elected as president, and hopes and expectations of the new government's ability to carry through changes were strongly articulated by improvement of the health outcomes of the South African health sector (Abdool, et al. 2009, 922, Kapp 2009, 776, Kleinert og Horton 2009, 759). The reason for hope was very much attached to the new health minister, Aaron Motsoaledi (Kapp 2009, 776). According to Salim Abdool Karim, director of CAPRISA, Motsoaledi "will tackle the serious issues [of the health sector]" (Kapp 2009, 776). The minister has, among other things, said

[41] The Treatment Action Campaign is the most influential AIDS activist organization in South Africa and was launched in 1998 to promote universal access to ARV treatment for all HIV positive South Africans. It is one of the most successful transnational social movements in the world (Leclerc-Madlala 2008, 143).

that he pledges to close the South African health gaps within a generation. He has also expressed agreement with the conclusions of a Lancet report's conclusions stating that radical changes are necessary if South Africa is to meet the Millennium Development Goals. These statements are, according to The Lancet editor in September 2009, signs of "a dramatic change in attitude to health within the heart of the new South African government" (Horton 2009, 759).

The installing of the new Health Minster has also been received with skepticism. In a reshuffling of the Cabinet in 2008 Barbara Hogan became Health Minister in the Mbeki government. According to Wouters et al. (2010), the reshuffling ended the era of denialism. Hogan declared HIV and TB top priorities and roll out prevention programs of mother-to-child transmission, which is one of the priorities of the national HIV and AIDS policy 2007-2011. Many hoped she would continue as minister after the election of 2009 and in that way be able to continue the momentum she had started. Instead she was replaced by Aaron Motsoaledi. The prominent South African civil society activist, Mark Heywood, and many others in the health sector, expressed great disappointment with the replacement of the former health minister, as they feared this would disrupt the continuity of the newly gained momentum forged by the initiatives of Hogan. Many are thus skeptical and have, according to Wouters et al., adopted a "wait-and-see attitude" towards Health Minister Motsoaledi (Wouters, van Rensburg og Meulemans 2010, 179-181).

The break with denialism seems to be permanent and also consolidated with the new Health Minister and the national HIV and AIDS policy 2007-2011. However, the implementation of the national policy is behind schedule. A policy versus policy implementation gap seems to prevail. This is not novel to South African national HIV policies but has been a characteristic since the introduction of democracy in 1994. HIV policies have been ambitious but the implementation has not been efficient (Wouters,

van Rensburg og Meulemans 2010, 180). We will continue by looking at how this gap puts great pressure on the current government in terms of delivering results of their HIV efforts and what this may mean for the incentive to implement circumcision for HIV prevention.

### 4.3.7. Results required

Former South African governments have been under great pressure to deliver results in terms of combating the AIDS epidemic, which, according to Wouters et al. (2010), resulted in the government implementing "quick-fix solutions" and short term solutions to HIV and AIDS. The former South African president Mbeki entered this position as president calling himself "mister delivery" (Wouters, van Rensburg og Meulemans 2010, 176), which can be interpreted as a manifestation of a government being aware of the demand for results and delivering and providing HIV services.

Several factors make it probable that the current government is likewise under pressure to deliver results in the area of HIV. South Africa is still the country with highest number of HIV infections in the world which amounts to 5.6 millions[42]. HIV and AIDS is still a spreading rapidly with 1000 new infections every day (Wouters, van Rensburg og Meulemans 2010, 181). In AIDS Accountability International's international rankings of countries' effort to control HIV epidemics, South Africa is ranking poorly. There are ten parameters including financing, civil society involvement, treatment, prevention, etc. and the countries are ranked in relation to how they are living up to their own set targets. Karim et al. conclude, based on these rankings that South Africa is underperforming in almost all areas of their HIV control efforts (Abdool, et al. 2009, 928-929). Especially heterosexual transmissions are high (Chopra, et al. 2009, 1025, Abdool, et al. 2009, 930).

[42] (UNAIDS 2009)

The conjunction of factors consisting of the bad performance on controlling the HIV epidemic, the high expectations uttered about the government that was elected in 2009 and the disappointment of the displacement of Hogan and the hopes or doubts of whether the current health minister, Aaron Motsoaledi can keep the momentum, may put further pressure on the current South African government. Furthermore, the government has underperformed in regards to deliver ARV treatment to 1.5 million South Africans before 2010, which is a target of the 2007-2011 HIV and AIDS policy. Only about half a million South Africans were on ARVs in 2009 (Chopra et al. 2009, 1026).Thus, the failure to implement effectively seems not only to be a historical problem.

In 2009 the Health Minister Aaron Motsoaledi said: "We want to undertake massive male circumcision. We believe that by 2011, male circumcision will be practiced all over"[43]. The number of men circumcised is a very tangible output. The intervention, as we see it, can be implemented very easily by the “new” government to prove their worth. If the implementation fails, it can however potentially undermine the legitimacy if they do not fulfill their promises as seen so many times before in the history of South African governments HIV efforts.

The government is undoubtedly, under pressure to deliver results in the area of HIV. Circumcision seems to be a welcome intervention that potentially can prove to the population that the government is taking the problem of HIV seriously. It can also consolidate the government’s image as a modern government that is breaking with the former government’s denialist and anti-scientific approach to HIV and AIDS.

[43] (Bodipe 2010)

# 5. Therapeutic state and citizens: 'Personal pain for collective gain' – the therapeutic, gendered and responsible citizen as an indicator of 'success'

Altering male's genitals through circumcision concerns both private realms and individual decision-making, in order to meet global expectations of HIV prevention. This analysis chapter will go in depth with relationship between the therapeutic citizen and the therapeutic state in HIV prevention. And we will analyze how the individual choice to circumcise is influenced by public health messages. The therapeutic state is a term we use throughout in the analysis chapters. The therapeutic state is not marked by geographical boundaries, but rather by national and international entities that provide technical assistance through development interventions and their global expectations to prevent HIV. We argue from a post-development theory perspective, that the circumcision intervention has controlling practices and discourses. The control, we argue, is embedded in the stressing of individual responsibility to 'solve' the problem of HIV spread. In South Africa, the therapeutic state is defined by WHO, UNAIDS, SANAC, and NGOs and their expectations to how individuals should prevent HIV. The actors mentioned are deciding actors in regards to forming policies towards male circumcision. In South Africa, there is not yet an official policy on male circumcision. In this chapter we will analyze policies on HIV testing in order to understand the tendencies that might influence on a drafting of the policy on male circumcision in South Africa.

## 5.1. From voluntary to provider-initiated: HIV testing policy in South Africa

In the analysis, we take as our point of departure the current South African HIV testing campaign, HIV Counseling and Testing (HCT), in order to approach an understanding of the efforts of the therapeutic state in controlling and preventing the spread of HIV through policies in South Africa. In 2010, a change of HIV testing policy took place in South Africa. Previously, Voluntary Counseling and Testing (VCT)[44] had been dominant. The policy change took place to accommodate the need of the therapeutic state to have 15 million tested by June 2011 and is a mixture of provider-initiated HIV testing and counseling and voluntary HIV testing and counseling. The impact of the policy change on questions of individual responsibility regarding the prevention of HIV by getting circumcised will be a focal point in this analysis.

Circumcision is a controversial procedure as it is an irreversible procedure that alters the genitals. One could argue that circumcision is a procedure that could be considered mutilation, as stressed by Gruenbaum (Gruenbaum 2001)since circumcision "entail damage to or removal of the healthy tissues or organs" (Gruenbaum 2001, 3). Our focus is however not on the physical violation but rather how individual decision making in relation to circumcision might be – if not violated then is challenged. In South Africa, the recent policy change demonstrates a shift from the individually based choice of HIV

[44] "For over 20 years, client-initiated HIV testing and counselling, also known as voluntary counselling and testing (VCT), has helped millions of people learn their HIV status. Nevertheless, global coverage of HIV testing and counselling programmes remains low. Efforts are urgently needed to increase the provision of HIV testing through a wider range of effective and safe options. In 2007, WHO and UNAIDS issued guidance on provider-initiated HIV testing and counselling (PITC) in health facilities to support increased uptake and improve access to HIV prevention, treatment and care. HIV counselling and testing (HTC) is a critical entry point to life-sustaining care for people with HIV, a key element of Treatment 2.0 and essential for prevention of vertical HIV transmission." (WHO 2011)

testing to public health providers'. The policy change from VCT to HCT will be analyzed below with particular focus on the potential implications for male circumcision.

## 5.2. From individual to collective decision-making

In South Africa, the change from Voluntary Counseling and Testing (VCT) to HCT symbolizes a significant change in the structure of HIV testing. The AIDS Law Project's (ALP)[45] *Final Review -January 2009 to March 2010* states the aim of the new policy:

> The new policy will, in effect, see the routine offer of HIV testing at all points in the health system. While testing will remain voluntary, health care workers will now be expected to play an active role in encouraging people to test and ensuring that access to HCT services is guaranteed (AIDS Law Project 2010, 55).

People's right to decide whether to get HIV tested balanced with the initiative of the therapeutic state to offer routine testing, could have different implications for the responsible and therapeutic citizen. SANAC emphasizes that HCT is not compulsory, but at the same time also underlines that the parts of VCT still in focus with the HCT policy are the privacy issues, such as respecting informed consent of the people getting tested, as well as confidentiality (SANAC 2010a). SANAC's document "Frequently Asked Questions on the HCT Campaign" also emphasizes the change from VCT to HCT:

[45] "The AIDS Law Project (ALP) is a human rights organisation that seeks to influence, develop and use the law to address the human rights implications of HIV/AIDS in South Africa, regionally and internationally. In particular, it uses legal an policy processes and litigation to protect, promote and advance the rights of people living with HIV/AIDS, as well as to change the socio-economic and other conditions that lead to the spread of infectious diseases and their disproportionate impact on the poor. In addition, it conducts and publishes research in order to assist with policy formulation and the development of appropriate legal and regulatory frameworks needed to respect, protect, promote and fulfil human rights. (AIDS Law Project 2011) (internet source 1)

> HIV Counselling and Testing (HCT) is a move to a service delivery model. HCT is a combination of VCT and Provider-initiated counselling and testing (PICT). In HCT an HIV test remains voluntary but the new guidelines require that as a matter of routine health care providers (e.g. nurses, doctors, pharmacists) offer an HIV test to all patients they consult, regardless of their health status. Because the test is voluntary patients have the right to decline the offer but HCT places the emphasis on health care providers making the effort to convince patients to test. (SANAC 2010b) (See appendix D)

This citation clearly states that the current HIV testing policy is a mixture between of voluntary and provider-initiated initiatives. The extent to which testing is voluntary in HCT can be disputed, as there is an increasingly large effort made to convince people test to for HIV.

The HCT campaign, which started in April 2010, ended in June 2011 and marked the end of The HIV and AIDS and STI Strategic Plan 2007-2011. In the draft of the National Strategic Plan for HIV and AIDS, STIs and TB 2012-2016, the aim is, by 2015, to circumcise 80% of men aged 15-49. This accounts for approximately 4.3 million South African men. By June 2011 237,812 medical male circumcisions had been conducted[46]. The numerical targets of circumcision could indicate that provider-initiated methods will play a larger role in HIV prevention in South Africa in order to achieve those targets.

[46] (South African Department of Health 2011)

## 5.3. Gendered precautions without gendered considerations

In the therapeutic state, the therapeutic citizen is defined by their HIV status. The biomedical condition is central to the definition of the therapeutic citizenship which is "a form of stateless citizenship whereby claims are made on a global order on the basis of one's biomedical condition (…)" (chapter two, p.).Whether the therapeutic citizen is HIV negative or positive determines the responsibilities the citizen is advised to live up to according to the expectations of the therapeutic state. The document (SANAC 2010b) states different precautions for individual behavior depending on the outcome of an HIV status test being negative or positive. The precautions are determined by the individual's biomedical status. Many of the expectations therefore revolve around responsibility (see appendix D), but we will in particular highlight the following, which are relevant when getting a negative HIV test. The document stresses that a HIV-negative person must try to remain negative by:

> · Using condoms every time you have sex – on every occasion with every partner.
> · Be responsible and know the HIV status of your sexual partner.
> · Talking to your sexual partner(s) about HIV and encouraging them to know their HIV status. If your partner(s) is HIV positive, support them and use condoms every time you have sex.
> · Alcohol increases the likelihood of having risky sex and thus of HIV infection. Be responsible when consuming alcohol and keep always keep condoms on you in case you or someone else needs them.
> · If you have been abstaining from sex and are thinking about becoming sexually active, be sure to go for a test with your partner before engaging in sexual activity. Know your partner's status.
> · Regardless of your status, if you are pregnant or planning to have a baby it is important to test for HIV because you can transmit HIV to your baby. During the course of pregnancy bear in mind that you can still contract HIV so please check your status regularly – especially before giving birth. (SANAC 2010b) (See appendix D)

The gendered precautions directed at men focus on alcohol abuse, several sexual partners, and condom use. The precautions directed at women are focusing on women as child bearers. The precautions directed at men are compliant with ABC messages as defined by the therapeutic state. Certain precautions, however, may have little to do with the gendered contexts that South African the man or woman navigates. The therapeutic state's approach to gender relations is rather standardized as it operates with WHO approaches that are not worked out in the specific context of South Africa. Therefore the approach, in our view, can be criticized for not gendering the therapeutic citizen. Gendering the therapeutic citizen would incorporate broader perspectives on men and women in their "local" sexual relations. In chapter six and chapter seven we will elaborate on the implications that this approach might have for women and men respectively.

In the context of HIV testing predominantly being provider initiated, the emphasis of the South African government on advising individuals to 'take responsibility' for HIV testing frames the choice of testing as an individual one. However, since HCT has a clear focus on provider-initiated testing, it could be implied that the individual does not particularly have 'a choice' in whether or not they wish to get tested, as they are strongly encouraged to test for HIV by the therapeutic state. Since HIV testing went from predominantly being voluntary to provider-initiated, circumcision may be conducted under similar frameworks where the major focus is on numbers of people that receive the HIV prevention services provided by the therapeutic state.

In the above section the policy change from VCT to HCT is analyzed. In the following, we will analyze the possible impact of circumcision for HIV positive men when circumcision becomes an indicator of a "responsible man".

## 5.4. Circumcision as an indicator of responsibility

In Robins' theory, a therapeutic citizen is defined by individuals following the expectations defined by the therapeutic state; expectations of individual responsibility that consequently hinders that the man and his sexual partners are infected with HIV. Circumcision is a physical mark of men who are HIV-negative, as only HIV negative men are recommended to circumcise. We will now explore how circumcision can become an indicator that marks 'responsible' citizens by their HIV negative status. The global expectations of circumcision to prevent HIV may accommodate the therapeutic state in controlling and halting the spread of HIV. The local expectation to men and women to procreate is a gendered reality, which the global expectations may not consider.

If circumcised are considered 'responsible men' circumcision may become an indicator to distinguish between 'irresponsible' and 'responsible men'. If circumcision indicates a negative HIV status it might have consequences for men in sexual relations. This could be relevant for women's choice of a sexual partner. Women may prefer circumcised men as this decreases the changes that man transmits HIV to the women and her unborn children. Consequently, men who are HIV-positive might be excluded from sexual relations due to not being circumcised. Thus HIV-positive men are not able to live up to the expectations from the therapeutic state as they are already HIV infected. Nor can they fulfill their social role to procreate if women do not wish to have them as their sexual partners. Social stigma of HIV positive men may then be a result of the marker of "irresponsible" versus "responsible men".

The HCT policy conveys messages such as: "I am responsible. We are responsible. South Africa is taking responsibility" (SANAC 2010c) as well as "Be responsible. Take the test. Join the campaign!" (SANAC 2010b) (See appendix D). Similar referrals to responsibility related to sexual issues and behavior is also emphasized with circumcision where WHO

refers to abstaining from risky sexual behavior, such as unprotected sex or having multiple partners. Robins mentions that public health practitioners often see men as 'villains' and blame them for spreading HIV while they should 'act responsibly'. Robins' understanding of a therapeutic citizen is, as mentioned earlier, a responsible citizen, which is defined by "political claims and demands based on individual responsibility, self-help, and 'caring for the self' " as well as 'responsible citizens' as produced in a balance between "the rights of individuals and the public health needs of society" (Robins 2006, 312). In the context of male circumcision and the efforts of the therapeutic state to manage and control HIV, a focus on the rights and privileges of individuals may overshadow the focus on the individual's free choice and the acceptability of a person's choice to also decline from becoming circumcised.

## 5.5. Male Circumcision in South Africa – personal choice or provider-initiated?

We will continue to explore the individual responsibility to circumcise in relation to meeting public health targets and expectations of the therapeutic state by analyzing a conditional cash transfer (CCT) program initiated by CAPRISA. CCT programs could be a way of using finances as an incentive for promoting male circumcision and changing risky sexual behavior.

A recent and ongoing initiative started by South African researchers in CAPRISA is testing whether financial incentives can stop HIV infections. The therapeutic state conveys several messages supporting global HIV prevention methods such as to abstain, be faithful, condom use, and similar ABC-messages. The focus of the therapeutic state is on encouraging people to stay HIV-negative. We bring in this perspective in order to analyze what the implications of conditioning individuals to stay HIV negative by avoiding HIV risks by cash incentives are. In the following sections we will focus on conditional cash program

as a method that might be used to in relation to male circumcision in South Africa. First we present a South African study which illustrates how conditional cash transfers are intended to improve HIV prevention efforts.

## 5.6. Financial incentives to change (risky) behavior

The program of CAPRISA, named Reducing HIV in Adolescents (RHIVA), is testing whether pocket money could give South African teenagers incentives to stay free of HIV. A group of researchers from the CAPRISA in Durban, South Africa, are conducting a study in KwaZulu-Natal to test whether male and female students aged 13 and above at 14 schools in a rural district will remain HIV-negative by being provided with cash. The amounts they are provided with could be amounts up to 2,700 rand[47] for which the students have to stay HIV-negative. The study runs over a period of 18 months and ends in June 2012. Students at seven of the 14 schools are offered payment, and students at the other seven schools are the control group. As part of the study, the CAPRISA trial will attempt to influence male behavior. The participant schools get cash for milestones achieved by the students:

> In addition, the intervention schools will receive cash incentives ranging from R50 - R100 for achievement of various milestones such as school attendance, academic performance, improving literacy levels, social engagement and self-initiated testing for HIV infection. It is hoped that these incentives will serve as catalysts for engaging young learners in healthy lifestyle behaviours.48

The conditional cash transfer program dictates how individuals should behave in order to stay HIV-negative in conjunction with the therapeutic state expectations. CAPRISA is

[47] Approximately USD 366,00
[48] (CAPRISA 2010) (internet source 4)

conducting the study but relying on the technical HIV prevention methods of WHO and UNAIDS, and places the responsibility to prevent HIV on individuals (the school and students). Sarah Hawkes, a sexual-health expert at University College London, has remarked about the conditional cash program that "Men are driving the epidemic — through their sexual behaviours, drug-taking, risk-taking and the fact that they often hold the balance of power in decision-making in intimate relationships."[49] CAPRISA thus investigates whether involving boys at school level may have implications on their likelihoods of engaging in risky behaviors later in life. The leader of the trial, Quarraisha Abdool Karim, has stated that: "The urgency of the AIDS epidemic warrants trying whatever might work[50]".

The conditional cash transfer program not only seeks to promote financial incentives to stay HIV-negative, but also to prevent HIV through targeting risky male behavior specifically. Similar to the behavior that circumcision campaigns seek to promote, conditional cash transfer programs may be a method for the therapeutic state to potentially use in the scale up of male circumcision. A post-development critique is that development interventions are often only targeting individuals, not structures, and encouraging individuals to transform into "modern people" according to specific definitions (see chapter two, p.). There is also a clear definition of how individuals should transform in the conditional cash transfer method. This transformation, which requires specific behaviors, is rewarded with cash.

In dealing with HIV and STI prevention several international organizations have pointed to conditional cash transfers as incentives to change risky behavior in regards to the spread of disease. In the following paragraphs we will examine a World Bank document

[49] (Shetty 2011) (internet source 14)
[50] (Shetty 2011)

presenting a theoretical background to the use of financial incentives as a means to influence behavior. The behavior can have both short and long term effects. We will now further our analysis by framing the consequences of a possible conditional cash transfer program on male circumcision in South Africa and the impact on individuals to stay HIV negative as is promoted by the therapeutic state.

## 5.7. Conditional cash transfers and the HCT policy change in South Africa

Traditionally, conditional cash transfers have been linked to economic theory and based on the assumptions of individuals making rational choices. The assumption is that individuals make rational choices based on maximizing individual well-being (Medlin and de Walque 2008, 5). Furthermore, traditional economic theory acknowledges that choices made by individuals have both benefits and costs. In terms of sexual and reproductive health, benefits translate into personal enjoyment and costs translate into health risks. In the short term, rewarding positive behaviors is assumed to bring health benefits in the longer-term. According to Medlin and de Walque, combining financial incentives and change of behavior in relation to HIV and STIs has different implications in short and long terms as "the decision to have sex involves a trade-off between the short-term benefit of sexual pleasure and intimacy, and the long-term (probabilistic) cost of getting pregnant, acquiring an STI, or contracting AIDS" (Medlin and de Walque 2008, 6) .

Research made in a voluntary counseling and testing (VCT) facility in Malawi regarding individuals testing for HIV, who consequently received payment ranging from $ 0-3 in order to retrieve their HIV test results is according to Medlin and de Walque, an example of a "relatively simple behavior change" (Thornton, 2006 in Medlin and de Walque 2008, 12). Medlin and de Walque (2008) specify that the global AIDS epidemic is fueled by risky behavior why the goal of HIV prevention is to discourage risky sexual behavior (Medlin

and de Walque 2008:4; 12). Conditional cash transfers for male circumcision could be possible method utilized in South Africa to achieve the goal of having 80% of South African men circumcised by 2015[51]. However, implementing conditional cash transfer programs for male circumcision may not have the intended outcomes. A relevant concern could be whether individuals will stop following the advice of responsible behavior until the provision of cash stops. Another critique could be that a conditional cash transfer program does not seem to address long term transformation of gender relations which could secure also a long term effect of the intervention. Conditional cash transfers may be effective in making people stay HIV-negative. An initiative offering cash for the prevention of risky male behavior could be targeting a reduction in number of sexual partners, self-initiated male circumcision, testing for HIV and other sexually transmitted diseases, and so on, in order to promote life-style behaviors that might be effective in preventing HIV risks. However, as it may be little transformative value in gender relations. As pointed to in chapter two, short term interventions may contribute to long term objectives of gender transformation (Chapter two, p.). Based on the analysis we find it reasonable to conclude that financial incentives for circumcision may contribute to the therapeutic state's goals of encouraging men to circumcise. However, it is doubtful that the method will contribute to long-term changes in gender relations and thereby secure HIV reduction in the long run.

## 5.8. Sub-conclusion

We have analyzed the implications of an HIV policy change in South Africa and the possible implications in terms of male circumcision. We have also analyzed the placement

[51] (South African Department of Health 2011)

of the responsibility of HIV prevention between the therapeutic citizen and the therapeutic state. The recent policy change from VCT to HCT represents a shift from focusing on the voluntary aspect of testing to health care providers playing an active role to encourage South Africans to test for HIV. The shift could result in that the future circumcision policy also strongly encourages individuals to circumcise without stressing that it is voluntary and completely acceptable to decline the service of circumcision. Throughout this analysis, we have argued that individual decision-making could be undermined in the process of meeting the needs of the therapeutic state of circumcising 80% of all South African men by 2015.

Implementing conditional cash transfers for male circumcision could likely contribute to undermining individual choice, by offering cash to control behavior that reduces the risk of HIV. When considering a conditional cash transfer program in regards to male circumcision, brochure A and B present behaviors like reduction of sexual partners and HIV testing which could be behaviors a conditional cash transfer program, as a component of male circumcision, could reward. However, we argue that both HCT and a possible conditional cash transfer program fail to address the problem of unequal gender relations and therefore may not have long term effects on HIV reduction. Circumcision is only recommended to HIV negative men. Thus, circumcision may become a marker of a 'responsible' who lives up to the expectations of the therapeutic state to stay HIV negative. An HIV-negative status indicated by circumcision may result in women preferring circumcised men to non-circumcised men. This could leave men who are HIV-positive to experience greater social stigma and not be able to have children.

## 6. Negotiations of masculinity ideals in South Africa

The SANAC recommendation "the procedure should be offered as part of a comprehensive sexual health package, including HIV counseling and testing (…)"[52] is a focal point in this analysis chapter. In chapter five we analyzed the implications of changes in HIV testing. In this chapter we will focus on another aspect of a comprehensive health package; namely men's involvement in HIV prevention and how that involvement is defined in the circumcision intervention and the Brothers for Life campaign.

In a SANAC position paper on circumcision for HIV prevention (2008), SANAC speaks for a comprehensive package of HIV prevention services and interventions, as male circumcision will not be an effective intervention alone. Part of that comprehensive package must include consistent promotion of sexual and gender equality and promotion of safer sex practices, including reducing the number of concurrent sexual partners (SANAC 2008, 2). These messages are directed at men, which the following quote indicates:

> SANAC should call on men to begin to take responsibility for their sexual health. Circumcision is an intervention that provides an opportunity for men to do this by encouraging them to make informed decisions about their sexual health (SANAC 2008).

The quote indicates how the circumcision intervention is an opportunity to engage men in HIV prevention by encouraging them to *begin* to take responsibility for their sexual health. The word "begin" clearly points to an understanding of men not taking responsibility for their sexual health at the present time.

[52] (Irin PlusNews 2009)

Men may have a dual role to play in HIV prevention as both the drivers of the epidemic but also as a part of the solution to prevent the spread of HIV[53] as highlighted in chapter two. We have pointed to gender and HIV research in South Africa, which states that a hegemonic masculinity in South Africa defines itself around control over women in sexual relations. A central argument for involving men in HIV prevention is that HIV prevention efforts will not be effective without. This chapter focuses on how men's involvement is defined in the circumcision intervention. Second, the analysis focuses on gender and behavioral change in WHO policies, and third, we analyze masculinities in two brochures on male circumcision by Brothers for Life. These perspectives all contribute to answer the research question: Which male representations are produced and reproduced in the scale-up of the circumcision intervention?

As described in our introduction of the thesis, the Brothers for Life campaign focuses on risks as a result of having multiple and concurrent relationships, men's limited participation in fatherhood and their reproductive and sexual health[54]. The messages Brothers for Life emphasizes are condom usage, in particular during high-risk activities, and promoting male sexual and reproductive health, including HIV testing and male circumcision, and being faithful to one partner[55].

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[53] In this thesis, we have pointed to several factors of male sexual behavior in South Africa and how these factors contribute to the spread of HIV, i.e. dominance and control in sexual relations over women, men having multiple partners, and sex as a way of proving manhood where use of condom for instance is considered unmanly (cf. chapter two). Addressing 'risky' male sexual behavior is thus in focus to halt the spread of HIV.

[54] (Soul Beat Africa 2011) ( internet source 15)
(Brothers for Life 2009) – see appendix C

[55] Ibid (08-02-2011)

Our notion of a gendered therapeutic citizen finds it critical to focus on the dynamics and negotiations of gender in HIV prevention interventions. This perspective also makes us critical of static or rigid representations of men in HIV prevention concepts. The overall analytical tool in this chapter is the notion of hegemonic masculinity. This concept provides a theoretical approach to counter an essentialist and rigid perspective of masculinities and to understand how masculinities are being produced and reproduced in the circumcision intervention.

The Brothers for Life campaign predominantly relies on international discourses of men's involvement in HIV prevention, where WHO is influential in setting the agenda. What this means in terms of masculinity representations will be scrutinized below and further in this chapter.

## 6.1. Essentializing "gender" in WHO circumcision policies

In our analysis we will argue that Brothers for Life is highly dominated by WHO representations of masculinity and is applying WHO strategies to address men in circumcision for HIV prevention. In 2007 when WHO and UNAIDS recommended circumcision for HIV prevention. WHO also developed an information package emphasizing that male circumcision should not stand alone:

> Male circumcision reduces the risk of HIV infection, but it only provides partial protection. Circumcised men are not immune to the virus. Male circumcision must not be promoted alone, but alongside other methods to reduce the risk of

> HIV – including avoidance of unsafe sexual practices, reduction in the number of sexual partners, and correct and consistent condom use.56

This particular quote indirectly targets men and thus WHO is 'gendering' the HIV epidemic as something that is progressed by men's irresponsibility. WHO primarily addresses "gender" in their circumcision information package by referring to the safe sexual behavior of men, particularly in having only one sexual partner, avoid risky intercourse, and similar ABC messages[57].

The advice to men in the WHO circumcision information packages is general and not considerate of the gendered realities of South African men. It seems problematic to apply a "one-size-fits-all" model to address masculinities in a context where gender relations and masculinities as unique as they are in South Africa. Throughout the chapter we will critically analyze the implications of international discourses on "gender" and male circumcision when implemented in gendered realities in South Africa.

Before we present and analyze the brochures, we will look into how circumcision for HIV prevention, promoted by Brothers for Life, is creating new meanings to the ritual of circumcision and definitions of what it means to be a man.

## 6.2. Traditional and modern meanings of circumcision

Male circumcision is both a medical and traditional practice in South Africa. Circumcision related to addressing male behavior in South Africa is not a new notion, as manhood formation has been part of the Zulu culture (with rituals of circumcision) and remains a

[56] (WHO 2007a)

part of the Xhosa culture (see chapter four). In traditional notions of circumcision men gain status within the community by enduring the pain of circumcision rituals and circumcision is a rite of passage to enter the collective of adult men and the rights that follow. The 'new' perspective on circumcision in South Africa is to get circumcised in order to prevent HIV. Louise Vincent (2008) elaborates on that:

> Campaigns for circumcision aimed at curbing HIV can be very confusing because they are layered onto other messages – of abstinence, sexual restraint and sexual responsibility on the one hand, and the rights and privileges that go along with Xhosa manhood on the other. They arise in a social context in which coercive, unequal and violent sexual relations lie at the root of particularly high rates of female heterosexual HIV infection (Vincent 2008, 433).

This extract quote points to that circumcision campaigns both draw on tradition notions of masculinities, emphasizing rights and privileges and on messages of sexual restrain and men's responsibility on the other. The two approaches to masculinity will be used thematically in the analysis on how male involvement in HIV prevention is promoted in two circumcision brochures.

## 6.3. Between modern and traditional notions of masculinities in South Africa

In the following section we will analyze representations of masculinity in medical male circumcision brochures titled "Time to get wise – Circumcise" (Brothers for Life 2010) (referred to as brochure A, see appendix A) as well as "Get circumcised. Know the facts" (The AIDS Helpline, The Department of Health KwaZulu-Natal, Brothers for Life, Sonke Gender Justice 2001) (referred to as brochure B, see appendix B).

We particularly focus on male identity in the context of traditional and medical circumcision, new and old patriarchy, and crisis of masculinity" (see chapter 2). The context of traditional notions of circumcision and manhood wedded with 'modern' circumcision criteria are two different and seemingly oppositional perceptions of circumcision and manhood. We seek to understand how these are used in the construction of the 'new man' presented by the Brothers for Life campaign.

In the previous chapter the notion of therapeutic citizenship helped us to explore the relationship between the therapeutic state and the therapeutic citizens. In our theoretical framework we argue that basing development on a narrow framework of how individuals are to develop (i.e. become responsible) and self-transform from traditional to modern people, is not taking into consideration the local, gendered realities of therapeutic citizens. Men's responsibility to transform is thus not only a matter of the therapeutic state offering a service of circumcision, but also concerns the individual man *and* the gender relations in which he is embedded. These gender relations include competing notions of masculinities that will influence the man's possibility of being a successful therapeutic citizen. Competing views of masculinities and the notion of hegemonic masculinity by Cornell (Connell 2009, Connell 2000b) will be the primary analytical tool in the forthcoming analysis, where we will analyze traditional and modern practices and perceptions of masculinities and circumcision in South Africa.

## 6.4. Rights and privileges of the circumcised man

In brochures A and B, the notions of masculinity are both appealing to the rights and privileges of the man, and focusing on the responsibilities and sexual restraint of the man. As mentioned with Vincent (2008), the focus on the rights and privileges of the man as well as his responsibilities is prevalent in HIV prevention messages in South Africa. In the circumcision campaign we see both approaches. The following sections explore how both

modern and traditional notions are coupled in the brochures and constructing a masculinity notion, which challenges hegemonic masculinity in South Africa.

## 6.5. Brothers for Life – transformation into a new man

Brothers for Life rely on what we consider several modern notions. First, their indicators of success are numerical, which the following quote demonstrates: “Over the next five years the government is aiming to circumcise at least 5.6 million men to reduce the number of new HIV infections and save the country billions of rand in future treatment-related costs" (Brothers for Life 2010) (Brochure A, 2010). From a development perspective, the problem is the spread of HIV, as well as the cost of HIV treatment, and circumcision is the presented as the solution to both. In the brochures there is no focus on notions of masculinity beyond ABC messages, or addressing of how cultural and social relations may impact the spread of HIV. In a post-development perspective, development is identified in narrow frameworks in which the solution to development problems is defined in terms of western notions of modernity in which development is promoted by focusing on transforming individuals. We argue that the Brothers for Life approach to implementing circumcision seeks to convince the South African man to transform physically through circumcision and mentally through behavior change, and in both cases convince him of the advantage. Presenting a new man into which the “old (irresponsible) man” needs to transform can be critiqued for not engaging with the complexity of competing masculinities in South Africa and the different meanings of manhood. The meanings of manhood in traditional circumcision are challenged and renegotiated by new meanings that are introduced through medical circumcision for HIV prevention. For instance, in the traditional understanding of circumcision, manhood is proved by the initiate enduring pain and having no contact with medical staff. Furthermore, women’s presence is not allowed during the ritual of circumcision. In medical circumcision men receive medical assistance, which in the traditional circumcision process is considered

unmanly. In the next section we will engage with the complexity of competing representations of masculinities in the circumcision intervention in South Africa. We will do so by identifying traits of old and new patriarchy[58] in order to analyze "the new man" promoted by Brothers for Life.

## 6.6. Addressing male behavior: A 'right and privilege' or 'responsibility and sexual restraint'

The policy change from VCT to HCT indicates a change in HIV testing as a shift where individual choice is challenged by provider initiated efforts. Male circumcision in the therapeutic state takes place to meet a public health need to decrease HIV infection. We argued in chapter five, the individual decision-making regarding male circumcision is under pressure in the context of the recent policy change. But what is expected of individuals in order to protect the nation from the spread of HIV besides being circumcised? What particular responsibilities does the therapeutic state emphasize?

Brochure B focuses on the rights that the procedure of circumcision implies, which is reflected in the statements: "You have the right to safe medical male circumcision in a hygienic and clean medical facility", "You have the right to counseling and HIV testing before undergoing circumcision" and "you can voluntarily undergo counseling and testing for HIV(…)" (The AIDS Helpline, The Department of Health KwaZulu-Natal, Brothers for

[58] In the theory chapter we refer to Morrell and his notions of old patriarchy and a new patriarchy. Old patriarchy is defined around authoritative and dominant masculinities where men are providers and in control. New patriarchy is based on not abusing women, but rather respect, tolerance, justice and openness.

Life, Sonke Gender Justice 2001) (Brochure B). In brochure B, an emphasis is made about informing men on the partial effect of male circumcision in protecting against HIV: “This means you cannot let your guard down. If you are circumcised, you should still use a condom every time you have sex, keep to one sexual partner and test for HIV to know your status so that you can make the best decision for your health” (The AIDS Helpline, The Department of Health KwaZulu-Natal, Brothers for Life, Sonke Gender Justice 2001)(Brochure B). Focusing both on the right to get circumcised as well as messages around condom use, faithfulness to one partner, and HIV testing is compliant with Vincent’s (2008) view on traditional messages around circumcision as a right and privilege, wedded with messages around sexual responsibility. In Brochure B, it is also emphasized that

> Medical male circumcision is the best option for your sexual and reproductive health. Circumcision offers a lifetime of benefits including better hygiene, reduced risk of sexually transmitted infections and HIV. It reduces risk of penile cancer and your partner’s risk of cervical cancer. Quite simply, getting a medical circumcision is the right thing to do (The AIDS Helpline, The Department of Health KwaZulu-Natal, Brothers for Life, Sonke Gender Justice 2001) (Brochure B).

That male circumcision is ‘the right thing to do’ shows a focus on male circumcision as a surgery the man has a right to undergo, but is also a privilege. On the other hand, circumcision is presented as the right thing to do in terms of a public health framework.

## 6.7. The South African man from uncircumcised to circumcised and responsible

Brochure A and B both elaborate on why a man should be circumcised, and the precautions he should take after being circumcised. Circumcision is described as a quick surgery with minimal side-effects. When arriving at the clinic, the man will:

> be counseled and tested for HIV and examined for other sexually transmitted infections. The full removal of the foreskin is done under local anaesthetic, so besides a small injection there is no pain. It only takes about 30 minutes. Once the foreskin is removed the wound is stitched and dressed and you are given painkillers to help manage any mild pain or discomfort you may have when the anaesthetic wears off (Brothers for Life 2010) (Brochure A 2010).

In terms of side effects, it is stated that "Like with any surgical procedure, there can be problems after circumcision, but in most cases these are slight, such as reaction to the pain injection, minor bleeding, or some swelling and pain" (Brochure A 2010). The overall impression to be derived from this statement implies minimal pain and minimal recovery time. There is no focus on a 'macho man' who has to endure pain such as in traditional circumcision rituals. Simultaneously, the minimal time to recover could appeal to the man who identify with the role of providers, as the procedure requires minimal days off work. As highlighted in the section on "crisis of masculinity" in South Africa (chapter two), many men may not in reality be able to claim the role of provider, but it is still considered an identity trait of the South African man. We will elaborate on that later in this chapter under the heading "Male circumcision – gain or loss of masculinity?".

On the other hand, if the procedure of circumcision required that men had to stay be in bed for several days and in need of extensive care, it might not have been as appealing for men who value a masculinity defined by being in control and invulnerable[59]. We see this as an example of the combination of traditional and modern notions. We argue that the traditional notions of the South African man, who is in control, invulnerable and privileged, are wedded with modern notions of the man's right to access medical health services and the assistance of health staff.

Medical circumcision has a focus on circumcision itself being a right and privilege, and a tool for promoting a man to be responsible for his own behavior, thereby protecting the health of the nation by preventing HIV. Can the seemingly different viewpoints of traditional and modern notions of masculinity be combined and be an effective approach in addressing individuals as gendered therapeutic citizens via the circumcision brochures? That will be the focal point of the next paragraphs.

## 6.8. Male circumcision – gain or loss of masculinity?

In South Africa, male identity is in crisis. This is described as "the crisis of masculinity". Men's authority is declining which has lead to men's a situation where control over women in sexual relations has become a central trait for the hegemonic masculinity in South Africa. Mantell et al. (2006) highlight a potential way of strengthening masculinity in a time of an HIV epidemic. Involving men in providing health care to their families could be both beneficial to himself and his family. In that way his masculinity can be

[59] Rather they need minimal care, and besides a check-up a few days after circumcision they are virtually independent of further help. The cleaning and changing of cloth is presented as a task the man can do himself, makes the man able to provide for his sexual health with minimal reliance on medical staff or spouse or kinship relations. (The AIDS Helpline, The Department of Health KwaZulu-Natal, Brothers for Life, Sonke Gender Justice 2001)

strengthened as he is able to play a role as a provider. This approach, however, could have negative effects in that it might reinforce inequality between men and women (Mantell et. al. 2006:2005). This will be further elaborated upon in the following paragraph.

## 6.9. Preventing HIV but promoting male dominance?

Bujra and Baylies explain that appealing to men's self-interest or paternalistic responsibilities can maintain and reinforce male control and dominance and thus have little transformative value in gender relations (Baylies and Bujra 2000, 196). Strategies that appeal to men's sense of responsibility may reinforce prevailing gender relations (Baylies and Bujra 2000, 196) and thus leave men in control of both men's and women's sexual health.

The campaign of Brothers for Life puts emphasis and responsibility on the man as the active party in HIV prevention. The role of women is not addressed beyond their being beneficiaries of men's improved role as the provider of health to the family. The role of women in this campaign is mostly is presented as women being someone the men should protect and consider, particularly in regards to preventing HIV transmission to a child.

WID and GAD have been subject to critique due to their women-centered approach to creating gender equality. The same critique can be applied to Brothers for Life who seem to target HIV and gender transformation solely from a male-centered perspective. The ideals of a new patriarchy consider men who are considerate and respectful towards women. What this might mean in terms of gender equality between men and women will be elaborated upon further in chapter seven.

Some men living in communities where old patriarchy and traditional gender values are dominate may have little room for conforming to the ideal of the new man. The notion of the new man presented by Brothers for Life promotes a new masculinity, but at the same time, presents an already defined masculinity with little room for negotiation or debate. Gendering the therapeutic citizen, we will argue, is happening by incorporating local views of gender rather than rigid frameworks supporting global definitions about men's involvement in HIV prevention. Addressing men by focusing on individual behavior may obscure the complexity of hegemonic masculinities and gender structures, which makes it difficult for individuals to make that change. This will be further discussed in chapter eight.

The focus on new patriarchy and the new man in the circumcision brochures wedded with positive masculine traits has the potential to promote a new gender order in South Africa. But in order to achieve a collective effort towards gender equality we will argue that it is necessary to gender the therapeutic citizen by local definitions in South Africa. The brochures, we argue, are essentializing men by ascribing them the role as problematic in the spread of HIV. In this approach we see a danger of polarizing men and women, which may not be constructive in terms of gender equality. The issues of polarization between the genders and gender equality will be elaborated upon in the next chapter.

## 6.10. Sub-conclusion

This chapter has examined how men's involvement is defined in the circumcision intervention and how masculinity representations are produced and reproduced in that process. We have argued that Brothers for Life, in their circumcision campaign, are representing masculinities through both modern and traditional notions. The traditional notion is represented through the focus on circumcision as a right and a privilege. The focus on men's responsibility and abstinence are modern notions which derive from

international discourses on men's involvement in HIV prevention promoted by WHO and UNAIDS.

We have argued that the "new man" that Brothers for Life promotes presents a challenge to hegemonic masculinity as it emphasizes traits of new patriarchy, as a notion that includes respecting women and taking responsibility of both own and the health of the family. The role as a provider of health to the family may strengthen the masculinity of the South African man in a "crisis of masculinity". On the other hand, the overarching focus on men's responsibility may also reinforce the notion of old patriarchy, in that the responsibility of the man may translate into an increased dominance in sexual relations, where men control both men's and women's bodies and sexual health.

We have argued that using international frameworks for men's involvement is problematic in that it may overlook the complexities of masculinity unique to a South African context. It creates essentialist representations of men and simultaneously does not take into account the structures of gendered relations that may make it difficult for men to change their sexual behaviors.

# 7. Female prevention issues related to male circumcision for HIV prevention

In this chapter critical issues concerning women's HIV prevention and the consequences of circumcision for women's HIV risk and their social gender positions are focused on. According to SANAC it is important to prioritize female condoms and other female HIV prevention programs simultaneously to the male circumcision intervention[60]. The SANAC Civil Society Sector's Position Paper on Male Circumcision as a HIV Prevention Strategy (2008) raises concerns on the potential negative implications of circumcision for women's risks of HIV transmission. In order to address these issues SANAC recommends that the funding of circumcision for HIV prevention should neither be taken from female condom distribution programs nor from other programs aimed directly at women.

The female condom is the only female controlled HIV prevention method, which is currently on the market (Peters, Jansen and van Driel 2010, 120). Its efficiency is much discussed. Some see female condoms as only a short-term solution to women's HIV risk, while others also see long-term potential in terms of the condom changing the underlying unequal gender relations that are reinforcing women's HIV risk (Kaler 2001). Berer, author of the international magazine "Reproductive Health Matters" critically comments on male circumcision for HIV prevention by saying: "Anyone who thinks that a technical solution to a socio-sexual problem can work on its own, no matter how many millions of dollars they can throw at it is, I believe, deluding themselves" (Berer 2007, 46). Berer argues that it is not sufficient to apply a technical solution to a problem, which is social in nature. This Berer quote introduces the tensions

[60] (Irin PlusNews 2009) (internet source 13)

between short term technical solutions in HIV prevention (such as circumcision but also female condoms) and long term approaches, such as addressing the unequal gender relations that hamper HIV prevention.

This analysis will focus on female condoms as a way of avoiding the perceived disadvantages that male circumcision may have on women's HIV risk in South Africa. Furthermore we broaden the discussion to how female condoms might influence gender relations in order to answer the research question: Can female condoms contribute to enhance women's control of their bodies and gender equality in the scale up of circumcision? This analysis part focuses primarily on women, and thus "gender equality" refers to strengthening women's position in heterosexual relationships.

We will structure the analysis by using notions of practical and strategic gender needs, and will be using WID and GAD perspectives to critically analyze the gender approaches that are being used by two women's rights initiatives (see chapter two). Furthermore, we draw on Amy Kaler's (2001) work on women's empowerment through female condoms. She conceptualizes the link between empowerment and female condoms by developing three notions, from which we will draw upon two. The notions describe different understandings of how women are empowered through female condoms (Kaler 2001, 784).

## 7.1. The claims of WHiPT and TVEP for women's HIV prevention

We analyze claims from two South African civil society initiatives on women's rights to HIV prevention through access to female condoms. The first initiative is

called “Women’s HIV prevention Tracking Project” (WHiPT)[61], which the report “Medical Male Circumcision for HIV Prevention: Are Women Ready?” is part of[62]. The second initiative, “The 2008 Thohoyandou Victim Empowerment Dialogues” [63] were held by Thohoyandou Victim Empowerment Programme (TVEP)[64] in Johannesburg September 10-11, 2008. The dialogue resulted in a report called “Universal Access to Female Condoms - A Human Rights Issue”[65]. In the analysis we refer to the two reports “WHiPT” and “TVEP”. The analysis commences by presenting the concerns that WHiPT and TVEP raise concerning the potential consequences that a lack of access to female condoms may have on women’s HIV risk in South Africa.

[61] “The Women’s HIV Prevention Tracking Project (WHiPT) is a collaborative initiative of the Global Advocacy for HIV prevention (AVAC) and the ATHENA Network launched in 2009 to bring community perspectives, particularly women’s voices, to the forefront of the HIV and AIDS response (…) The pilot phase of WHiPT has focused on strengthening women’s knowledge about, engagement with, preparedness for, and monitoring of medical male circumcision (MMC) for HIV prevention in countries where rollout was underway or imminent.” The project involves five countries: Kenya, Namibia, South Africa, Swaziland and Uganda. (AVAC 2011)(internet source xx)

[62] Arnott and Kehler, Aids Legal Network, South Africa, have developed the report “Medical Male Circumcision: Are Women Ready”. The contents of the report is also presented in the joint report of WHiPT “Making Medical Male Circumcision Work for Women” which contains one chapter for each country involved in WHiPT. We have chosen to refer to the report “Medical Male Circumcision: Are Women Ready” as it is more elaborated than the chapter on South Africa in the report “Making Medical Male Circumcision work for Women.” (AVAC 2011)

[63] The background and target for the two-day dialogues were the following: “TVEP is driving a process on universal access to female condoms in South Africa by bringing together stakeholders from various sectors” with the aim of adopting “sector position papers and formal work plans that will be endorsed by sector representatives to ensure that the lobby moves forward in a politically strategic way” (Thohoyandou Victim Empowerment Programme 2008)

[64] “TVEP is a rural organisation providing support to women and children who have been abused. This focus has led to HIV issues being included in the project with priorities being HIV prevention, destigmatisation and ensuring access to antiretroviral drugs (Thohoyandou Victim Empowerment Programme 2008).

[65] Ibid.

"Women's HIV prevention Tracking Project" (WHiPT) has made a joint study on the perceived risks that male circumcision presents for women in five African countries, one of them being South Africa. The South African part of the study report is based on qualitative data collected in communities in KwaZulu-Natal and Eastern Cape. The report concludes that "women's specific risks and vulnerabilities to HIV" should be "an integral part of MMC (medical male circumcision) programme and policy implementation" (Arnott and Kehler 2010, 35). The report raises concerns on how women's HIV risk might increase when circumcision is scaled up. WHiPT emphasizes that women generally have very limited possibilities of influencing HIV prevention methods, as men tend to be in control of sexual relations. According to the report, women fear that circumcision will make it even harder for them to insist on condom use, as men might think that they are protected from HIV after being circumcised. Consequently women will be put at a greater risk of contracting HIV. These issues may lead to conflicts between men and women and increase gender based violence (Arnott and Kehler 2010, 29-35).

WHiPT advocates for HIV prevention that women can control, and highlight female condoms as a method that can achieve this objective. We clearly see WHiPT as advocates of the female condom. First, in the introduction of their report, they say: "Female condoms are not freely available and/or accessible to women in South Africa, and are not even actively promoted; and the development of microbicides is still very much in the beginning stage" (Arnott and Kehler 2010, 8). They present this as a problem as South Africa is a patriarchal society, and men dominate in sexual decision making, including the use of male condoms. This gives women limited possibilities of protecting themselves from HIV transmission (ibid.). TVEP is very explicit in its advocacy for female condoms:

> Civil society is faced with what could very well be one of our biggest advocacy challenges of the next few years – that of universal access to the female condom. The need for a concerted national effort to ensure that this goal is

> reached, is clearer now than at any other time in our country's history. Our long term goal to ensure that every woman is able to access the female condom will only be realised with concerted, targeted efforts by donors, civil society and service providers (Thohoyandou Victim Empowerment Programme 2008, 2).

Universal access to female condoms is, according to TVEP, a crucial target that requires the collaboration of donors, civil society and service providers. In their view the target may be one of the most challenging advocacy issues for civil society.

In the next paragraphs we will analyze how the two initiatives argue for female condom usage and what the perceived effects are for women in the short and the long term. The first part focuses on how female condoms can meet practical needs, and the next part on the possibilities of meeting strategic gender needs.

## 7.2. Practical gender needs – why women need female condoms

The WHiPT report calls for greater access and availability of women-controlled prevention methods and recommends better access to both female and male condoms. In the report it is highlighted that female research subjects call for prevention methods that they can control (Arnott and Kehler 2010, 31). The report states:

> The greatest failure of available HIV prevention interventions programmes is the continuing lack of women-controlled HIV prevention options and women therefore have limited power to independently prevent the transmission of HIV (Arnott and Kehler 2010, 8).

According to WHiPT a lack of female-controlled HIV prevention options is the greatest failure in HIV prevention, because it renders women unable to independently protect themselves from HIV transmission. The TVEP report (2008) refers to women's rights to

sexual and reproductive health and stating that the South African government does not secure women these rights, as they do not provide sufficient female condoms (Thohoyandou Victim Empowerment Programme 2008, 13) [66]. In an online article "South Africa and the 2010 World Cup: pushing Women's Rights Further to the Fringe", Tian Johnson, Research, Advocacy and Special Projects Advisor at the TVEP, describes the lack of access to female condoms in South Africa as "a silent genocide"[67]. TVEP frames the discussion on access to female condoms as a matter of life and death. The urgency of access to female condoms is strongly conveyed in both the WHiPT and TVEP advocacy of female condoms.

The female condom is, in the arguments above, serving to meet a specific need of women – a practical gender need, which is urgent. The female condom provides a solution to a problem women are facing in heterosexual relationships; men being reluctant to use HIV prevention methods such as condoms. The WID approach focuses on the transfer of technology and providing "technical fixes" to women in order to improve women's situations (Rathgeber 1990, 491). Similarly, the women's rights initiatives convey a strong belief in female condoms as a measure that will improve women's sexual health by making them less exposed to potential HIV transmission. The argument seems to be that men, through circumcision, are provided with a prevention options will protect them from HIV transmission and increase men's dominance in gender relations. To balance this, women must equally be provided with a

[66] "The distribution of male condoms increased from 308.5 million in 2007, to 495 million in 2010 (a 60% increase). However, what this translates to an individual level is still very low: 14.5 per adult male per year (15-49) in 2010 against 12.7 per adult male in 2008.6 The number of female condoms distributed free has increased from 3.6 million in 2007 to 5 million in 2010 (a 39% increase)" (South African Department of Health 2011).

[67] (Johnson 2010) (internet source 12)

prevention option, which will strengthen their position in gender relations. The underlying assumption seems to be that equal opportunity to access prevention methods will increase gender equality.

A fundamental change, such as greater equality between men and women takes time, and while working towards deeper changes it can be necessary to protect women that are constrained by their context (Heise and Elias 1995 in Baylies 2000, 17-18). WHiPT underlines that women in South Africa live in a context of male domination in sexual decision-making, and a lack of recognition of women's sexual rights (Arnott and Kehler 2010, 8). From this perspective, there are substantial reasons to provide women in South Africa with female condoms, as they live in a context of constrained opportunities to protect themselves.

The premise of our thesis is that gender relations are impacting HIV prevention efforts, and are changed by HIV prevention efforts. We have focused on WHiPT and TVEPs claims about how gender relations hamper prevention efforts for women. We will now proceed by analyzing the potential changes that female condoms could bring to gender relations.

## 7.3. Empowerment through female condoms

The WHiPT report calls for increased access to woman-controlled HIV prevention methods and it highlights (referring to SANAC's recommendations) that circumcision should not divert funds from HIV prevention programs benefitting women directly (Arnott and Kehler 2010:6.). Furthermore in the concluding remark of the report it is stated:

> Lastly, for medical male circumcision to effectively impact on HIV prevention it seems crucial to address the existing challenges of, and barriers to, HIV

> prevention, such as gendered power imbalances and inequality, so as to ensure women's access to, control over, and participation in HIV prevention options that truly reduces women's risks and vulnerabilities (Arnott and Kehler 2010:36).

In this quote WHiPT emphasizes the importance of addressing gender inequality in order to reduce women's risks and vulnerability. Clearly, WHiPT values women's control over HIV prevention highly. They seem to be linking women's increased access to -and control over HIV prevention options to gender equality. This approach is similar to one of Kaler's three notions of how the links between female condoms and women's empowerment is to be understood. The empowerment notion Kaler introduces focuses on women's reproductive and sexual rights. This approach, which the feminist movement has influenced, has been central to international discourse since the International Conference on Population and Development in Cairo in 1994. The Cairo Programme of Action[68], which was an outcome of the conference, emphasizes women as bearers of rights. The rights are defined around control and autonomy, whereas control refers to women's right to control their bodies, reproduction and childbearing. Control must be enhanced by developing technologies that provide women with this control. Autonomy refers to the right of women to act autonomously and not have male partners and institutions dictating their actions, and be freed from reliance of their male partners to protect them from

[68] The Cairo Programme of Action is a result of the International Conference on Population and Development convened by the United Nations and held in Cairo in 1994. The Program of Action gives prominence to reproductive health and empowerment of women (McIntosh and Finkle 1995). The Conference is remembered for its overriding emphasis on women and the Program of Action contains and entire chapter on "gender equality, equity and empowerment of women" (Cohen and Richards 1994). According to Kaler, the female condom almost always carries connotations of women's empowerment and the possibility of greater sexual autonomy for women, as they are the first new "post-Cairo" technology (Kaler 2001, 783).

sexually transmitted diseases (Kaler 2001, 786-787). The argument would therefore be that female condoms empower women, as they provide autonomy and control for women in sexual relations. Women's gendered realities however, may make it difficult for women to use female condoms, which we will elaborate upon later in this analysis chapter.

International development agencies, such as the WHO, UNAIDS and USAID are major international promoters of the female condom, and emphasize the empowering potential of female condoms for women (Kaler 2001, 786). The WHiPT initiative is funded by UNAIDS, among others, and a WHO staff member is specifically mentioned and acknowledged for her contribution in the WHiPT Advisory Group. WHO and UNAIDS statements are also referred to in the report to underline the report's own points. This strongly indicates that the WHiPT approach is in accordance with the approach of these organizations. The same goes for TVEP that explicitly expresses its support to the Cairo-model in that they call for an effective implementation of the Cairo Programme of Action (TVEP 2008, 21). How female condoms are to strengthen women's position and thus increase gender equality will be further presented in the following section on the Cairo-model.

## 7.4. Meeting strategic gender needs through female condoms

When the "Cairo-model" emphasizes the importance of providing women with technological prevention methods, the goal is not only to prevent HIV and pregnancy. The objective is to give women autonomy to control their own bodies, which gives women the opportunity to act according to their rights and thus be empowered in a broader sense (Kaler 2001, 787). In the Cairo-approach, which we argue TVEP and WHiPT both are in line with, empowerment through female condoms is "empowerment-as-meeting-strategic-

gender-needs" (Kaler 2001, 786). This expresses a belief that female condoms might transform unequal gender relations into relationships of gender equality. The following quote, which is also an example of a "Cairo-model" approach to female condoms, presents concrete suggestions as to changes that female condoms potentially bring about in sexual relationships: "use of the female condom can empower women, give them a greater sense of self-reliance and autonomy, and enhance dialogue and negotiation with their sexual partners" (Mantell, Stein and Susser in Peters et al. 2010, 120).

According to the quote, female condoms do not only give women greater autonomy, but also enhance dialogue and negotiation with sexual partners. Women's lack of negotiation power over prevention is an issue, which is described as a problem by TVEP and WHiPT (and many others) and as a central factor increasing women's HIV risk. From the Cairo-model perspective men's dominance in decision-making concerning HIV prevention is a manifestation of inequality in sexual relations. Women are not autonomous and do not control their own body, and thus are subordinate to men. The argument stands that strengthening women's power in decision-making regarding HIV prevention, through the introduction of female condoms in sexual relations, contributes to greater gender equality.

Inequality in gender relations has led to the creation of female-initiated disease prevention methods, such as female condoms. It is these very same structures of inequality, which make it difficult for women to use female-initiated methods (Mantell, et al. 2006, 2000). As we operate with relational notions of gender, we argue that female condoms are not only changing women roles and control over sexual health, but also men's. We will proceed by analyzing how the role of men impacts the promises of female condom use to bring about greater gender equality.

## 7.5. Are female condoms a threat to masculinities?

The promotion of female condoms is based on the assumption that female-initiated technologies will empower women and give them autonomy and control. However advances for women, such as female condoms, can however in some settings become interpreted as loss of power to men (Mantell, et al. 2006, 2000-2011) .

The WHIPT report points to the negotiation over male condoms (after men have been circumcised) and how that can affect women negatively and increase gender based violence (violence against women) (Arnott and Kehler 2010, 9). However, the reports do not raise the concern that female condoms may likewise contribute to gender based violence. To explain the link between female condoms and gender based violence, we will again draw on one of Kaler's three notions of the relationship between female condoms and empowerment. According to the notion, female condoms are perceived as gained power to women and lost power to men. In other words, empowerment of women means disempowerment of men; thus it is a zero-sum game. This also means that men may perceive empowerment of women through female condoms as threatening, and consequently are not supportive of the contraception method (Kaler 2001, 793). Kaler's article is based on interviews with providers of female condoms in clinics in Kenya and South Africa[69], and she refers to a specific clinical worker to exemplify this zero-sum perception. The clinical worker explains that men in his clinic perceived the female condoms as "a threat to their masculinity". The threat consists was due to women taking charge in sexual relations, by for instance using a female condom without telling her partner (Kaler 2001, 793).

Another informant in Kaler's study points to studies that show that men will "cause problems for women", if women use female condoms, and questions the empowerment

[69] Kaler does not distinguish between the two countries in her studies.

effect of female condoms if the use of female condoms will lead to “negative consequences from their men” (Kaler 2001:787-788). The same informant underlines that gender inequality cannot be changed by a ‘piece of plastic’ (red: female condoms) (Ibid.). This statement is similar to the Berer quote in the beginning of this chapter where it is argued that “Anyone who thinks that a technical solution to a socio-sexual problem can work on its own, no matter how many millions of dollars they can throw at it is, I believe, deluding themselves” (Berer 2007, 46). She is referring to male circumcision, but her statement is also applicable here as the debates are similar to those on female condoms and their influence on gender relations. Female condoms bring about shifts in gendered power relations, which may not be welcomed by men who feel that their control in sexual relationships is being threatened if women use female-controlled methods (Mantell, et al. 2006, 2001-2003).

Notions of hegemonic masculinity in South Africa give us reason to believe that female condoms may be perceived as a threat by men whose masculinity is heavily defined in relation to sexual dominance over women, and thus decision making over HIV prevention methods. Mantell et al. point to gender based violence and sexual coercion of women, which is associated with increased risk of HIV and AIDS, as what may be one of the most extreme examples of backlashes of female condoms (Mantell et al. 2006, 2001). Gender based violence an indicator of imbalance between men and women and may be the strongest indicator of gender inequality (Jewkes et al. 2003 in Karim et al. 2010, 126). So negotiation over female condoms may, in the same way as negotiations over male condoms, increase gender based violence. This indicates that changes in gender relations, brought about by introducing female condoms, may actually increase gender inequality as opposed to gender equality, as suggested by the Cairo-model and WHiPT and TVEP as “supporters” of the model.

WHiPT and TVEP use the global discourses that derive from the Cairo-conference – namely women's rights to reproductive health. A critique could be that TVEP and WHiPT overlook important aspects of the gendered reality they seek to address, namely the one that prevents women from using female condoms even if they had access to them. It can be argued, as is also the critique of WID, that the attempt to change women's positions by targeting women is putting too much responsibility on women in a patriarchal South African setting, where women do not autonomously control their own bodies.

Men's involvement in HIV prevention has, as already described in the theoretical chapter, become a major focus in HIV prevention. The Brothers for Life campaign on circumcision seeks to use the scale up of male circumcision to transform the South African man into a "new man". The new man is, among other things, not violent towards female partners, and he contributes to halting the transmission of HIV in South Africa. Their HIV prevention method is "men-centered" as is argued in chapter six. The two female condom advocates, WHiPT and TVEP however, are mainly focusing on decreasing women's HIV risk by addressing only women. We now proceed by discussing the limitations of a women-centered approach if women's needs – both practical and strategic gender needs - are to be met, followed by a discussion on how men can become involved in promotion of female condoms.

## 7.6. Can the needs of women be met without the involvement of men?

Both WHiPT and TVEP have a strong focus on women's rights and how women can be emancipated from subordination to men. The name of the organization, Thohoyandou Victim Empowerment Programme (TVEP), also highlights this focus. The organization's name contains both "victims" and "empowerment". It therefore seems clear that women are victims who need to be empowered in order to diminish their HIV risk. In portraying women as victims, we also see a clear representation of men as the perpetrators. Their

mistreatment of women lies in exposing women to HIV infection by a reluctance to use condoms. This is in line with the notion of the women's vulnerability paradigm. The women's vulnerability paradigm suggests that women biologically have a higher susceptibility to HIV than men, and have reduced sexual autonomy due to men's power and privilege. These factors make up women's particular vulnerability to HIV. Furthermore it is assumed within the paradigm that women want to protect themselves against HIV and men do not (Higgins, Hoffmann and Dworkin 2010, 435).

According to Chant, it is not beneficial to stereotype women as "good" and men as "bad" as it keeps the genders in opposition to each other (Cornwell 1998, White 1997 in Chant 2000, 10). In the zero-sum perspective of Kaler, increased power through female condoms is perceived as decrease of power to men. This creates opposition between men and women. WHiPT and TVEP focus on empowering women in sexual relationships through female condoms. It can be argued that this focus may contribute to creating opposition between the genders. Also the approach may not be effective due to unequal gender relations. According to Wood and Jewkes, targeting women alone can be even more problematic, especially in the area of sexual health, as women do not autonomously control their own bodies and thereby their own sexual health. Their sexual health is highly dependent on men. Therefore, they argue, men's involvement is crucial (Wood and Jewkes 1997 in Chant 2000, 11).

According to a demographic researcher, cited by Kaler, it may take up to twenty years before women in rural settings will be allowed to use female condoms by their husbands (Kaler 2001, 787-789). If men are not allowing women to use female condoms, female condoms are not female-controlled but male-controlled. In that case female condoms are not increasing women's autonomy to control own sexual health. Kaler furthermore highlights that female condoms may in reality only appeal to women who *are* already empowered. Disempowered women would not act autonomously to their men, and

would not be empowered by female condoms (Kaler 2001, 787-789). Again, the belief in female condoms as a way of empowering women can be critiqued for not taking into account the gendered realities, where women cannot independently from men decide to use female condoms[70].

The WHiPT initiative refers to the need for "changing gender relations" as a way of improving women's situations, and the report calls for greater involvement of women in the roll-out of circumcision (Arnott and Kehler 2010, 23). Addressing gender relations is in line with GAD's emphasis on involving both men and women in solving development issues together. However, the main focus of the report is on women's concern regarding increase in their own HIV risk as a consequence of circumcision for HIV prevention. The solution to women's HIV susceptibility is "women's access to, control over, and participation in HIV prevention options" (Arnott and Kehler 2010, 36). We find that WHiPT may be using the GAD terminology of changing gender relations, but in practice form their activities according to the WID – women-centered approach, which seems problematic if men are opposing female condoms. Mantell et al. (2006) suggest that men should be engaged in the promotion of female initiated methods from the development of the product to the time it reaches the market. Furthermore, they suggest working on messages that equate female-initiated prevention methods with masculinity and manliness, and responsibility for men's own and others' health. These messages should appeal to "men's desires to maintain authority in decision making, protectiveness towards their partners, families (…)" (Mantell et al. 2006, 2004-2005). The suggested messages are

[70] In our method we have already pointed out that we are operating with very broad categories of men and women. This means that we do not address internal differences within the categories of "men" and "women". At this point we find it relevant to point attention to the major differences in men's acceptability of female condoms, depending on the type of gender relations in question. Acceptability of female condoms seems more difficult in steady relationship with a "trusted partner" than in a one-time sexual encounter (Kaler 2001, 789) and men's control over a regular partner's sexual health is greater than that of a once-off sexual partner. Although an interesting issue, further analysis of this issue is not within the scope of our thesis.

similar to the messages that are being conveyed in the circumcision campaign in South Africa. Promoting female condoms alongside the circumcision campaign could perhaps secure men's acceptance of, if not men's support of female condoms, if the matter is framed as a man taking authority by securing the health of his family. As mentioned in chapter six, this could strengthen the masculine image of the South Africa man who is in a state of 'masculinity crisis'.

To round up our discussion on whether female condoms can contribute to more gender equality in the context of a scale up of circumcision, we will link the notion of the responsible citizen to gender equality. Similarly to the argument of the responsible citizen in regards to men targeted in the Brothers for Life circumcision campaign, we will discuss how women are responsible citizens through use of female condoms.

## 7.7. Women as responsible therapeutic citizens

In the same way as men are encouraged to act as responsible therapeutic citizens through circumcision and condom use; female condoms can be women's way to become responsible citizens that are contributing to the health of the nation. By use of female condoms, women can become successful citizens who can remain HIV negative and will not transmit HIV to sexual partners. It can therefore be argued that women, similarly to men, would be able to be responsible citizens if they had access to female condoms.

The current HIV and AIDS and STI National Strategic Plan for South Africa 2007-2011 budgets the provision of the purchase of 425 million male condoms and three million female condoms[71]. According to Peters et al. (2010) the benefits of circumcision are less obvious than those of female condoms, but still it is circumcision programs that are being scaled up and receiving major amounts of international funding, as opposed to female

[71] (Johnson 2010) (internet source 12)

condom programs. In the opinion of Peters et al., female condoms should become a higher priority in HIV prevention and receive more funding (Peters, Jansen and van Driel 2010, 122-125). From a post-development perspective, priorities of how to develop underdeveloped countries are dominated by international development actors and agencies who define the solutions to development problems. In this case male circumcision has been prioritized over female condoms as a way of solving the problem of HIV and AIDS transmission in heterosexual relationships. This has very tangible effects on the horizontal level of gender relations where the power relations are challenged and changed by the type of development interventions that are implemented. Priorities in HIV prevention methods lead to forming the landscape in which women and men can "choose" to become a responsible citizen, depending on the prevention option accessible. Would it be possible for both men and women to play active roles in HIV prevention in a context where the new man would be the dominant masculinity?

## 7.8. Can the 'new man' accept female condoms?

Brothers for Life are representing a "new man" who is concerned about gender equality and this is evident in his opposing gender based violence, sticking to one partner, using condoms, and similar ABC messages. The overarching message of the campaign is that a man should take responsibility for protecting the health of the nation including the health of female partners, so that women and children will not be infected with HIV. Men are being encouraged to be responsible for preventing HIV, without women playing an active part in prevention. Women are instead presented as someone you should protect and consider (chapter six). As already said, it is suggested that promotion of female condoms may be more effective if messages appeal to "men's desires to maintain authority in decision making, protectiveness towards their partners, families (…)" (Mantell et al. 2006, 2004-2005). There is however a danger in this approach. Mantell et al. point to that appealing to a "masculinist discourse" leads to "masculine-bolstering behaviors" which

reinforces gender inequality and harms women (ibid.). As already argued in chapter six, men are encouraged to take responsibility for women's and men's health rather than taking responsibility together with women. Such masculinity discourses may imply that men's identities continuously will be defined around dominance in sexual relationships, which includes decision-making regarding HIV prevention. "Responsible men" might feel their masculine identity threatened if women also acquire a role as responsible citizens through use of female condoms, as this would challenge men's control over sexual relations, including women's bodies and sexuality. Within this scenario women's opportunities to execute a role as responsible citizens may not necessarily be possible, even if TVEP and WHiPT and other advocates of universal access to female condoms in South Africa should reach their target of universal access to female condoms. Hence, gender relations may not necessarily become more equal in terms of women gaining more control and autonomy through the use of female condoms, even if men take on a 'new man's identity'. As we work with a dynamic notion of gender which is continuously being negotiated, the 'new man' is a category, which currently may not accept women's control over their own bodies and sexual health, but possibly might do so in the future.

The female advocates TVEP and WHiPT are targeting women's equality in gender relations through a female-centered approach. The efficacy of female condoms depends, according to Mantell et al., on engaging men and women simultaneously as gender is relational (Mantell et al. 2006:2003) and thus impacts both genders and their sexual health. The same could be said about male circumcision where we argue that the Brothers for Life campaign in that it only targets men, sidelines women's role in HIV prevention.

Baylies and Bujra emphasize that closer linkage between women's empowerment and male involvement need to be established for strategies of protection against HIV and AIDS (Baylies and Bujra 2000, 196). A danger which we have identified in both the female and male-centered HIV prevention approaches is that men and women are put in opposition

to each other. And we have argued that none of the approaches enhance gender equality but instead further bolster gender inequality, including weakening women's control over own sexual health. The question is then if female condoms in a time of scale up of circumcision will create more gender equitable relations. Based on this analysis, we will suggest that this depends on whether both women and men will play active roles in both HIV prevention programs targeting the needs of men and women and programs of women's empowerment and men's involvement.

## 7.9. Sub-conclusion

We argue that TVEP and WHiPT are in line with the Cairo-model that emphasizes that female condoms empower women by giving them control and autonomy over their own bodies, and thus sexual health. This may enhance women's position in gender relations. Female condoms may also however lead to less gender equality. The same gendered realities that WHiPT and TVEP seek to address by advocating universal access to female condoms, may also be the ones that hamper women's use of female condoms. The gendered realities include men's control of women's bodies and decision-making regarding use of prevention, which means that some men may see female condoms as "a threat to their masculinity". The result may be that men are not allowing women to use female condoms, and increased gender violence and thus less gender equality due to this.

Involvement of men in HIV prevention may be a solution to the acceptance of female condoms. This could be done by through messages that equate female-initiated prevention methods with masculinity and manliness, and appeal to the responsibility for men's own and the health of the nation, like has been done in the circumcision for HIV prevention campaign. The new man, promoted by Brothers for Life, is encouraged to take responsibility for his own and his family's health. In that context, men may feel threatened regarding their role as "responsible for the family's health" if women take on a

role as “responsible citizens”, who also play an active part in decision making about prevention in sexual relations.

TVEP and WHiPT seek to strengthen women’s position in heterosexual relations by targeting women. Brothers for Life have a male-centered approach to HIV prevention. None of the approaches increase women’s and men’s collaboration in HIV prevention, but further weaken women’s control over own sexual health. We suggest that the likelihood of achieving more gender equality depends on involving both men and women in both women’s empowerment and men’s involvement HIV prevention programs. This may prevent the polarizing effect of women’ and men’s centered programs and create more equality in that both men and women are given an opportunity to play active role in HIV prevention.

# 8. Discussion

SANAC recommends that "communities should be informed that male circumcision was only partly effective in preventing HIV infection"[72]. This recommendation points to the importance of informing communities about the partial preventive effect of circumcision. Based on experience from Sub Saharan African countries, the concern is, among other things, that men in South Africa will think that circumcision provides them with total protection from HIV transmission, and consequently refrain from using male condoms (see chapter four). Catherine Hankins, advisor to UNAIDS, emphasizes the necessity of clear and consistent messages of the "partial protection" of male circumcision in order to inform men and women that male circumcision cannot stand alone in preventing HIV. Circumcision must be combined with a delay in the onset of sexual relations, a reduction in the number of sexual partners, consistent and correct use of female/male condoms, and other ABC-related messages. Hankins calls for the reinforcement of "partial protection" messages, so that both men and women are fully informed of the fact that male condoms must continuously be used, even if a man is circumcised. According to Hankins, if men and women understand the message of partial protection, women's negotiation power will be further facilitated (Hankins 2007, 65).

## 8.1. Changing men through individual approaches?

In our analysis we have argued that the main focus of the intervention of circumcision and the Brothers for Life circumcision campaign is on the individual. Emphasizing individual responsibility when addressing a reduction of HIV infections as a public health concern, we argue, limits the complex issues surrounding gender and HIV prevention to a question

[72] (Irin PlusNews 2009) (internet source 13)

of whether the individual has the sufficient knowledge that will impel them to change. The prospects of achieving the intended targets of the scaling up of circumcision becomes a question of individuals understanding that circumcision only provides partial protection and the necessity of combining the prevention option with ABC practices. But what are the possibilities of creating more fundamental changes in masculinities and male behavior through the circumcision intervention in South Africa?

In order to create long term solutions to address the spread of HIV, gender issues are crucial to address, as they are main drivers of the HIV epidemic (Jewkes 2009, Boesten and Poku 2009, Susser 2009, Jewkes and Morrell 2010). Addressing masculinity and encouraging men's involvement are in particular being highlighted as central solutions in HIV prevention. Men's involvement in the circumcision intervention consists of men undergoing circumcision and acquiring or maintaining sexual behaviors that are considering non-risky in terms of spreading HIV. The behavior change approach is quite common in men's involvement programs. Cunha (2007), who writes on the South African context of HIV prevention, highlights that individual determinants of HIV infection including multiple sexual partners, are often the focus in HIV research. HIV prevention interventions are often designed to change individual behavior through addressing knowledge, attitudes and beliefs (Cunha 2007, 213). Akeroyd (2004) emphasizes that several studies and HIV prevention programs are based on the Knowledge, Attitudes, and Practices approach (KAP). In addition, Akeroyd refers to ABC messages reinforcing the KAP approach by focusing on individual notions of self-protection like abstain, be faithful, condom use. Approaching individuals with such messages presumes that they are in a situation to change circumstance if they so choose (Akeroyd 2004, 90).

Cunha critically states that often social structures limiting a person's ability to make healthy decisions are not addressed in HIV prevention, and instead behavior change is at focus (Cunha 2007, 213). According to Gupta et al. (2008) structural level interventions do

not target individual's behavior, instead it "addresses factors affecting individual behaviours, rather than targeting the behaviour itself" (Gupta, et al. 2008, 766). The circumcision intervention clearly primarily target individual behaviors and not structural factors. Gupta et al. argue that structural factors can act as barriers to HIV prevention efforts targeting individuals and the individual's adoption of HIV-preventive behaviors (Gupta et al. 2008, 765). We have also identified structural factors, such as hegemonic masculinity ideals, which is a gender structure that limits the decision-making of the individual man in adopting practices to change his behavior. Susser (2009) argues "if we do not understand what circumcision might mean for the interaction between men and women then we cannot rely on demographic arguments regarding the HIV reducing effect in the population as a whole" (Susser 2009, 217-218). She questions the outcomes predicted by mathematical models, if gender relations are not taken into consideration. These arguments, we find, speak for structural changes in gender relations if the circumcision intervention is to have long-term effects. However a large scale reduction of HIV prevalence in the population as a whole may not materialize if gendered relations are not taken into consideration. Addressing structures that influence on gender relations is crucial, as men's and women's lives and choices, including the use of prevention options, are determined by gender relations that open up or limit control of sexual health in gender relations.

## 8.2. Combined prevention strategies – including structural approaches

Gupta et al. speak for structural approaches as part of combined prevention strategies. A central argument for this is to avoid oversimplified individual approaches that are utilized across different populations (Gupta, et al. 2008, 764-771). Applying structural approaches however, seem to be conditioned by a willingness to stop prioritizing interventions with an individual approach. Gupta et al. illustrate that mainstreaming structural approaches revolves around "the extent to which prevention does not simply respond to pressure for

lists of intervention or overly simplistic magic bullets and individual approaches" (Gupta et al. 2008, 773). We argue that circumcision as it is promoted in the circumcision brochures is individual in its approach. However, it may potentially have a greater effect combined with structural approaches addressing relevant structures in South Africa. Gupta et al. emphasize that structural approaches facilitate "community processes that catalyze social and political change" and "can be applied in combination with behavioral or medical interventions targeted at individuals" (Gupta et al. 2008, 766). Examples of programs that are structural in nature include micro-finance programs, which can potentially generate an income to women. The aim is for women to escape financial dependency on men, which may empower women in their negotiations and in sexual relations. Another structural approach to create more gender equality is to work with changing social norms and expectations of masculinity (Gupta et al. 2008, 766-767). Gupta et al. highlight examples of men's programs, which they define as structural in their approach. Such programs focus on gender roles and norms in order to transform social norms that contribute to HIV vulnerability. In Program H in Brazil young men have been encouraged to "question traditional gender norms and promoted both discussion and reflection about the costs of inequitable definitions of masculinity and the advantages of more gender equitable behaviour" (Pulerwitz et al. 2006 in Gupta et al. 2008, 767). In South Africa there are several community programs for men that stimulate similar discussion and dialogue focusing on health and gender. They are however still small in scale (Peacock, et al. 2008, 2).

## 8.3. Local Brothers for Life community groups

Even if Brothers for Life are focusing mainly on behaviors, they clearly seek to promote a new identity to South African men. Our definition of a citizen in the therapeutic state is a citizen whose gender identity is contingent with norms in the local context. The new man's identity is bound to a national level, in being a responsible South African man.

However, norms of identities are often determined by gendered relations on a local level, which means that men identify primarily with ethnic male identities and secondary with national male identity. That has different implications in terms of addressing masculine identity. First, the masculinity that Brothers for Life is addressing might have an identity that is primarily bound to a local setting and so the messages to the "South African man" in a broader notion may not appeal to him. Second, gender structures of the local context may prevent the individual from adopting HIV-preventive behaviors (Gupta et al. 2008, 765). Forging community groups on masculinity and HIV would therefore, in our view, provide a way of discussing the identity of the new man in the local setting. Addressing masculinity identity collectively to men in a given setting might facilitate collective changes in masculinities. In that way the gendered realities, or gender structures, could change and not long be obstacles that prevent individual men from adopting sexual behaviors that are non-risky in terms of the spread of HIV.

# 9. Conclusion

The thesis aims at scrutinizing how circumcision, as an intervention that involves men in HIV prevention, is influencing gender relations and men's and women's control over own sexual health in South Africa. To answer this we have posed four research questions that each leads to conclusions that contribute to answering our problem formulation.

Our first research question *what are the implications of an individual responsibility to circumcise wedded with public health targets of HIV prevention in the South African context of circumcision scale up?* focuses on men's choice to circumcise. We argue that circumcision campaigns are putting pressure on men to circumcise by appealing to their responsibility as therapeutic citizens. A successful therapeutic citizen is both HIV negative, circumcises and adopts non-risky sexual behaviors in order not to transmit HIV. This also means that being circumcised may become a marker of a "responsible men" versus an "irresponsible man". HIV positive men are not encouraged to circumcise and they may be put in the category of irresponsible men. In that way circumcision can become a way that HIV positive men are stigmatized. The responsibility that men are encouraged to take on them consists in that they contribute to the health of the nation by protecting their own health by getting circumcised. The pressure to take personal responsibility for HIV prevention is further reinforced by a shift in national HIV strategies in South Africa that currently emphasize that individuals must take responsibility and test for HIV. This shift means that even circumcision is a right and a service a man can choose to receive, the choice is less emphasized, in that health providers strongly encourage individuals to undergo circumcision. In other HIV prevention interventions men have been paid money if they adopt a sexual behavior which is non-risky in terms of HIV spread. This method is called "conditional cash transfers" and we argue that if this would be applied in relation to circumcision, the individual choice to circumcise would be further undermined. Additionally we argue that it might be an effective short term method. However,

underlying gender structures that contribute to HIV spread are not addressed in the method, and we therefore doubt the method's efficiency in the long run.

Our second research question *which male representations are produced and reproduced in the scale-up of the circumcision intervention?* helps us scrutinize how masculinity is being constructed in the messages of the Brothers for Life campaign. We argue that the campaigns masculinity notion of a "new man" is a combination of traditional and modern notions of masculinity. The traditional consists of presenting masculinity as a privilege and a right of the South African men, which we argue are traits from the hegemonic masculinity in South Africa. The modern aspects focus on men as "responsible men" and strongly rely on "men's involvement" strategy of the WHO where the focus is on changing men's irresponsible sexual behaviors into behaviors of ABC (abstinence, be faithful and condomize). Brothers for Life appeals to men's paternalistic responsibilities by focusing on the man's responsibility of both his own, women's and family's health. In a context where the South African man is in a state of crisis and lost their role as the providers of the family, this approach may motivate men to take on a role as providers of health to their families. We however see a danger in the campaign's emphasis on men's responsibility to both protect their own and women's health. This may lead reinforcing the old patriarchy where men control both men's and women's sexual health.
We criticize the standardized approach to men's involvement through circumcision and behavior change, as essentialising men and representing a rigid and narrow notion of masculinity. Furthermore the notion is not context-bound and it overlooks gendered realities which makes it difficult for individual men to choose to adopt ABC-behaviors if this goes against the norms of the rest of the community.

The third research question is *can female condoms contribute to enhancing women's control of their bodies and gender equality?* By analyzing two women's rights initiatives, we have explored what the effect of female condoms might be in a time of scale up of

circumcision. The initiatives advocate for universal access to female condoms in South Africa and argue that this will secure women's control over own sexual health and create gender equality. We however point to that female condoms may be perceived as a threat on men's masculinities. The hegemonic masculinity in South Africa is defined around control of women's bodies and also decisions concerning prevention. This means that many men will not allow women to "take control" by using female condoms and expose women to gender based violence if they embark on using female condoms. Gender based violence is a strong indicator of gender inequality and thus female condoms may lead to less gender equality. A way men might accept female condoms is to frame it in the same messages as the circumcision campaign. Men's support to female condoms may become an indicator of a man who is a "responsible man" in that he provides health to his family. We have suggested that female condom may provide women an opportunity to play an active role in preventing HIV. Thereby, men and women are given equal opportunity to be active in contributing to the health of the nation through adopting HIV preventive options. The "new man" as a man who takes responsibly for both his own and the women's health may however be an obstacle as men might feel threatened on their role as "responsible therapeutic" citizens if women also play an active role in HIV prevention. The Brothers for Life campaign emphasize men's role in HIV prevention and the two women's rights initiatives have a women-centered approach to women's HIV prevention and women's empowerment. We argue that one-gendered approaches do not contribute to gender equality but rather polarize men and women. We therefore argue that initiatives including both genders may be fruitful. This might contribute to increased collaboration of the two genders where both men and women are equal in terms of actively contributing to HIV prevention and the health of the nation.

Finally, we have discussed: *What are the possibilities of creating more fundamental changes in masculinities and male behavior through the circumcision intervention in South Africa?* We argue that the circumcision intervention and the Brothers for Life represent

individual approaches to HIV prevention, which means that they address individual behaviors. The approach emphasizes that men need to be properly informed about the advantages of circumcision and non-risky behavior and the assumption seem to be that this understanding will lead to a change in behavior. Structural approaches, on the other hand, address the structures that determine individual behaviors. Men are encouraged to transform and to adopt non-risky sexual behaviors. We argue that gender structures, including masculinities, at the local level are barriers that hinder individuals to adapt new behaviors. In order to address masculinities in local settings, campaigns, such as Brothers for Life, could add a component of community based groups. In these groups men can discuss male identities and discuss the masculinity norms that contribute to spread of HIV. Addressing men at a local level may contribute to a collective change in masculinities which removes the barriers that hinder individual behaviors change.

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