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## Sexual &amp; Reproductive Healthcare

journal homepage: [www.srhjournal.org](http://www.srhjournal.org)

# 'I have made children, so what's the problem?' Retrospective self-circumcision and the sexual and urological health needs of some Somali men in Sweden



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## ARTICLE INFO

## Article history:

Received 23 April 2016

Revised 29 August 2016

Accepted 14 September 2016

## Keywords:

Male circumcision

Men's health

Penile reconstruction

Reproductive health

Migrant healthcare

Sexual wellbeing

## ABSTRACT

Unskilled traditional healers are widely blamed for complications to male circumcision performed in low- and middle-income settings. However, attributions of culpability are mostly anecdotal. We identify self-circumcision in adults that was performed during adolescence, hereby termed retrospective self-circumcision, and unexpectedly discovered during interviews with Somali men in Sweden in 2010. This study explores the phenomenon with the aim to increase our understanding about the health needs of this group. Two focus group discussions (six and seven participants), one informal discussion with three participants, and 27 individual interviews were conducted in 2010 and 2011 with Somali-Swedish fathers, guided by a hermeneutic, comparative natural inquiry method. Eight participants had performed retrospective self-circumcision while living in rural Somalia. Actions were justified according to strong faith in Islam. Genital physiology was described as adequate for producing children, but physical sensation or characteristics were implied as less than optimal. Few had heard about penile reconstruction. There was hesitation to openly discuss concerns, but men nevertheless encouraged each other to seek care options. Presently no medical platform is available for retrospective self-circumcision. Further systematic exploration is recommended in sexual, reproductive and urological health to increase interest in this phenomenon. Our findings suggest approachability if health communication is enabled within an Islamic context.

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## Introduction

The current literature on male circumcision is diverse and founded on seminal papers justifying the procedure on cultural and religious terms or as a medically beneficial protection against STIs and HIV infection [1–3]. Studies extolling its medical benefits tend to target certain geographic regions, such as those populated by sub-Saharan groups known not to practise traditional male circumcision [4]. Research targeting a specific religious profile has also linked the procedure to medical benefits in such settings as the Muslim Middle East and Turkey, and Muslim sub-Saharan Africa [5–8]. However, uptake of the procedure across HIV prevalent areas has proved irregular, and systematic evaluations of men's improved health have not been replicable in other low- and middle-income regions, such as in the Caribbean, where STI and HIV prevalence have been shown as increased among circumcised men when compared to uncircumcised [9,10]. In addition, uptake of male circumcision on the

foundation of improved sexual health outcomes has recently been met with widening scepticism.

Male circumcision is a common, worldwide surgical procedure that removes some or all penile foreskin, also termed prepuce. Depending on the cultural context, the procedure is performed across all developmental ages, from infancy to adulthood. Reported negative outcomes include uncontrollable bleeding, maiming, penile strangulation, and injuries requiring surgical intervention [11]. The overall complication rate depends on the country, as well as on the indications for circumcision, and on who performs the procedure [12]. This variability explains why the rates of complications for male circumcision vary globally from 0.2% up to 55% [13–15]. Anecdotal accounts of serious complications following the procedure are common, but are supported by reports of numerous pre-pubescent boys attending formal care because of post-circumcision complications [14]. The most serious complications are blamed on traditional circumcisers where, in some countries, 85% of the traditional circumcisers are devoid of medical training [5,16]. Whereas rather few studies across the globe actually justify this high rate of unskilled error, incompetent traditional circumcisers and healers are used as justification to medicalise the procedure.

Can traditional circumcisers be fully to blame? Serious complications, such as penile necrosis, are also reported in a handful of

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published case studies identifying the use of a medically unapproved plastic ring for self-circumcision [17,18]. The reason these men performed self-circumcision was identified as a desire to be protected from poor sexual health and medical outcomes. However, there is, according to Natali and Rossetti [18], a cause for concern about the increased presence on the Internet of these plastic devices, which presumes future adverse effects following their use by anyone wishing to perform the procedure on themselves.

Self-circumcision, with or without the use of a plastic device, is presently an underexplored area in men's sexual and urological health. In particular, a paucity of attention is demonstrated about physical outcomes and sexual health concerns of adult men that had performed self-circumcision as an adolescent, a phenomenon we term *retrospective self-circumcision*. Medical researchers may be unaware these men exist. Or the men may be hidden within the scores of reported injuries stemming from untrained traditional practitioners. Or these men's experiences might lay outside the wider debates on the medical value of male circumcision.

This explorative paper reports the experiences of a few Somali men, who had as adolescents in Somalia, performed self-circumcision. These data emerged within a larger, medical anthropological project on. Early in the data collection, one father explained having had no prior experience organising someone else's circumcision, but he could personally elaborate on having performed his own. Following this unanticipated revelation, we added an informed question to all subsequent meetings with male participants, and report these findings here. The objectives of this emergent sub-study thus became to explore the phenomenon of retrospective self-circumcision among married immigrant Somali men, to identify any unmet needs related to their sexual health, and to encourage greater interest among sexual and reproductive health professionals in western settings.

## Methods

Ethics approval came from the Regional Research Ethics Board for conducting hermeneutic data collection with immigrant African parents. All participants gave informed consent for participation in the project. The main study collected qualitative data from 27 Somali fathers using individual, in-depth interviews, one informal discussion with three participants, and two ( $n = 13$ ; 6 and 7 men, respectively) focus group discussions (FGD; Bernard [19]). Recruitment was conducted with a single inclusion criterion that a man should have witnessed at least one birth while living in Sweden, presumably that of his intimate partner. Seven key informants were identified by snowball sampling in seven different cities across Sweden, and these agents then purposefully recruited interested participants from their local community organisations – a typical sampling procedure in medical anthropology research [19].

Four fathers declined participation after being approached, and three had agreed to participate but then left early because the start-up process took too long. The latter left the session before contact details could be obtained or they refused to provide them. The main reason for declining participation was dissatisfaction with previous research outcomes about Somalis living in western countries as reported by the public media. The demographic of participating fathers included an age range of 22–66 years. All men were born and had grown up in Somalia at least through the age of 13, and one father emigrated at the age of 62. Length of time in Sweden ranged from at least 6 months to at most 19 years. Range of children was 1–14. Some of the participants had had children in Somalia before arriving to Sweden. At the time of the study, all men were married to the same woman with whom they shared the child-birth experience. Professional status included student, jobseeker, business professional, and community-level politician. At least one Imam identified himself as such. The location of a participant's

upbringing in Somalia relied upon self-disclosure, since it was not possible to confirm city/village of birth in this context.

## Data collection

All tape-recorded sessions were conducted at a participant's home, at a conference centre of the researcher's hotel, or in a room at a community social centre. The full length of the individual interviews took 20–90 minutes, restricted in time only by the man's discontinued willingness to be interviewed. The FGDs lasted 4–5 hours, and were again dictated according to the men's preferences. The aims of this present paper were explored using the open-ended question, "Have you heard about any Somali boys who have attempted to circumcise themselves?" The question was introduced well into an ongoing session, after an explicit level of openness (interpreted as trust) was established in the dialogue. Consistent with the main study, these data were collected in English or Somali by the first author, a medical anthropologist, and the second author, a university educated (psychology) female Somali research assistant. A second female, doctorate-level researcher volunteered as Somali-English interpreter for part of the data collection. Continuous live debriefings occurred routinely during all sessions, as well as during numerous rest breaks. Refreshments were served, but participants were not otherwise compensated. Misinterpretation between the first author, interpreter, and participants was dealt with immediately. Random back-translation of four transcripts containing this dialogue was performed by a third Somali-English translator (professional), a Somali-British man who was hired from Kenya and not affiliated with the research group.

## Analysis

Data were analysed by all four members of the research team using hermeneutic naturalistic inquiry and a process of constant comparison akin to grounded theory method [20,21]. This method is operationalised by initially using emergent design to expand in-depth, open-ended questions throughout the process of collecting data. During later analysis, the process of constant comparison was used across the full dataset to identify commonalities in the men's experiences while anchoring the insights to their individual contexts as having grown up in rural Somalia. All four authors read and reread the transcripts, which contained anthropologically relevant information, such as sighs, long silences, and laughter, to help convey the participants' voices. We ultimately came to agreement about which intuitions were most relevant to the study aims. There were no disagreements among the team about the importance of one identified intuition over another, except when it came to anticipating which future researchers might be most interested in the results. The final themes were thereby emphasised to reflect both medical and social science interests. The three interpreted themes about these participant's experiences with self-circumcision are as follows: *Widespread awareness but limited communication*, *Survival equates to an honourable act*, and *Undetected injury: reproduction is not the problem*.

## Findings

Among the total number of participants ( $n = 43$ ), eight had reported performing retrospective self-circumcision as a teenager, without the help of a traditional healer or any other adult. Participants in the first FGD explained about a historic tradition in Somalia, where young boys learned from their male elders about a religious necessity for circumcision. This notion was confirmed by member-check during in all subsequent data collection sessions [21]. Typical male circumcision of boys was explained as being organised by the father, and performed in the cities by a medical professional or a trained non-medical practitioner, or in the countryside by

either a trained or untrained male traditional healer/practitioner. One participant contradicted this prescribed norm by saying that, in his village, a female traditional midwife had performed the circumcisions on both boys and girls for “as long as he could recall” (FGD2, rural, 6 children). Modern boys living in cities, such as Mogadishu or Hargeisa, would usually have the procedure well before the age of 2 years, but men in their 60s were described as also having self-circumcised if their parents had not made arrangements. A boy in the countryside, including those living a nomadic lifestyle, had to wait for a traditional practitioner to visit his area, and for his father to organise payment. The target age in rural villages was 7–8 years.

#### *Widespread awareness but limited communication*

Most participants, despite urban or rural upbringing, responded to our posed question with a simple “No”. However, among those willing to answer, a general response was to acknowledge that boys, mostly in the rural countryside, have been known to self-circumcise. Memories of having heard rumours about boys nearly bleeding to death fuelled their anecdotal awareness. One man in his 60s added, “It happened more than you think. The situation for boys in our Somali countryside was tough, if you compare what we have today, but they wished to keep their faith in Islam. I think their motives were quite innocent, and they proved to themselves strong beliefs in Islam” (FGD1, rural, 12 children). Another man in the same session added,

Yes, I know of two boys who tried that, one was 11 and the other 14, and they both nearly bled to death. They had made their own pact to help each other take care of it. But we became very worried because it took every one of us in [that part of our village] to help stop the bleeding (FGD1, rural, 8 children).

When this finding was presented by the researchers to the three men in the second group session, one man spontaneously offered:

Yes! Exactly! What was I supposed to do? My father was working in Mogadishu and so he was never there to organise my circumcision. Every time the healer came through, my mother just told me to be patient. I decided to take matters in my own hands when I turned 12, and took the razor blade my mother used to cut meat when she prepared our food. I could not believe there was so much blood. My friend was playing nearby. I called for him to bring my mother, and it felt like it took that guy such a long time to come back! My mother told me to clamp down and she put herbs to stop the bleeding. It seemed that I had nearly scraped off the tip of myself (FGD2, rural, 4 children).

Another in the same group offered, “Yes, I think that also happened a lot in my village. Maybe some boys did not want the lady midwife to perform this because they were too old and embarrassed” (FGD2, rural, 6 children). One interview participant explained that he grew up in a rural region of Puntland before moving to the city, and was aware of adolescent boys nearly bleeding to death while attempting to perform this procedure on their own. He reflected,

City boys ... don't even think of their circumcision again until their wife gives birth to a son. And those in the countryside are really out of luck if the healer has just come through [the village] before they were born. They have to wait and wait, and sometimes they are even 14 years old. But, if they have not been circumcised by the time they are a teenager, and they are becoming aware of the teachings of Prophet Muhammad, may peace be upon Him, then I think it can be they may feel pressure do the circumcision. I also know of teenage boys who have attempted to perform circumcision on each other, but that is not what you are interested in here (Interview 12, rural, 3 children).

Among the participants expressing disbelief, most came from Somalia's major cities. For example, in the third FGD, a participant from the countryside, who now has 10 children, answered our question by explaining that he had performed his own circumcision using a very sharp knife, which he had attempted to sterilise by using a match. The tip of his penis became infected, even after his mother spread herbs on the wound to keep infection away, which he considered might have been a widespread problem for others who also tried to self-circumcise. Two participants sitting directly across the table simultaneously widened their eyes and exclaimed, nearly in unison, “What? You cut yourself? You must be joking!” (FGD3, urban, respective 1 child and 7 children). One of these fathers quipped, “Isn't that *haram* [taboo]? I mean, you could have potentially made yourself sterile and not just that knife! How would you have had children in that case? I cannot believe you did this, and I cannot believe that anyone would do this” (FGD3, urban, 1 child).

A few participants took the opportunity to reflect about the impact of self-circumcision on intimacy or satisfaction. One man questioned the researchers:

Do you want us to talk about gratification? You people in the West are fixated on sexual pleasure.... Somali men do not discuss sexual pleasure in public, and they don't even talk about it with their wives. I think if a Somali man had trouble with his [feelings of] intimate pleasure because he had circumcised himself, then no one would ever hear about it. He could have problems having sex or his penis could look strange, or he could have pain [while urinating]; but it would be his own burden, and he will never talk about that. I have never been asked here in Sweden by any doctor whether I have trouble having pleasure with my wife. So, I think you will never find these people (FGD3, urban, 8 children).

The researchers rebutted by explaining that the voice of self-circumcised men may come out through process of discussion, similar to this data collection, so men might feel encouraged to gain access to reconstructive surgery. The same man clicked his tongue and said, “That can be done?” (FGD3, urban, 8 children). Another man in the group added,

We don't have anything to be ashamed of, if this is a sexual problem. A Somali man can be too proud, and might not see that when we left Somalia it might have been a good thing for our health. And, I mean all of our health. I have been in therapy for other reasons that have to do with not wanting to have sex with my wife, and so we men should be talking more about our sexual problems. I felt better after I went to talk to someone! Once we get over the mental image that we would actually cut ourselves, then there can be some kind of interest for surgical repair. I cannot imagine that a man would do [circumcision] only for mutilation, which is probably what the Swedes will say if they hear this. But, no, for reasons we believe are important. But Somali men will never see the positive side of seeking healthcare for sex until they ask for it the first time (FGD3, urban, 4 children).

#### *Survival equates to an honourable act*

The self-circumcised participants in the FGDs did not cease discussing the matter after publicly offering their experiences. These men appeared unphased by the other participants' surprised reactions to their act. A few men attempted to justify the reasons for self-circumcision. For example, “My beliefs were so strong, and I survived. My survival strengthens my knowledge that Allah was protecting me, and so I cannot be blamed for *haram*” (FGD3, rural, 4 children). This reflection was similar to one offered during an interview: “My father did not organise the circumcision. My mother was unable to do it. No uncles could find the healer, and no goat

was put up to pay for it. I had a burning desire in my heart to honour [Islam], and so the responsibility was mine" (Interview 21, rural, 6 children). Another interviewed informant explained,

What did I know as a [young person]? I thought I was doing the right thing [according to Islam], and that I could show my strong faith. I was old enough to understand that I was becoming a man, and men honour their responsibilities. I did not care if I bled to death or died from blood disease. I did not die, and so it was the right thing. No one can say now that it was the wrong thing to do (Interview 5, rural, 7 children).

#### *Undetected injury: reproduction is not the problem*

No participants were explicitly forthcoming in this venue about the resulting physical alterations made by the self-circumcision. Moreover, at the outset of this emergent line of inquiry, one man rolled his eyes, laughed, and said, "Wow! That is really a private question! Do you ever get anyone to tell you an answer to that question, since you and your translator are women?" (Interview 10, urban, 4 children). During two other interviews – interviews 14 (rural, 5 children) and 27 – self-circumcised men were more forthcoming, exemplified by one man's response,

I have discussed with my doctor in Somalia about why some [feeling] down there makes pain, and sometimes I don't feel anything at all, and sometimes the feeling is a good feeling when I am together with my wife. I am a practical man, so even though I asked about this problem before I left Somalia, we simply did not have any money to fix it. So for me, this has just been something I live with, and I accept that I did this to myself. But I do worry about whether I satisfy my wife (Interview 27, urban, 4 children).

Some were willing to share in a cryptic way about implicit physical problems resulting from their self-circumcision. For example,

I don't understand why you are asking this question, because we are obviously already fathers, no matter about any circumcision, and so there has been no problem creating children or probably pleasing our wives. It obviously does not matter that the skin is uneven and rough, or that there are scars. I don't know the difference if I am missing sensations. And, my wife has only been with me, and so she does not know the difference. She has never complained. The action of making a child still functions perfectly, so what can I say? Her "kitchen" is already closed for other reasons, but that has nothing to do with my "gudniinka wiilasha" [male circumcision] [*Laughter from the other participants*] (FGD3, rural, 11 children).

## **Discussion**

This sub-study identifies eight (8/43) of our adult male study participants had reported performing self-circumcision retrospectively as an adolescent. To our knowledge, the phenomenon of retrospective self-circumcision among Somali immigrants has not been explored earlier in the literature – neither in reports on male circumcision nor in individual case studies of self-circumcision. The latter are reports on adult men who have used an instrumental device, and who were reportedly motivated by a presumed wish for healthy sexual outcomes [17,18]. Our participants shared their deep desire to uphold Islamic traditions while living in a situational context in the rural countryside of Somalia, which did not allow for them to be circumcised in the typical way by a traditional practitioner or medically trained professional.

The men did not explicitly describe the physical state of their genitals or any sexual problems they had experienced. This may result from the research team consisting only of women, which might

have created a social barrier against gaining deeper insight into the men's private experiences. For this reason, deeper exploration leading to meaningful insights on this sensitive topic may require consultations with male health care providers. In addition, this qualitative inquiry was dependent upon having access to the men by means of the original research questions, which pertained mainly to child-bearing. One potential limitation may be the depth of inquiry, which remained entirely explorative and dependent upon participant contributions. In addition, the study relies on men's own self-reporting and not medical examination – clarification is an issue for future research. The literature contains a few studies demonstrating poor reliability of self-reported male circumcision. Upon examination by a physician, Lilienfeld and Graham [22] reported disagreement with 34% of 191 self-reporting men in Upstate New York, USA, who were found to be uncircumcised. Similarly, Thomas et al. [23] found that upon physical examination following self-reporting by 64 male participants from Lesotho, 23% demonstrated no evidence of male circumcision, 27% had partial, and 50% had complete circumcision. Notably, these studies confirm that future researchers should confirm self-reports with physical examination, which we were unable to perform in this study. The potential strength of our aims was not to inquire about whether men had been circumcised, but whether they performed the procedure themselves. Use of a hermeneutic data collection strategy gave participants the freedom to express their own experiences according to their own definitions and willingness to share [20]. We can thus interpret the men's superficial responses as either unwillingness to reveal deeper insight into the outcome of their choices to self-circumcise or as being uncomfortable discussing such an intimate topic as their genitals in a public forum.

Our data reveal that some men are willing to at least approach discussing their own sexual health experiences. Probing the topic from the perspective of "retrospective self-circumcision" may provide a venue for intimate reflection. However, explicit requests made by the men for medical evaluation seem, at present, unlikely, which is a finding similar to a report that Somalis in Sweden are reticent towards intimate sexual communication following childbirth with spouses or maternal health providers [24]. Western men's health professionals may consider our findings as a green light, especially those urologists with immigrant patients who are adherent to Islam. Natali and Rossetti's [18] suggestion for urologists to take a front-runner interest in men's self-circumcision is supported here. Our work further suggests that some Somali men are willing to chastise members of their own social group about a normative unwillingness to seek care for matters related to sexual ill-health. If urologists and other interested men's health professionals team up with Somali advocates, men may be very willing to become increasingly open to this line of healthcare.

Presently, male circumcision is a highly debated topic, and traditional healers are mostly to blame for mutilated penises following the procedure in boys. Additionally, retrospective self-circumcision appears outside the general interest of the debate. However, our study participants may likely comprise only a minor fraction of some unknown number of injured men from self-circumcision. Perhaps the most important take-away message from these findings is that men who have self-circumcised as an adolescent should be medically evaluated for any possible revisions to their genitals. Revision should be encouraged especially if they are disappointed in the physical, functional or cosmetic results of the circumcision [25].

Medical interest in penile revision for retrospective self-circumcision has wider global health implications for HIV and STI susceptibility. According to Morris and Castellsague [26], complete male circumcision is an essential component of strategies to reduce the burden of HIV and STIs, including HPV, herpes HSV-2, chlamydia, and penile and cervical cancers, to name a few. Partial removal of the foreskin thus suggests an adverse influence on study

outcomes that explore male circumcision against, e.g., biological markers, and should become a point of interest for these epidemiological investigations. Maughan-Brown et al. [27] identified among Xhosa men in South Africa that full male circumcision at an earlier age lends protection against contracting HIV, but that partial foreskin removal conferred a 7% point greater risk for HIV positive status than fully circumcised men. Medical observation and, revision where needed, among men who performed retrospective self-circumcision has potential to offer wider implications for subsequent HIV and STI risk reduction.

Current literature extolling the medical virtues of male circumcision rely on a comparison to injurious outcomes, conducted in non-medical settings by untrained traditional practitioners [14,28–30]. Our study enters the ongoing debate by posing a query about why retrospective self-circumcision has been overlooked in favour of exclusive blame on incompetent traditional healers. It is conceivable that men who self-circumcised as an adolescent are hidden within the easier-to-conceive demographic of incompetent practitioners, since men are presumably unlikely to admit having caused their own injuries. Alternatively, and relevant to this group of participants, the incidence of circumcision *per se* may simply have become settled in the minds of immigrant Somalis now living in western countries, where the practice is not considered normative for either boys or girls [31]. Only systematic interest in the aetiology of what we term *retrospective self-circumcision* can scientifically elucidate its influence. Furthermore, men's own voices are required to explain their experiences, in light of their own rights to have performed this procedure on themselves. Our findings thus offer encouragement for future mixed method epidemiological investigations, which would benefit from addressing self-reporting versus objective observation, as well as such contextual factors as age at circumcision and cultural factors laying outside the typical dialogue about religious motivation or sexual functioning [10].

## Conclusions

Adult Somali men who have migrated to western countries are anecdotally aware of the historical incidence of self-circumcision among adolescent boys. However, there is presently no western clinical platform available to men who self-circumcised as a young person about negative sexual health consequences. Some men are very reticent to discuss any sexual health needs, even with their wives, but especially with apparently uninterested medical professionals. One forum for engaging retrospective self-circumcised men about their sexual health problems might be available following the birth of a child, when postpartum health professionals are available for counselling about sex-related matters. However, ultimately, men's health professionals should be engaged to identify negative physiological outcomes from this self-inflicted injury, as should systematic exploration of its full impact on wellbeing.

## Conflict of interest

None of the authors have any conflicts of interest.

## Acknowledgements

All authors have no financial or relationship conflicts of interest that can inappropriately influence this work. The Swedish Council for Working Life and Social Research (FAS 2006–2007) and the Faculty of Medicine at Uppsala University, Sweden, are acknowledged for financial support.

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