Why do male patients request circumcisions?

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ABSTRACT

Background
Circumcision has been performed for centuries. The popularity of the procedure waxed and waned during the ages. In South Africa, cultural circumcision is often regarded as the only way to attain full adulthood, and consequently many patients request circumcision by medical personnel. The aim of this study was to explore the motivations and perceptions of patients requesting circumcision at Kalafong Hospital.

Methods
In-depth interviews were conducted with patients requesting circumcision. Interviews were tape-recorded and transcribed and themes were identified. Triangulation was used to enhance the trustworthiness of the data.

Results
The themes that were identified were cultural acceptance, fear of mountain school, improved intercourse, prevention of disease and improved hygiene.

Conclusions
Doctors should adopt a compassionate attitude when patients request circumcision. It is imperative to discuss patients' expectations. If this is not done, patients' problems may remain unsolved. The perception that circumcision provides effective protection against sexually transmitted diseases is dangerous and should be addressed fully.
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The history of circumcision

Circumcision has been performed in Africa for the past 5000 years. The technique for circumcision was illustrated in a bass relief on the wall of the temple of Ankhama-Hor at Saqqara during the 5th dynasty, 2400 BC.[1,2] At first, the procedure in Egypt was limited to members of the priesthood, but was later adopted by the royalty and nobility and finally became universal practice.[1]

It is unclear where the procedure originated. Some anthropologists believe that it originated independently in different cultures. This theory is supported by the fact that some of the males of the first nations in the "New World" were circumcised when they were discovered by Columbus.[3]

Non-religious circumcision was introduced in English-speaking countries as a method of treating and preventing masturbation in the 1800s.[4] The procedure's popularity escalated between 1920 and 1950.[5] By 1970, approximately 40% of Canadian and 80% of American newborns were circumcised.[2]

The popularity of the procedure waxed and waned in the following decades. As evidence gradually emerged linking a lack of circumcision to various health risks, the conservative stance against circumcision relaxed, with the American Association of Pediatrics releasing a statement concluding that the procedure had potential medical benefits, as well as disadvantages. It was advised that the decision to circumcise was best made after careful consideration of the risks and benefits by parents in consultation with the physician.[2, 6]

Currently about 25% of men world-wide are circumcised. These are mostly men from North America and Africa and the Muslim and Jewish communities of the Middle East and Asia.[2]

In many parts of Africa, male circumcision is linked to culture and

religion and signifies a transition from one social status to another. Although the practice of circumcision is widespread, there are marked regional differences in male circumcision practices within the continent. A large belt of non-circumcising communities runs from southern Sudan to southern Namibia. It appears, however, as if circumcision is gaining popularity under some non-circumcising tribes, for instance in Tanzania.[7]

Indications for circumcision may be classified as medical or ritual. Medical indications for circumcision are not very common and do not occur in the normal neonate. Therefore, circumcisions for medical indications are mostly performed on adults.[8]

Motivation for study

Kalafong Hospital is situated in Atteridgeville township. Most of the patients are from the Sepedi and Tswana groups. A large number of patients with no medical indication request circumcision at Kalafong. The small urology department at Kalafong only carries out circumcisions for medical indications. The Department of Family Medicine has a weekly morning theatre list for small procedures carried out under local anaesthetic. This list has, in actual fact, increasingly turned out to be a circumcision list!

There may be many motivations for the increased number of requests for circumcision. The assumption that the reason for the increase is to escape the mountain school with its incidence of complications has never been confirmed by research.

Family medicine as a discipline identifies with the following principles set out by McWhinney: The physician is committed to the person and seeks to understand the context of the illness; Every contact is seen as an opportunity for prevention and for health education; Importance is attached to the subjective aspects of medicine.[9] It was therefore deemed necessary to investigate the perceptions of the patients and their reasons for requesting circumcision. This would give insight into the issues and provide an understanding of the motivations involved. It would allow the physician to assist the patients to make informed decisions regarding their health and lifestyle.

Method

According to De Vos et al., the researcher in qualitative research attempts to understand reality by discovering the meanings people attach to it in a specific setting. As the aim of this research was to understand the patients' perceptions and context, it was decided that a qualitative study was appropriate.[10]

Sample:
In-depth interviews were held with adult male patients requesting circumcision at Kalafong Hospital. Patients under the age of 18 were excluded to minimise possible problems regarding the obtaining of informed consent. All other patients qualifying for participation were selected. New participants were interviewed until no further themes were identified. Five patients were interviewed.

Participants had to speak English, Afrikaans or Sepedi sufficiently well to enable understanding of the informed consent form and to explain their perceptions about circumcisions to the interviewer. The interviewer was a male Afrikaans general practitioner, fluent in English and Sepedi.

Permission for the study was granted by the ethical committee of the University of Pretoria.

Data collection procedure

Participants were asked to explain to the interviewer why they were requesting circumcision. There were no further questions. Probing questions were only used to explore and clarify ideas raised by the participants themselves.

The interviews, which were conducted by the main author, were tape-recorded. Field notes of each interview were made by the interviewer and an independent observer. The independent observer was a colleague from the Department of Family Medicine who was not otherwise involved in the study.

Analysis

Each interview's audio recording was transcribed. The transcripts of each interview were studied to identify the major categories. Themes and sub-themes were noted.

To enhance the trustworthiness of the identified themes, an independent co-coder also coded the data. The researcher and co-coder finally reached consensus on the identified themes. The co-author acted as independent co-coder and was not present during the interviews.

Limitations of the study

It would have been optimal to interview each participant in his mother tongue. Limited resources made it impossible to provide such a variety of interviewers.

The possibility exists that, because the interviewer was from a different cultural group, the participants may have been reluctant to mention perceptions that they assumed would not be shared by the interviewer. Contrarily, the cultural difference may have been advantageous, as the participants may have felt at liberty to criticise cultural beliefs that they did not share with their communities.

Results

The interviews were conducted in an office in the training section at Kalafong Hospital to ensure privacy and exclude interruptions. Most of the participants were relaxed and willing to discuss their reasons for requesting circumcision. Two participants found the topic embarrassing, but nevertheless attempted to provide relevant information. Participants sometimes found it difficult to elaborate on the reasons for their request. This could be due to language-related difficulties, but it appeared to be more a result of them not considering that there was more to elaborate on regarding the topic. The interviews lasted approximately 45 minutes, with the shortest being 35 minutes and the longest one hour. The themes identified are given in Table 1.

Theme I: Cultural acceptance

The theme of cultural acceptance

Table I Themes

Theme	Sub-themes	Quotations
1.Cultural acceptance	a. General comments	"It is my culture." "I have my beliefs in our culture."
	b. Sign of manhood	"To qualify to be a man." "I want to be a real man."
	c. Sign of manhood, disagree	"I could be a man without going to the mountain."
2.Fear of mountain school		"They come back sick, others they die." "I don't think it is safe there; a major number come back dead or sick."
3.Improves intercourse	a. Improved penetration	"It facilitates the penis just to go through." "It brakes because of the skin. The whole penis cannot go inside."
	b. To pleasure partner	"To make my girlfriend enjoy."
	c. Less pain	"Girl gets pain, both of us."
4.Prevention of disease		"For health by the body and safe by the sex…the drop and the HIV." "I was advised it helps in the prevention of STDs." "The foreskin would not be able to cover that kind of disease – HIV, gonorrhoeae."
5. Improved hygiene		"Those rubbish that is inside the flesh after a day becomes a drop." "I find white stuff." "The body is always fresh if you do that thing."

occurred in the interviews with three of the participants through general remarks and by reference to circumcision as a sign of manhood. Participants felt that the uncircumcised are "looked down upon" and that an uncircumcised male would be ridiculed if he should shower with other men.

Two participants said that they wanted to be circumcised "to be a man", while participant D went further, verbalising the underlying thought that they could be men without going to the mountain school. It appears that the outward sign of manhood is necessary to relieve peer pressure, but participants did not support the community opinion that it is necessary to go to the mountain school to be able to act as a man.

Theme 2: Fear of the mountain school

While all five participants mentioned the mountain school and its traditions as part of their explanation for requesting a circumcision, only three stated that they feared attending the mountain school. The main reason for this fear was that it was unsafe, as initiates died or became ill and had to be treated in hospital.

Theme 3: Improvement of intercourse

A theme mentioned by all five participants was the perception that circumcision would improve intercourse. Four of the participants were under the impression that penetration would be facilitated if the foreskin was removed. The impression existed that the foreskin obstructed penetration in some way. The perception was that intercourse would be more pleasurable for both partners because it would be less painful.

Theme 4: Prevention of disease

Theme 4, prevention of disease, and theme 5, improved hygiene, were seen as interconnected by participant B, who had the perception that "those rubbish that is inside the flesh, after a while it becomes a drop". Four participants were of the opinion that circumcision prevented sexually transmitted diseases and three specifically mentioned either gonorrhoea and/or HIV.

Theme 5: Improved hygiene

Four of the five participants were of the opinion that circumcision improved hygiene by keeping "the body fresh" and specifically that it prevented the formation of smegma, which was referred to as "white stuff".

Discussion

Theme1: Cultural acceptance

Tension between traditional and modern customs has been evaluated mostly in relation to marital expectations and the effect on the relationships between partners. It was found that women strive for a more western or modern lifestyle, while men strive for a more traditional marital model.[11, 12]

From the literature it is clear that there is great pressure on young men to be circumcised during attendance at the mountain school. According to Mayatula and Mavundla, it is regarded as the only manner in which

a boy can attain full adulthood. The uncircumcised individual is likely to be an outcast and the uncircumcised have been attacked and beaten for their lack of conformity.[13]

Theme 2: Fear of the mountain school

No academic literature was found on this theme, but the fear is substantiated every year by press reports of youths who lose their lives.[14] This was confirmed again in 2002 with the Heidelberg tragedy.[15,16]

Theme 3: Improvement of intercourse

No mention of the perception that circumcision facilitates penetration could be found in the literature. Few studies have investigated the relation between male circumcision and sexual pleasure or satisfaction. In Uganda, where men are usually uncircumcised, women have indicated that they derive greater sexual pleasure from circumcised men. American female college students expressed preference for circumcised penises, which "looked sexier". Fifty percent of the women with uncircumcised partners preferred vaginal sex with a circumcised man. The percentage was even higher in the case of oral sex.[2]

Circumcision decreases sexual stimulation by keratinisation of the glans penis and loss of the nerve endings in the prepuce.[17] However, this does not appear to be a major problem, as Moses et al. concluded that "loss of sensory function seems not to be an important consideration by men and women more troubled by premature ejaculation".[2] This conclusion is supported by the higher tendency for sexual dysfunction found amongst uncircumcised American men. Circumcised men also reported a more elaborated set of sexual practices, in particular a higher masturbation frequency.[18]

Theme 4: Prevention of disease

Most studies reporting on the association between circumcision and sexually transmitted disease conclude that there is a significant association between circumcision and a lower risk for HIV, chancroid and syphilis infection. The evidence for association between genital herpes, gonorrhoea, other causes of urethritis and circumcision is weaker. Support for the notion that circumcision may protect boys from urinary tract infections (UTI) also exists, although the American Academy of Pediatrics concluded that the absolute risk for UTI is so low that this did not merit a routine recommendation for circumcision.[19,20] Reports on the association between circumcision and genital warts are contradictory.[2,21]

Theme 5: Improved hygiene

Although no differences were found in self-reported hygienic practices between circumcised and uncircumcised men, both men and women in a Ugandan study felt it was easier to maintain genital cleanliness in circumcised men. The relation between genital hygiene and the risk for HIV and other genital infections still requires clarification.[2] Laumann concluded that circumcision in Africa is heavily influenced by social factors, with important implications for sexual practices and partner choice. According to him, without rigorous systematic control for cofactors relevant to the particularities of the African context, the prophylactic status of the presence or absence of the foreskin remains an open question.[22]

Recommendations

Doctors should adopt a compassionate attitude when patients request circumcision. The tremendous pressure that men are under to comply with cultural traditions must be considered.

It is imperative to discuss patients' expectations. If this is not done, it may lead to the procedure being performed for the wrong reasons. It is particularly important to elicit a history of sexual dysfunction in order to advise and treat patients appropriately. Patients may otherwise end up dissatisfied with the medical services, as their problems remain unsolved.

Finally, the perception that circumcision protects effectively against sexually transmitted disease is dangerous and should be addressed fully. The concept of risk, the significance of lower risk and the implications for the patient should be explored so that the patient is not left with the false impression that it is unnecessary to practise safe sex after circumcision.

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References:

1. Shokeir AA, Hussein MI. The urology of pharaonic Egypt. *BJU International* 1999;84(7):755-61.
2. Moses S, Bailey RC, Ronald AR. Male circumcision: assessment of health benefits and risks. *Sex Transm Inf* 1998;74:368-73.
3. Dunsmuir WD, Gordon EM. The history of circumcision. *BJU* 1999 Jan;83(1):1-12.
4. O'Hara K, O'Hara J. The effect of male circumcision on the sexual enjoyment of the female partner. *BJU International* 1999;83 Suppl 1:79-84.
5. Schmitt BD. The circumcision decision: Pros and Cons. *Clinical Reference Systems Annual* 2001:1958.
6. American Academy of Pediatrics. AAP releases statement on infant circumcision. *American Family Physician* 1989;39(5):382-3.
7. Nnko SN, Washija B, Urassa M, Boerma JT. Dynamics of male circumcision practices in Northwest Tanzania. *Sex Transm Dis* 2001;28(4):214-8.
8. Holman JR, Lewis EL, Ringler RL. Neonatal circumcision techniques. *American Family Physician* 1995 Aug;52(2):511.
9. McWinney IR. *A textbook of family medicine*. New York: Oxford University Press; 1997.
10. De Vos AS, editor. *Research at grass roots: a primer for the caring professions.* Pretoria: Van Schaik: 1998.
11. Steyn MG. *Marital expectations of the formally trained black late-adolescent and the implications for a marriage preparation programme* [dissertation] UNISA;1996.
12. Kabini GE. *Towards and understanding of wife battering in Zulu society* [dissertation] University of Zululand;1994.
13. Mayatula V, Mavundla TR. A review on male circumcision procedures among South African blacks. *Curationis* 1997;Sept:16-20.
14. Botched circumcision deaths mount. *The Star*, 2002 July 8;Available at http://www.iol.co.za.
15. Remaining initiates recovering in hospital. *Daily News;* 2002 June 20. Available at http://www.iol.co.za.
16. Ndaba B. Teen dies after returning to 'hill of death'. *The Star;* 2002 July 1. Available at .
17. Taylor JR, Lockwood AP, Taylor AJ. The prepuce: specialised mucosa of the penis and its loss to circumcision. *BJU* 1996;77(2):291-5.
18. Laumann EO, Masi CM, Zucherman EW. Circumcision in the United States: prevalence, prophylactic effects and sexual practice. *JAMA* 1997;277(13):1052-6.
19. Teresa TO. Cohort study on circumcision of newborn boys and subsequent risk of urinary tract infection. *JAMA* 1999;281:494.
20. Voelker R. Circumcision isn't necessary. *JAMA* 1999;281:1075.
21. Mallon E, Bunker C. Circumcision and genital dermatoses. *JAMA* 2000;284:25.
22. Laumann EO. Advantages and disadvantages of neonatal circumcision [Letter]. *JAMA* 1997;278:201.