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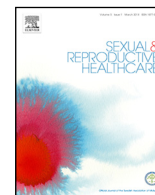

'I have made children, so what's the problem?' Retrospective self-circumcision and the sexual and urological health needs of some Somali men in Sweden

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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 childbirth 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

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