Published in final edited form as:
Cult Health Sex. 2012 October ; 14(9): 991–1005. doi:10.1080/13691058.2012.712719.

Popular perceptions of circumcision among Colombian men who have sex with men

Felisa A. Gonzales[1], **Maria Cecilia Zea**[1], **Carol A. Reisen**[1], **Fernanda T. Bianchi**[1], **Carlos Fabian Betancourt Rodríguez**[2], **Marcela Aguilar Pardo**[3], and **Paul J. Poppen**[1]

[1] Department of Psychology, The George Washington University, Washington, DC, USA

[2]Antropología Médica Crítica, Universidad Nacional de Colombia, Bogotá, Colombia

[3]Profamilia, Bogotá, Colombia

Abstract

Circumcision has received increased attention for its potential to reduce sexual transmission of HIV. Research on the acceptability of circumcision as a means of HIV prevention among MSM is virtually non-existent. Men who have sex with men (MSM) in Bogotá, Colombia either participated in a focus group in which they shared information regarding their perceptions of circumcision, or completed a survey which assessed circumcision experiences, attitudes, beliefs, and willingness. Few participants reported they were circumcised, yet most participants reported knowing something about the procedure. Overall, attitudes towards circumcision were mixed: although circumcision was viewed as safe, it was also viewed as unnatural and cruel to babies. Beliefs that circumcision could improve sexual functioning and protect against STIs and HIV were not widely endorsed by survey participants, although focus group participants discussed the potential impacts of circumcision on the availability of sexual partners and sexual performance. Some focus group participants and many survey participants reported a hypothetical willingness to get circumcised if strong evidence of its effectiveness could be provided, barriers removed, and recovery time minimised.

Keywords

HIV; circumcision; MSM; Colombia

Introduction

Although male circumcision has been practiced for centuries for cultural, religious and medical reasons (Auvert et al. 2005), new attention has been given to this procedure as a potential method of limiting HIV transmission. Three randomised controlled trials of medical circumcision of adult heterosexual men in Africa provided evidence to support a causal role for circumcision in the prevention of HIV transmission from HIV-positive women to HIV-negative men (Auvert et al. 2005; Bailey et al. 2007; Gray et al. 2007). Estimates of protective efficacy ranged from 55% to 60% across three different locations. Based on these results, circumcision is being promoted as a means of HIV prevention for heterosexual men in some parts of the world. Circumcision is not yet being promoted among men who have sex with men (MSM) because there is reason to believe that it will be less efficacious for MSM than for heterosexuals. MSM can assume an insertive or receptive role during anal intercourse, and the previously mentioned randomised controlled trials have

felisag@gwmail.gwu.edu.

only demonstrated a protective effect for circumcised men who perform an insertive role exclusively with female partners.

Some research suggests a potential protective effect of circumcision for MSM who primarily or exclusively practice the insertive role. A recent prospective study of gay men in Sydney found that while circumcision status did not reduce the risk of HIV infection overall, circumcision showed a significant protective effect for MSM who reported a preference for performing the insertive role during unprotected anal intercourse (Templeton et al. 2009). Among Latinos, multiple studies suggest a modest protective effect for MSM who exclusively practice the insertive role. A study of 1,091 Latino MSM living in three urban locations in the USA found reduced odds of being HIV-positive among MSM who reported being an exclusively insertive partner during recent unprotected anal intercourse (Millett et al. 2007). In a smaller sample of 482 Latino MSM living in New York, Reisen and colleagues found lower rates of HIV prevalence among circumcised partners who self-identified as the active or top partner as compared to those who did not (Reisen et al. 2007). A recent study of 1,822 MSM in the USA and Peru similarly found a reduction in HIV acquisition among those who reported being the insertive partner for at least 60% of their sexual encounters in the past three months. This reduction was not statistically significant however (Sanchez et al. 2011). Several other studies have not found a protective effect of circumcision against HIV among insertive MSM overall (Millett et al. 2007; Millett et al. 2008; Jameson et al. 2010; Gust et al. 2010); thus, results regarding the impact of circumcision on HIV acquisition among insertive partners are mixed. A lack of randomised clinical trials of circumcision among MSM (AIDS Vaccine Advocacy Coalition 2007) prohibits firm conclusions about the efficacy of this prevention option for MSM.

Efforts to change circumcision practices have had to account for existing cultural beliefs and the social values in countries where ritual circumcision occurs (Lee 2006); Peltzer and Kanta 2009). Similarly, in countries where circumcision is relatively unfamiliar, the promotion of medical circumcision as a potential HIV prevention method will require an understanding of existing attitudes and beliefs towards the procedure. Currently, two main research strategies are being utilised to explore potential impacts, benefits, and acceptability of circumcision for MSM: exploratory studies to determine whether randomised clinical trials of circumcision among MSM are feasible and/or appropriate, and acceptability studies that assess perceptions of circumcision among MSM. A few studies of circumcision acceptability have been conducted with diverse populations. Westercamp and Bailey conducted a review of thirteen studies assessing the acceptability of circumcision in sub-Saharan Africa among heterosexual men and women (2007). At least two studies of circumcision acceptability among MSM (in China and Ecuador and Peru) have been conducted, both part of exploratory research that assessed concerns and willingness regarding participation in randomised clinical trials of circumcision (Ruan et al. 2009; Sanchez 2007). The current study assesses circumcision acceptability in Colombia using a mixed-methods design.

HIV transmission in Colombia occurs primarily as a result of risky sexual behaviours. The HIV rate among adults aged 15 to 49 in Colombia is 0.5% (Joint United Nations Programme on HIV/AIDS 2010) but the rate is estimated to be as high as 20% among MSM (Montano et al. 2005). Circumcision is not commonly practiced in Colombia: it is estimated that fewer than 20% of all men are circumcised (UN Interagency Task Force 2007). Convenience samples obtained in cervical cancer studies of women and their partners in Colombia have found the rates of circumcision to be as low as 7% to 11% (Weiss et al. 2007), whereas in a convenience sample of immigrant Colombian MSM living in New York City the proportion reporting being circumcised was 27% (Reisen et al. 2007). In order to determine how MSM in Colombia, a country with relatively low rates of circumcision, might respond to circumcision as a means of HIV prevention, focus groups and a pilot survey were conducted

with MSM living in Bogotá, Colombia. This paper details their knowledge of and attitudes towards circumcision, beliefs regarding the impacts of circumcision on one's health and sexual life, and recommendations for HIV prevention efforts targeting the adult MSM population.

Methods

Data for this paper were collected as part of a five-year mixed-methods research project on HIV prevalence, sexual behaviours, and attitudes towards circumcision among Colombian MSM funded by the Eunice Kennedy Shriver National Institute of Child Health and Human Development. Findings reported here pertain only to circumcision and come from focus groups and a pilot survey. The focus groups were conducted first and provided information on how circumcision is understood and viewed by Colombian MSM. This information was then used to design pilot survey questions on circumcision attitudes, beliefs, and willingness.

Participants

Focus groups—Seventy-eight men in Bogotá, Colombia participated in a total of nine focus groups that were held between September and November of 2008. Each focus group was comprised MSM from one of several sub-populations because homogeneous grouping often leads to more candid conversation (Stewart, Shamdasani, and Rook 2007). The groups were: gay and HIV/AIDS activists (n=7), young men under the age of 26 (n=9), adults ages 26–49 (n=11), Bogotá strata[i] one and two individuals (low-income) (n=11), Bogotá strata three and four individuals (middle-income) (n=10), bisexual men (n=9), sex workers (n=4), transgendered individuals (n=11), and people living with HIV (n=6).

Survey—One hundred MSM living in Bogotá, Colombia were recruited over a period of seven weeks in the Fall of 2010 using respondent-driven sampling (RDS) (Heckathorn 1997); Heckathorn 2002). This recruitment strategy relies on peer referral and dual-incentives to recruit members of hidden populations for which a sampling frame of the entire population cannot be obtained. Previous research among Latino gay men has shown this recruitment strategy to provide larger population coverage, and thus more reliable and valid population estimates, than time-location sampling (Ramirez-Valles et al. 2005). Four invited participants, and ninety-six referred participants, completed the survey. Tables 1 and 2 describe the demographic and social characteristics of the focus group and survey samples, respectively.

Procedure

Focus Groups—Individuals from the Colectivo LGBT aided with the recruitment process. Targeted sampling methods were utilized to ensure a diverse representation of MSM. All focus groups were held at the premises of Colectivo LGBT or Profamilia (a local NGO), both of which are recognised as offering a safe space for gay people. On average, focus groups lasted about two and a half hours. All focus groups were conducted by at least one member of the gay community in Bogotá, accompanied by at least one note taker.

Towards the end of the focus groups, after discussions regarding men's perceptions of life, social climate, and sexual attitudes and activities in Bogotá, participants were informed that recent research had shown circumcision to provide partial protection against HIV among heterosexual men. Participants were then asked about attitudes towards circumcision in their

[i]Housing in Colombia is classified by estratos (strata) according to physical characteristics of homes and neighbourhoods. Strata classifications range from one (the poorest) to six (the wealthiest) and were originally intended to determine costs of utilities. Strata are highly correlated with socioeconomic status (Departamento Nacional de Planeación)

community. Additionally, participants were asked to identify some potential benefits of and barriers to circumcision that would be relevant for any public health interventions to promote circumcision as a means of HIV prevention among MSM. Participants in the focus groups were not asked to report directly whether or not they were circumcised, although some participants voluntarily offered this information in the course of the discussions. In addition to their participation in the focus groups, participants were asked to complete a brief demographic information sheet. Participants were compensated 50,000 Colombian pesos (approximately US$30).

Survey—As noted above, survey participants were recruited using RDS. In this sampling strategy, "seed" participants are initially invited to participate in the research project, and provided with coupons to give to their peers who meet eligibility criteria for the study. For the current project, four seeds that varied in terms of education, geographic location, and socioeconomic status were identified by project staff in Colombia. Upon completion of the survey, participants were provided with three coupons to invite other MSM between the ages of 18 and 49 who lived in Bogotá to participate in the study. The coupons contained the study name, a telephone number to schedule an appointment to complete the survey, the location, and a unique identification number to track referrals. For each referred participant who completed the survey, the participant-recruiter received 30,000 Colombian pesos (approximately US$20). A total of 177 coupons were distributed, and ninety-six non-seed MSM returned a coupon and completed the survey.

Surveys were administered using touch-screen Audio Computer-Assisted Self-Interview (A-CASI) technology. Participants were seated in front of a laptop and presented with questions and responses in text that were accompanied by a corresponding audio recording, which allowed for the participation of individuals with limited reading skills. Circumcision experiences, attitudes, beliefs and willingness were measured at the end of the A-CASI survey, after participants had received a description and graphic showing the difference between a circumcised and an uncircumcised penis. Only uncircumcised participants were asked questions about willingness to be circumcised (n=85); of the circumcised participants (n=15), only those circumcised as adults (n=6) were asked to provide reasons for circumcision. All participants were asked to respond to items assessing circumcision attitudes and beliefs. In addition to circumcision, the survey assessed topics such as recent sexual activity, substance use in the last three months, and sexual and mental health. Psychological constructs such as depression, social support, and discrimination were also assessed. On average, the surveys took forty minutes to complete. Participants received 70,000 Colombian pesos (approximately US$40) upon completion of the survey.

Data analysis

Focus groups—All focus groups were conducted, tape-recorded and transcribed in Spanish by Colombian staff and research assistants. Data were entered into NVivo 8 software and were coded in Spanish by a team of five researchers, two of whom were in Colombia and three of whom were in the USA. All nine focus groups were topically and analytically coded (Richards 2005) by four of the researchers in teams of two from each country. The US team was comprised of one native Spanish speaker and one bicultural, bilingual member. The Colombian team had two local qualitative researchers who were members of the LGBT community. The fifth bilingual, bicultural researcher served as a reviewer and compared the coding of each focus group completed by the two teams of coders in order to identify discrepancies. Discrepancies were brought back to the group of researchers from both countries for discussion in bi-weekly meetings using Skype technology. The approach for coding data was constructivist and iterative in nature; a conceptual framework and a pre-established set of codes based upon the focus group

questions guided the coding process, but ideas were constantly revised and definitions expanded based upon the new understanding gained from the coding and review process (Richards 2005).

Survey—Use of A-CASI technology allowed for real-time storage of survey data. These files were imported into SAS 9.0 in order to generate the descriptive statistics reported here.

Results

Qualitative and quantitative data are organized around four topic areas: prevalence and knowledge of circumcision; attitudes towards circumcision; beliefs regarding sexual and health impacts of circumcision; and circumcision willingness and HIV prevention. Because the data obtained from the two sources are complementary, they are woven together to provide a nuanced picture of the four topic areas. The quotes presented were translated from Spanish to English, and every effort was made to stay true to the content and intent conveyed by the participants.

Prevalence and Knowledge of Circumcision

Several focus group participants' knowledge of circumcision appeared to have been shaped by the experiences of others. Of those who had known an adult who had been circumcised, the circumcision was often due to physical problems. One participant from the youth focus group noted that although he was not certain of the reasons for his friend's circumcision, he believed it was due to a tight foreskin. Similarly, a participant in the activist group noted that circumcision was likely to be accepted if recommended by a doctor:

Participant: What I have seen among my friends is that, if a doctor suggests [circumcision], then they do it.

Interviewer: And why does the doctor recommend it?

Participant: For continuous infections, but not for other reasons, as far as I know.

Participants in four focus groups voiced their belief that circumcision was an acceptable way to address a medical need, but was unnecessary in the absence of health problems. The participants' understanding of circumcision was mainly as a procedure that is performed on young children for cultural or medical reasons, and on adults for medical reasons only. These ideas were supported by survey results. Only fifteen of the MSM who completed the survey reported being circumcised. Of these, six were circumcised as adults for reasons related to health, sexual functioning, and hygiene.

A couple of focus group participants noted a lack of willingness among family members and friends to openly discuss anything associated with male sexual organs, either due to embarrassment or cultural taboos. One participant in the sex worker focus group shared that he had been circumcised at a very young age due to medical issues, but no one in his family had ever explained why his penis did not look like other penises. Another participant in the youth focus group shared the following:

> It's amusing to see that there are many people that are not able to, I don't know, are ashamed to ask about any surgery that has to do with their genitals, whether it be circumcision or a vasectomy.

Because circumcision is not normative and norms in the larger society are perceived to discourage open discussion of genitals, knowledge of circumcision ranged considerably in this Colombian sample. Participants in three different focus groups were not sure whether

the procedure could be performed on adults. A few activists from the first focus group jokingly discussed the lack of understanding of the surgical procedure by sharing the following anecdote:

Participant 1: I had a conversation with a partner of mine…And I asked him "Are you circumcised?" And he had no idea if he was. He said that he was going to ask his mother…It is not common; that is, there are people who do not even know if they are circumcised or not.

Participant 2: They know where, but not what! (laughs)

Survey results confirmed that most MSM have heard something about circumcision (94%), but only slightly more than half of these (56%) reported knowing exactly what it was or entailed. Although some focus group participants lacked information regarding the surgical procedure, two participants in different groups were able to provide detailed explanations of circumcision as a health or religious practice. Thus, participants' knowledge of circumcision (the surgery and the reasoning behind it) ranged from very little to extensive. No patterns of relationships between knowledge and social class or education could be discerned among focus group participants, and a Spearman rank-order correlation failed to yield evidence for a significant relationship for survey participants.

Attitudes Towards Circumcision

Men's attitudes towards the surgical procedure were influenced by concerns about pain during and after surgery and limitations during the post-operative period. Participants in the focus groups comprised of youth and low-income individuals specifically asked whether the procedure was painful. Other participants in the youth and remaining groups -- based on their own experiences or those of their friends or family members-- generally agreed that pain was to be expected during the first few days after the procedure but that in most cases the healing process proceeded relatively smoothly. A participant in the youth focus group recounted information he received from a friend:

> I knew of a person who did it as an adult. He says that it is a very simple procedure, and it is very quick…The process of healing is a little complicated; painful the first and second day while you get used to the situation, but it is a tolerable discomfort.

A couple of participants shared stories they had heard about more painful recuperation periods. After a nurse in the middle-income focus group described someone who had come into the emergency room in desperate need of post-circumcision care, another participant in the group noted that Jewish people have been undergoing circumcision for centuries so the number of major problems must be limited.

Another potential negative consequence was scarring. A participant in the middle-income focus group shared the experience of his friend who was left with a very noticeable scar.

> I have a friend and we feel very comfortable with each other. He also was circumcised, [and the penis] looked disgusting, as if he had another gland. A disgusting scar.

Participants who worked in the sex trade noted that scarring is likely to be different (and perhaps more noticeable) among adults as compared to children. Such a consequence may be particularly difficult for MSM, given the value associated with the aesthetic appearance of male genitalia in gay culture. As expressed by a participant in the seropositive focus group, it is important that "aesthetically [the penis] looks pleasing".

Despite the fact that focus group participants reported having heard that circumcision as an adult can be quite painful and possibly result in scarring, large majorities of MSM completing the survey did not agree that circumcision can injure the penis (72%), is an attack on the penis (82%), or is dangerous (77%). However, 48% reported that circumcising babies is cruel, and another 53% indicated that an uncircumcised penis is natural. This suggests that while circumcision is largely viewed as safe from a medical perspective, it is not widely acceptable from a cultural perspective.

Sexual Beliefs about Circumcision

Participants in the focus groups and surveys reported potential impacts of circumcision on sexual partner preferences and sexual functioning. Although participants in the seropositive focus group noted that circumcision was not a criterion by which potential partners' penises were evaluated, some participants in the middle-income focus group noted that one's preference depended upon one's cultural context, which could either result in a preference for the familiar (e.g., a Colombian man seeking uncircumcised Colombian partners) or a preference for the unfamiliar (e.g., an American seeking uncircumcised partners). This was particularly an issue for those participants who worked as internet sex models, one of whom stated:

> Now, in terms of preferences, I am going to tell you about the things people like. Americans have the idea that here [in Colombia] we all have foreskins, because circumcision is very common over there. So when they go to the web page, they ask you if you are cut, uncut, circumcised, or not circumcised…Over there, they have a super obsessive fetish about the foreskin. But that is their issue. We here in Colombia, "indigenous" as we are, we do not have that. I think that some would like it and others wouldn't.

Some participants expressed a clear preference for uncircumcised penises for sexual reasons. The foreskin was viewed as an important part of sex:

> Part of the attractiveness of a penis, to me, is grabbing the foreskin. Bringing it down, bringing it up. To me, it seems a part of it.

However, in response to a question about personal tastes, one participant said:

> Yes, of course, better circumcised. Aesthetically it is much more beautiful. And in cleanliness. And in terms of sex, too.

In addition to having an impact on partner selection, circumcision was noted as having the potential to affect sexual functioning in the short-term and long-term. Even if the pain were temporary, some participants voiced concern about the lack of opportunity to have sex during the post-operative period. In the words of one participant in the youth focus group:

> The most traumatic thing could be not having sex during the post-operative period.

This impact was noted to be above and beyond any possible physical pain.

Participants from the seropositive and middle-income focus groups shared experiences of acquaintances who had been circumcised as adults. In both cases it was noted that circumcision had led to decreased sensitivity, but in one case the surgery was also reported to have resulted in increased stamina. Although decreased penile sensitivity was raised as a potential negative consequence of circumcision, others noted increased sexual pleasure as a result of circumcision among those who had experienced penile problems.

> I tell you on behalf of some friends who have done it and it has gone well for them. They began to enjoy their sexuality because not being circumcised would generate

> a pain in the [penis]. Upon being circumcised, now they have (sexually) pleasing relations.

Similarly, a participant in the transgender focus group shared the experience of a friend who was circumcised as a young adult and now has better sexual relations than before.

When asked directly about beliefs regarding the impact of circumcision on sexual functioning, survey participants showed uncertainty. Almost half did not know whether circumcision could increase sexual pleasure (41%), result in firmer erections (42%), or increase stamina (48%). Of those who did hold a belief about these sexual impacts, most did not think there was a difference between circumcised and uncircumcised men in terms of the amount of sexual pleasure experienced (47%), firm erections (71%), or stamina (77%).

Health Beliefs about Circumcision

As indicated previously, hygiene was seen by some men as a potential health benefit of circumcision. A participant in the youth focus group associated circumcision with higher levels of hygiene and cleanliness as the removal of the foreskin would allow for easier access to the head of the penis. However, a middle-income focus group participant was quick to note that circumcision in and of itself did not immediately result in better hygiene:

> Personally, in terms of hygiene, cleanliness, it doesn't matter if he is circumcised or not. It depends on the person's rules of hygiene.

An interesting benefit of circumcision that emerged during two of the focus groups was that correct condom use may be more difficult for uncircumcised men. A participant in the youth focus group shared the following:

> Here in Latin America, the majority of us are not circumcised and in North America, which is where condoms are manufactured, they are. So many men complain that they do not use condoms because it hurts them. But it is also because of the way that people put on the condom.

A participant in the bisexual group argued that incorrect condom use by uncircumcised men could lead to breakage and subsequent penile infection due to friction between the foreskin and the condom. In the survey sample, 47% did not know if condoms would be more comfortable for a circumcised or uncircumcised man. One-quarter (27%) believed there would be no difference in comfort level, whereas 7% believed condoms would be less comfortable for circumcised men, and 19% believed condoms would be less comfortable for uncircumcised men.

Beliefs that circumcision can minimise one's risk of acquiring an STI or HIV were not widespread. A participant in the sex worker focus group admitted he had never heard of circumcision as a means of HIV prevention, and a participant in the activist group stated his disbelief that circumcision could decrease risk of HIV infection. Approximately one-third of the survey participants did not know whether being circumcised or uncircumcised made it easier to get STIs (34%) or HIV (32%), and approximately half believed that circumcision would not make a difference in STI (42%) or HIV (53%) risk.

Willingness and Recommendations for HIV prevention campaigns

Men in two focus groups expressed their unwillingness to undergo the procedure. However, participants in other groups mentioned situations in which circumcision would be acceptable. First, participants in three different groups noted that if they were to experience a medical need, then they might consider circumcision. Second, if there were more information about the benefits and reliable information about the risks, then participants in two groups noted their potential willingness to consider circumcision as a means of HIV

prevention. Lastly, one participant in the transgender group noted his belief that circumcision was becoming more common among the upper classes, which could lead to the procedure becoming seen as fashionable.

Colombian MSM noted a need for more information about circumcision before any intervention promoting the procedure among gay men should be undertaken. Participants in five different focus groups expressed a need for more detailed information about the surgical procedure itself and its aftermath. Of utmost importance would be strong evidence of the efficacy of circumcision as a means of HIV prevention, including estimates for both insertive and receptive partners. One participant in the older adult group and one from the middle-income group noted that provision of this information would lead to informed decision-making even in the face of a potentially painful recuperation period:

> As soon as it is demonstrated that the possibility of [HIV] infection is lower when people are circumcised, it is something that I would totally support.

The value of this type of information should not be underestimated. A great majority of uncircumcised survey participants indicated a willingness to get circumcised if definitive evidence could be provided that it protected against HIV (85%) or STIs (86%). The next most convincing reasons to get circumcised were related to improvements in one's sexual life. Increases in sexual pleasure or improvements in the appearance of the penis were endorsed as important motivators to get circumcised by 86% and 83%, respectively, of the survey participants. Proof that the surgery would not be painful (81%) and would heal quickly (82%) would be similarly convincing. Lastly, the elimination of financial costs would encourage 70% of participants to undergo the procedure.

If circumcision is found to provide protection against HIV and STIs, and if large numbers of MSM undergo the procedure, information should address possible protection for sexual activities other than anal intercourse. For example, one participant in the sex worker focus group humorously noted that circumcision would not be likely to protect him, as there are other sexual activities by which HIV can be passed on.

> As a form of prevention I will not do it if it comes to be, because then I would also need to circumcise my mouth and my tongue.

Focus group participants also discussed the potential danger that risk compensation would occur among circumcised MSM. Specifically, the bisexual focus group participants were worried that previous progress in promoting condom use could be undone if circumcised MSM believe they are fully protected against HIV and other STIs.

> If being circumcised is promoted as a method of avoiding infection, I don't know if Colombia could handle that. Because I think that if people are told "get circumcised and you will be less susceptible to HIV", they will begin to have sex often and without a condom and then the situation changes.

They discussed how difficult it had been to convince people of the need to use condoms, although some success has finally been achieved in this regard, and expressed their concern that circumcision might provide an excuse for individuals to have unprotected intercourse.

Participants from the low-income, bisexual, and sex worker focus groups felt that the most effective way to reduce HIV transmission in Colombia would be to promote the engagement in multiple risk reduction strategies. For example, one of the participants from the low-income group articulated the following:

> I would think that it could be a good step in the desired direction but it would be an insufficient strategy. It is not circumcision per se. It seems as though it does reduce

> [HIV risk] but there is more to do. This could be part of an activity, of a broader strategy.

A couple of participants in the bisexual focus group also recommended that public health campaigns frame circumcision in terms of general sexual health and genital hygiene in order to increase the likelihood that a broader audience would find the message relevant.

Discussion

The perceptions of circumcision among men in this sample were shaped by their experiences as citizens of a country where circumcision is not normative and as members of a community that highly values the penis for its appearance and function. Nevertheless, the findings of this circumcision acceptability study reflect those of similar studies conducted among heterosexual African heterosexuals (Westercamp and Bailey 2007) and Chinese (Ruan et al. 2009), Peruvian, and Ecuadorean MSM (Sanchez 2007). Pain (both during and after the surgery) emerged as a primary concern in all four samples of heterosexual men and MSM reviewed here (Westercamp and Bailey 2007; Ruan et al. 2009; Sanchez 2007). Risk compensation, or engagement in additional risky sexual behaviours once circumcised, was also identified as a possibility by Colombian MSM, Ecuadorian and Peruvian MSM (Sanchez 2007), and heterosexual Africans (Westercamp and Bailey 2007). These three groups also noted the possibility for welcome and unwelcome changes in their partner selection pool due to differing personal preferences and tastes concerning the appearance of circumcised and uncircumcised penises (Westercamp and Bailey 2007; Sanchez 2007). In all four groups, genital hygiene has been noted as an advantage afforded by circumcision (Westercamp and Bailey 2007; Ruan et al. 2009; Sanchez 2007). Additionally, some of the Colombian MSM, Chinese MSM (Ruan et al. 2009), and heterosexual Africans (Westercamp and Bailey 2007) noted the belief that circumcision could increase pleasure. For both heterosexual men and MSM, perceived sexual impacts are likely to influence their decision to get circumcised.

It is perhaps not surprising that heterosexual men and MSM share many of the same concerns about circumcision. However, Colombian MSM were unique in two important ways. Colombian MSM who participated in the current study were largely unaware that circumcision could decrease HIV and STI risk: less than 15% of the survey sample believed this. However, nearly half of the Chinese MSM who participated in a recent study of circumcision acceptability noted their belief that acquisition of HIV and STIs was easier (e.g., more likely to occur) among uncircumcised men (Ruan et al. 2009). It appears as though information about circumcision as a means of HIV prevention is not yet widely available in Colombia. Dissemination of this information could increase circumcision willingness: most participants responded affirmatively to a hypothetical question regarding their willingness to undergo the procedure if there was strong evidence to show it protected against HIV or STIs. Even so, we do not know to what extent this reported willingness would be related to actual behaviour should medical circumcision be made widely available to MSM as a recommended form of HIV prevention. Given that previous knowledge about circumcision, as well as its relationship with HIV, was limited or non-existent, efforts to educate the public about circumcision will require thorough explanations so as to prevent the tendency to discount evidence on this unfamiliar topic. Furthermore, the anticipated lower degree of protection afforded to MSM than to heterosexual men (who are exclusively insertive during intercourse) could lessen motivation to undergo circumcision.

Aesthetic preferences concerning penises among the men in our focus group sample also distinguished them from MSM in other studies of circumcision acceptability. Perhaps because circumcision beliefs and concerns of Chinese (Ruan et al. 2009), Peruvian and Ecuadorean (Sanchez 2007) MSM were assessed via close-ended surveys, aesthetic

preferences in these two samples were not elaborated upon. Although we also did not assess aesthetic preferences directly in our survey, many survey participants agreed that improved appearance of the penis would be a motivation to get circumcised. Additionally, our mixed methods approach provided us with qualitative information about the potential role of aesthetic concerns in decision-making about circumcision. The Colombian participants discussed penis aesthetics to a greater degree than performance, which indicates that appearance is an important function in this population. Although some participants indicated that they chose partners based on characteristics other than those of the penis, some expressed a clear preference for uncircumcised or circumcised penises. Partner preferences often reflected the participant's own circumcision status, and MSM who participated in the focus groups noted their preference for the familiar.

Although results of the current study provide a picture of popular perceptions of circumcision among MSM in Bogotá, an important qualification of the methodology warrants mention. Focus groups are an appropriate tool for exploring phenomena about which little is known (Stewart, Shamdasani, and Rook 2007), and they yield the most (and the most honest) information when participants are similar to, but unfamiliar with, each other (Krueger 1994). Despite being selected for participation in a focus group based on specific characteristics (age, socioeconomic status, occupation, gender identity, and HIV status) that would facilitate synergistic responses, all participants were members of relatively small MSM community. Thus, it is possible that participants did not feel comfortable sharing their own thoughts and opinions with a group of potential sexual and social partners. This may explain why some participants shared circumcision-related stories about friends and family members instead of themselves. These may have been true stories, but they may also reflect a strategic way of sharing one's personal beliefs or experiences without incurring the judgment of similar others.

Public health efforts to promote circumcision must take into account cultural attitudes, beliefs and practices (Lee 2006); Peltzer and Kanta 2009). For example, even were circumcision to be shown to be effective in reducing HIV transmission among MSM, attempts to promote circumcision among Colombian MSM would require multiple culturally appropriate strategies, including ways of addressing beliefs that could contribute to risk compensation among MSM circumcised as adults. Neonatal circumcision is being promoted as a long-term strategy to control the HIV epidemic in countries where there are high rates of HIV and low rates of circumcision (Binagwaho et al. 2010; Kalichman 2010; WHO/UNAIDS Technical Consultation 2007). Given the low rates of HIV in the general population, this strategy may not be appropriate for the Colombian context. Nearly half the participants in this study viewed this practice as cruel. Efforts to promote circumcision among adults or children would need to address existing negative attitudes and beliefs about the procedure, as well as to provide education concerning health benefits.

Acknowledgments

Funding for this study was provided by grant #R01 HD057785 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development. We are grateful to our partners in Bogotá, Colombia (Profamilia and Colectivo LGBT) for their support in the recruitment of participants and the hosting of focus groups. We also wish to thank Adriana Ortiz for her help with the coding of the focus groups.

References

AIDS Vaccine Advocacy Coalition. [Accessed November 3, 2009] A new way to protect against HIV? Understanding the results of male circumcision studies for HIV prevention. 2007 Sep. http://www.avac.org/ht/a/GetDocumentAction/i/3136

Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R, Puren A. Randomized, controlled intervention trial of male circumcision for reduction of HIV infection risk: The ANRS 1265 trial. PLos Medicine. 2005; 2(no. 11):1112–1122.

Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN, Williams CFM, Campbell RT, Ndinya-Achola JO. Male circumcision for HIV prevention in young men in Kisumu, Kenya: A randomised controlled trial. The Lancet. 2007; 369:643–656.

Binagwaho A, Pegurri E, Muita J, Bertozzi S. Male circumcision at different ages in Rwanda: A cost-effectiveness study. PLoS Med. 2010; 7(no. 1):1–10.

[Accessed October 6, 2010] Departamento Nacional de Planeación. Sistema nacional de evaluación de gestión y resultados. http://www.dnp.gov.co/PortalWeb/Programas/Sinergia/EvaluacionesEstrat%c3%a9gicas/EvaluacionesdeImpacto/Estratificaci%c3%b3nSocioEcon%c3%b3mica.aspx

Gray RH, Kigozi G, Serwadda D, Makumbi F, Watya S, Nalugoda F, Kiwanuka N, Moulton LH, Chaudhary MA, Chen MZ, Sewankambo NK, Wabwire-Mangen F, Bacon MC, Williams CFM, Opendi P, Reynolds SJ, Laeyendecker O, Quinn TC, Wawer MJ. Male circumcision for HIV prevention in men in Rakai, Uganda: A randomised trial. The Lancet. 2007; 369:657–666.

Gust DA, Wiegand RE, Kretsinger K, Sansom S, Kilmarx PH, Bartholow BN, Chen RT. Circumcision status and HIV infection among MSM: Reanalysis of a phase III HIV vaccine clinical trial. AIDS. 2010; 24:1135–1143. [PubMed: 20168206]

Heckathorn DD. Respondent-driven sampling II: Deriving valid population estimates from chain-referral samples of hidden populations. Social Problems. 2002; 49(no. 1):11–34.

Heckathorn DD. Respondent-driven sampling: A new approach to the study of hidden populations. Social Problems. 1997; 44(no. 2):174–199.

Jameson DR, Celum CL, Manhart L, Menza TW, Golden MR. The association between lack of circumcision and HIV, HSV-2, and other sexually transmitted infections among men who have sex with men. Sexually Transmitted Diseases. 2010; 37(no. 3):147–152. [PubMed: 19901865]

Joint United Nations Programme on HIV/AIDS. [Accessed December 23, 2010] Report on the global AIDS epidemic: 2010. 2010. http://www.unaids.org/globalreport/global_report.htm

Kalichman SC. Neonatal circumcision for HIV prevention: Cost, culture, and behavioral considerations. PLoS Med. 2010; 7(no. 1):1–2.

Krueger, RA. Focus groups: A practical guide for applied research. 2nd ed. Thousand Oaks, CA: Sage Publications; 1994.

Lee RB. Filipino experience of ritual male circumcision: Knowledge and insights for anti-circumcision advocacy. Culture, Health & Sexuality. 2006; 8(no. 3):225–234.

Millett GA, Ding H, Lauby J, Flores S, Stueve A, Bingham T, Carballo-Dieguez A, Murrill C, Liu KL, Wheeler D, Liau A, Marks G. Circumcision status and HIV infection among Black and Latino men who have sex with men in 3 US cities. Journal of Acquired Immune Deficiency Syndrome. 2007; 46(no. 5):643–650.

Millett GA, Flores SA, Marks G, Reed JB, Herbst JH. Circumcision status and risk of HIV and sexually transmitted infections among men who have sex with men. Journal of the American Medical Association. 2008; 300(no. 14):1647–1684.

Montano SM, Sanchez JL, Laguna-Torres A, Cuchi P, Avila MM, Weissenbacher M, et al. Prevalences, genotypes, and risk factors for HIV transmission in South America. Journal of Acquired Immune Deficiency Syndrome. 2005; 40(no. 1):57–64.

Peltzer K, Kanta X. Medical circumcision and manhood initiation rituals in the eastern cape, South Africa: A post intervention evaluation. Culture, Health & Sexuality. 2009; 11(no. 1):83–97.

Ramirez-Valles J, Heckathorn DD, Vazquez R, Diaz RM, Campbell RT. From networks to populations: The development and application of respondent-driven sampling among IDUs and Latino gay men. AIDS and Behavior. 2005; 9(no. 4):387–402. [PubMed: 16235135]

Reisen CA, Zea MC, Poppen PJ, Bianchi FT. Male circumcision and HIV status among Latino immigrant MSM in New York City. Journal of LGBT Health Research. 2007; 3(no. 4):29–36. [PubMed: 19002268]

Richards, L. Handling qualitative data: A practical guide. Thousand Oaks, CA: Sage Publications Ltd; 2005.

Ruan Y, Qian HZ, Li D, Shi W, Li Q, Liang H, Yan Y, Luo F, Vermund SH, Shao Y. Willingness to be circumcised for preventing HIV among Chinese men who have sex with men. AIDS Patient Care and STDs. 2009; 23(no. 5):315–321. [PubMed: 19335172]

Sanchez, J. Cutting the edge of the HIV epidemic among MSM; Paper presented at the Future Direction of Male Circumcision in HIV Prevention conference; November 29-30; Los Angeles, CA. 2007 Nov. http://149.142.76.35/TEMPMAT/MaleCirc2007/Sanchez%20LA.pdf

Sanchez J, Sal y Rosas VG, Hughes JP, Baeten JM, Fuchs J, Buchbinder SP, Koblin BA, Casapia M, Ortiz A, Celum C. Male circumcision and risk of HIV acquisition among men who have sex with men. AIDS. 2011; 25(no.4):519–523. [PubMed: 21099672]

Stewart, DM.; Shamdasani, PN.; Rook, DW. Focus groups: Theory and practice. Applied social research methods series. 2nd ed.. Vol. Vol. 20. Thousand Oaks, CA: Sage Publications; 2007.

Templeton DJ, Jin F, Mao L, Prestage GP, Donovan B, Imrie J, Kippax S, Kaldor JM, Grulich AE. Circumcision and risk of HIV infection in Australian homosexual men. AIDS. 2009; 23:2347–2351. [PubMed: 19752714]

UN Interagency Task Force. [Accessed November 3, 2009] Information package on male circumcision and HIV prevention. 2007. http://www.who.int/hiv/pub/malecircumcision/infopack/en/index.html

Weiss, H.; Polonsky, J.; Bailey, R.; Hankins, C.; Haperin, D.; Schmid, G. Male circumcision: Global trends and determinants of prevalence, safety and acceptability. World Health Organization and Joint United Nations Programme on HIV/AIDS; 2007. http://www.who.int/hiv/pub/malecircumcision/globaltrends/en/index.html

Westercamp N, Bailey RC. Acceptability of male circumcision for prevention of HIV/AIDS in sub-Saharan Africa: A review. AIDS and Behavior. 2007; 11:341–355. [PubMed: 17053855]

WHO/UNAIDS Technical Consultation. New data on male circumcision and HIV prevention: Policy and programme implications. Montreux, Switzerland: 2007 Mar. http://data.unaids.org/pub/Report/2007/mc_recommendations_en.pdf

Table 1

Demographics of participants

	Focus Groups		Survey	
	n	%	n	%
Sexual orientation				
Homosexual/gay	61	78.2	74	74.0
Bisexual	11	14.1	23	23.0
Queer*	4	5.1	0	0.0
Heterosexual	1	1.3	3	3.0
Not reported	1	1.3	0	0.0
Age				
15–19	13	16.7	6	6.0
20–29	39	50.0	68	68.0
30–39	16	20.5	22	22.0
40–49	9	11.6	4	4.0
Not reported	1	1.3	0	0.0
Level of Education (highest completed)				
Primary (grades 1–5)	2	2.6	16	16.0
Secondary (grades 6–11)	22	28.2	64	64.0
University (BA, MA, PhD)	46	59.0	20	20.0
Not reported	8	10.3	0	0.0

*This category includes 3 men who identified as queer and 1 who identified as pansexual

Table 2

Social and health characteristics of participants

	Focus Groups		Survey	
	n	%	n	%
Strata *				
1	1	1.3	1	1.0
2	19	24.4	16	16.0
3	25	32.1	49	49.0
4	23	29.5	30	30.0
5	2	2.6	4	4.0
6	1	1.3	0	0.0
Not reported	7	9.0	0	0.0
Main Partner				
Yes	39	50.0	45	45.0
No	38	48.7	55	55.0
Not reported	1	1.3	0	0.0
Tested for HIV				
Yes	54	69.2	60	60.0
Positive	10	18.5	9	15.0
Negative	40	74.1	47	78.33
Not reported	2	7.4	4	6.67
No	23	29.5	36	36.0
Not reported	1	1.3	4	4.0

* Housing in Colombia is classified by *estratos* (strata) according to physical characteristics of homes and neighborhoods. Strata classifications range from one (the poorest) to six (the wealthiest) and were originally intended to determine costs of utilities. Strata are highly correlated with socioeconomic status (Departamento Nacional de Planeación).