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Male Circumcision Rates in Patients From a Sexually Transmitted Disease Clinic in Southern Florida and Acceptability of Circumcision Among Hispanics

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Abstract

The objectives of this study were assessment of the prevalence of male circumcision (MC) among patients attending the Miami-Dade County (MDC) sexually transmitted diseases (STDs) clinic and exploration of attitudes of MC among Hispanic STD clinic attendees.

Prevalence of MC was assessed by a review of 500 clinic records. Attitudes toward MC were explored during focus group sessions. The overall rate of MC was 27%. Men associated acceptability of MC with sexual performance, their partner's anticipated responses to MC, and scientific proof of STD protection; whereas women focused on experiences with previous partners and hygiene. We found a low rate of circumcision in males attending the MDC STD clinic.

Approximately half of the Hispanic men and women in focus groups also found MC acceptable or desirable.

Keywords

circumcision; HIV prevention; Hispanics; STD

In 2010, Miami, Florida had the highest rate of new HIV diagnoses (56.6 per 100,000 persons) among metropolitan statistical areas of residence in the United States (Centers for Disease Control and Prevention [CDC], 2010). The epidemic of HIV infection in Miami is primarily driven by sexual transmission, with relatively high levels of heterosexual transmission compared to the rest of the country (CDC, 2008; Miami-Dade County [MDC] Health Department, 2009). These distinct epidemiological characteristics make the HIV epidemic in Miami similar to the international pandemic, suggesting that preventive strategies being employed in high incidence populations internationally may be applicable to Miami.

There is now extensive scientific evidence that male circumcision (MC) reduces the risk of acquiring HIV through heterosexual intercourse in males by approximately 51%–60% (AIDS Alert, 2007; Auvert et al., 2005; Bailey et al., 2007; Gray et al., 2007). This level of

protection exceeds the 30% risk reduction set as a target for an AIDS vaccine and is similar to the 67.5% relative reduction in the risk of maternal–infant transmission of HIV with the use of zidovudine in pregnant women infected with HIV (Connor et al., 1994). The evidence of the effectiveness of MC in decreasing the risk of HIV infection in males was so compelling that in March 2007, the World Health Organization and the Joint United Nations Programme on HIV/AIDS held a technical consultation on MC and produced a document that stated that MC should be recognized as an efficacious intervention for the prevention of heterosexually acquired HIV infection in men (Joint United Nations Programme on HIV/AIDS, 2007). In 2008, the CDC published its position recommending individual men to consider circumcision as an additional HIV preventive measure.

MDC is primarily (65%) Hispanic and could potentially benefit from the protective effect of circumcision (U.S. Census Bureau, 2010). Hispanics have traditionally had the lowest circumcision rates of all ethnic groups in the U.S. general population (Xu, Markowitz, Stemberg, & Sevgi, 2007). In addition, Hispanics have the lowest circumcision rates among STD clinic attendees (McKinney et al., 2008; Millett et al., 2007; Mor, Kent, Kohn, & Klausner, 2007). However, the uptake of adult MC relies on its acceptability, and the willingness to circumcise among Hispanics in the Southeastern United States is unknown. MDC Health Department maintains four dedicated STD clinics strategically located in areas of high demand in the county. This study was conducted in the “Downtown” or main clinic. This clinic is centrally located and serves approximately 800 individuals per month. Approximately 60% of the clients are self-identified as African Americans, 35% Hispanics, and 5% of other ethnic groups. The objectives of this pilot study were to quantify rates of circumcision among males at high risk of HIV infection and to assess the acceptability of adult MC within Hispanics in this population.

Methods

Male Circumcision Rates in Sexually Transmitted Diseases Attendants

To address the first objective of this study, we conducted a retrospective review of 500 medical records of male patients of the Downtown MDC STD clinic. These records were randomly selected for abstraction. A staff member of the clinic selected every fifth record of all new male patients seen in the clinic to complete approximately 50 records per week from December 2008 to February 2009. Collected information included date and place of birth, race and ethnicity, information regarding prior or concurrent (at the time of the STD clinic visit) STDs, circumcision status as documented by STD clinic provider after physical exam, and sexual orientation. This information was entered in an Excel database and analyzed by descriptive statistics.

Attitudes Toward Male Circumcision

To address the second objective of this study, a convenience sample of 39 Hispanic participants was recruited from the Downtown MDC STD clinic from January 2009 to May 2009 to participate in gender-matched focus groups first, and then to complete quantitative assessments by staff-administered questionnaires. STD clinic personnel were briefed on the study objectives and were requested to refer potential candidates to the study coordinator.

Eligibility criteria to participate in this phase of the study were (a) 18 years of age and older and (b) self-identified as Hispanic. After providing informed consent, participants were provided with an appointment at the study offices off site.

All assessments were verbally administered by a trained interviewer in the individuals' preferred language (Spanish, English) in a private room after their participation in the gender-matched focus groups. Protocols for assessment were created in both English and Spanish. Study assessments were an average of 1 hr in duration, and participants were provided with monetary compensation for their time and travel. All study materials, including informed consent, focus group probe items, and individual assessments were previously available in Spanish or translated into Spanish using the back-translation strategy, in which two different individuals translated to Spanish and back to English, prior to submission to the institutional review board (IRB) for approval.

Focus Groups

We conducted qualitative assessments on attitudes regarding circumcision (six focus groups: men [three groups], $n = 19$ and women [three groups], $n = 20$). Groups were led by two gender concordant facilitators: one medical provider and one psychologist.

Focus groups and key informant interviews were conducted in both English and Spanish and were audio recorded. These focus groups were conducted after participants signed the informed consent and prior to the administration of any of the questionnaires. Focus group leaders and key informant interviewers used an established protocol of items and probed for additional information when appropriate.

Questionnaires to Focus Group Participants

Demographics Questionnaire—This questionnaire included information on time in the United States, country of birth, religion, education, employment, income, residence, marital/current partner status, gender, medical treatment, access to health care, and service delivery.

Circumcision Attitudes Questionnaire—Kebaabetswe's Circumcision Attitudes Questionnaire (Kebaabetswe et al., 2003) is a six-item measure that includes questions on willingness to circumcise your child, willingness to be circumcised, attitudes toward cultural acceptability of circumcision, opinion on optimal circumcision age, and opinion on optimal setting for circumcision. Items are rated using a 3-point scale, that is, willingness to circumcise a child or circumcise self (adult males), 1 (*would definitely do it*), 2 (*would definitely not do it*), and 3 (*unsure*); and cultural acceptability of circumcision, 1 (*acceptable*), 2 (*not acceptable*), and 3 (*don't know*).

Acculturation Questionnaire (Bidimensional Acculturation Scale)—The Bidimensional Acculturation Scale (BAS; Marin & Gamba, 1996) consists of 24 items measuring two dimensions of acculturation (Hispanic and non-Hispanic). The Hispanic dimension reflects a preference for the Spanish language and a perceived proficiency for reading, understanding, and speaking Spanish. The non-Hispanic dimension reflects a preference for the English language and a perceived proficiency for reading, understanding,

and speaking English. These two scales are used together to assess level of acculturation to the host culture and cultural pluralism (degree of linguistic participation in both cultures). The range of scores for each dimension is 1–4. A score of 2.5 or higher in a given dimension (i.e., Hispanic or non-Hispanic) indicates a high level of adherence to that acculturation dimension. A score of 2.5 or higher in both the Hispanic and non-Hispanic dimensions indicates biculturalism. Thus, by combining scores on the two dimensions, the cultural orientation of participants is classified as Hispanic, non-Hispanic, or bicultural.

Medical Record Abstraction—Information collected included demographics, race, ethnicity, current and past STDs, and circumcision status as documented by the examining practitioner.

Qualitative Data Analysis

Audio recordings were transcribed and translated into English for review and qualitative analyses. Transcriptions were coded line by line using descriptive codes for common themes and patterns and grouped into broad categories. Data analysis was guided by a system in which transcripts from each session were reviewed first to develop a list of themes and concepts. Next, further reduction of data and coding was done through the use of NVivo7 (from the system Non-numerical Unstructured Data Indexing, Searching, and Theorizing [NUD*IST]) computer software. Themes and patterns regarding each of the main interview and focus group topics were identified using established coding procedures. The analytic coding categories were used to categorize initial coding data and were expanded to accommodate new findings. Themes related to children and neonatal circumcision are more extensively presented in our previous publication (see Castro et al., 2010).

Quantitative Data Analysis

Data from assessments were analyzed using PASW17.0. Descriptive statistics were conducted. Characteristics of study participants were stratified by gender regarding attitudes toward circumcision; chi-square analyses were conducted. Most independent variables were dichotomous (“yes,” “no”) or rank order preference (“prefer, do not prefer, unsure”).

This study was approved by the IRB of the University of Miami Miller School of Medicine and the Florida Department of Health prior to study onset in accordance with the provisions of the U.S. Department of Health and Human Services regarding the conduct of research.

Results

Circumcision Rates in Sexually Transmitted Disease Clinic

STD clinic patient charts ($N = 500$) were reviewed (see Table 1). The circumcision rate for all races/ethnicities in the STD clinic was low, especially for Hispanics (information on the circumcision status was not available on one record). Approximately half of the samples were Hispanic (236 or 47%); two thirds of the Hispanic sample (68%) were heterosexual, with the remainder being men who have sex with men (MSM). Both groups had low rates of circumcision: heterosexual 28/161 (17%) and MSM 11/75 (15%). Information on the country of origin was available for 186 Hispanics: 66 were born in the United States

(circumcision rate is 24/66 or 36%) and 120 were not born in the United States (circumcision rate is 11/120 or 9%).

Participant Qualitative Data

The acceptance rate to participate in this study was high; approximately 80% of the people asked to participate in this study agreed to it, although many of them were not familiar with the term “circumcision.” At the beginning of each session, the facilitator explained the objective of the session and the intention to hear their perceptions about MC. The facilitator introduced themes and asked open questions to each group. Participants were instructed to speak one at a time and wait until all participants have spoken to speak for a second time. In most of the sessions, there were at least a few participants per group who were completely unfamiliar with the term circumcision and asked questions to the facilitator. Other participants had misconceptions about circumcision; for example, a male participant thought circumcision was a surgical procedure to increase the size of the penis and another thought it was a surgical procedure to sterilize men. Three male focus groups and three female focus groups were held. In general, all participants were enthusiastic to participate in these focus groups. Twenty themes emerged and were collapsed into 11 areas: acceptability, appearance, circumcision and children, circumcision and HIV, cost, cultural differences, fear of injury to the penis, knowledge and personal experiences, religion, sexual and personal hygiene, and sexual performance. All themes were common to both men and women, although some themes were more salient or of more interest to men or women. Few participants had knowledge of the association between HIV and circumcision and all felt that cost was a deterrent to obtaining the procedure and no one raised concerns about the scientific proof of its benefits. In both groups, misconceptions about circumcision were fairly common.

Males—Most men personalized the issue of circumcision, relating it to their own status or that of their children, whereas some were not familiar with the procedure. About half viewed circumcision for themselves as too great of a change, and half expressed willingness to be circumcised for hygiene and the health benefits if the information were to be presented by a medical professional. Men agreed that women did not care about whether they were circumcised or not, but some were concerned that women would object to scarring of the penis or at least were concerned about women’s acceptability of a circumcised penis. For example, a male participant recalled what a woman said . . . “she had a partner that had it done who had a scar and it looked very ugly.” None expressed fear of the procedure or concern about risks or effects to sexual performance; in fact, some men conjectured that circumcision would allow the penis to become bigger, the reduction in skin allowing it to enlarge more fully.

Females—Women asserted that men were the final decision makers regarding circumcision of children, some relating a plan to circumcise other children that had been vetoed by their partners. None were familiar with any complications associated with the procedure and some were not familiar with the procedure of circumcision at all. Overall, they were receptive to neonatal circumcision. Women felt that acceptability of circumcision could be best influenced by education or classes delivered by medical personnel that would

“scare” men into circumcision. Women conjectured that adult males would not be willing to be circumcised primarily because of fears of pain; for example, a participant said, “Guys usually want to avoid pain. Not like women. We tolerate pain. Guys are just babies. They want to avoid pain as much as possible.” Most women preferred the hygienic benefits of circumcision and about half had a preference for circumcision for their partners and children. For example, a participant said, “A lot of my friends prefer a circumcised man to an uncircumcised man because of the hygiene issue.” Male machismo, or chauvinism, difficulty in coping with pain, and a lack of information were seen as the primary barriers to circumcision decision making among men.

Focus Groups’ Participant Quantitative Assessment

STD clinic participants ($n = 39$: male, $n = 20$; female, $n = 19$) were assessed (see Tables 2 and 3) on demographics, circumcision attitudes, and acculturation. Demographic characteristics were relatively similar among men and women. Most of the participants were foreign born and more than half of both men and women had a monthly income less than \$1,000. Most of both men and women described a preference to circumcise their children and thought circumcision is culturally acceptable; however, only half of the men were willing to be circumcised.

Acculturation and Gender—To evaluate the impact of gender on circumcision attitudes, we conducted chi-square analyses. Men and women’s attitudes did not differ regarding the perceived cultural acceptability of circumcision or the perceived acceptability of neonatal circumcision. To assess the relative impact of acculturation on circumcision, we compared Hispanic, non-Hispanic, and bicultural acculturation. Participants did not differ by culture or level of acculturation with regard to their attitudes regarding the acceptability of circumcision ($\chi^2 = 1.13, p = .89$) or circumcision of neonates ($\chi^2 = 2.29, p = .68$). We then separated men and women to examine differences in gender and acculturation regarding circumcision attitudes, and no differences were observed regarding acceptability ($\chi^2 = 1.36, p = .51$) or neonatal circumcision ($\chi^2 = 5.46, p = .065$). Finally, we did not find differences in women’s preferences regarding circumcision by acculturation ($\chi^2 = 2.9, p = .821$) or in men’s preferences regarding their own willingness to circumcise ($\chi^2 = .014, p = .91$).

Discussion

This pilot study sought to assess MC rates and attitudes toward circumcision among MDC Health Department STD clinic attendees. Results indicated a low rate of circumcision among males attending the STD clinic. However, approximately half of the Hispanic men and women assessed found MC acceptable or desirable; and almost half of the women assessed preferred a circumcised penis. More than half of the men assessed were willing to be circumcised and more than half of both men and women found circumcision culturally acceptable. Similar acceptability was also found in focus group discussions.

This study had a high proportion of foreign-born individuals from countries with low circumcision rates, many of whom reported relatively high rates of circumcision acceptability. Possible explanations for this relatively high rate of acceptability may be related to the procedural format of the consent and assessment. Although this pilot study did

not provide formal information on circumcision, prior to the interview, some information about the medical benefits of circumcision was included in the informed consent. It is possible that participants became more aware of information on MC during the consent process because study staff explained to potential participants that the study inquire about their knowledge and preferences about circumcision, and several potential participants inquired about what was circumcision. It is also possible that participants may have discussed the topic of circumcision among themselves in the waiting room.

Neonatal circumcision received the highest ratings of acceptability. This finding is similar to results obtained in other studies in different populations (Brito, Caso, Balbuena, & Bailey, 2009; Castro et al., 2010; Jayeoba et al., 2012; Madhivanan et al., 2008; Wang, Macklin, Tracy, Nadel, & Catlin, 2010). Recently, we found that 85% of Hispanics in a prenatal clinic in South Florida expressed willingness to circumcise their future sons if circumcision was offered free of charge, done in a hospital, and within 30 days of birth (Castro et al., 2010).

The rates of circumcision in this study were lower than rates found in the National Health and Nutritional Examination Survey (NHANES; Xu et al., 2007) and lower than the rates in that survey's Mexican population (Xu et al., 2007). The low rate of circumcision in our STD clinic sample could be explained in part by the relatively high percentage of foreign-born Hispanics, a population known to have very low rates of circumcision. However, it is also possible that men who are uncircumcised may be overrepresented in STD clinics because of the relative protection of circumcision against acquisition of HIV and some STDs. This might also explain the low rates of circumcision among the non-Hispanic men attending this clinic compared to the national average. However, the rate of circumcision in the African American non-Hispanic population in our sample (36%) is lower than the national average (73%; Xu et al., 2007) and lower than STD clinics in other cities, for example, African Americans in STD clinics in New York (58%–68%; McKinney et al., 2008) and San Francisco (62.2%; Mor et al., 2007). This study raises an additional question: Is the lower rate of circumcision seen in African Americans in the MDC STD clinic driven by lower rates of circumcision in African Americans or by Haitians, both of whom may be reported as "African American." Both groups have very high rates of HIV infection in Miami. Although this study focused on Hispanics, given the high rates of HIV and relatively low rates of circumcision in African American and Haitians seeking treatment for STDs, it should be a priority to develop studies to further investigate the acceptability of circumcision in these two additional populations.

Results of this pilot study may represent a preliminary indicator that lower rates of circumcision, not only in Hispanics but also in other at-risk populations in Southern Florida, could be attained through MC HIV prevention campaigns directed toward men at high risk for HIV infection. It can be legitimately argued that the failure to inform Hispanics about the medical benefits of MC represents an unfair deficit in public health education—as evidenced in this study's focus groups—in which only a few participants had knowledge of the existence of circumcision, much less the association between circumcision to avert HIV infection. The high rate of MC acceptability found in this study should be explored; if confirmed in subsequent, larger samples, coordinators of public health campaigns could include information about the degree of protection offered against the acquisition of HIV

and STDs provided by MC. This would be especially relevant when these public health campaigns are targeted to populations with high rates of HIV/STDs and low rates of circumcision. This perspective has been validated by a recent report from the United States that found that newborn circumcision resulted in lower than expected HIV-related treatment costs, particularly in Blacks and Hispanics (Sansom et al., 2010).

It may not be possible to continue to sustain provision of care to an ever-growing population of individuals infected with HIV if the rates of new infections are not dramatically reduced. This situation is already occurring in Florida, where people relying on AIDS Drugs Assistance Program (ADAP) are going to a waiting list to receive HIV medications. We believe that other cities or metropolitan areas with very high rates of HIV need to analyze the specific factors, such as low rates of circumcision, present in their communities that may increase their vulnerability to the spread of HIV. As a strategy for the general male population, of whom 80% are already circumcised, a circumcision campaign is probably unnecessary. But for regions or communities with high rates of HIV and STDs and low rates of circumcision, MC may represent a biomedical HIV prevention intervention that can eventuate in a significant reduction in HIV transmission.

With the advent of new biomedical interventions for the prevention of HIV infection, such as preexposure prophylaxis, it may be necessary to continue to expand the multidisciplinary approach to HIV prevention in health care. Such an approach should include all members of the health care team and take particular advantage of the potential role nurses can play to introduce and engage at-risk individuals in discussion of the benefits and limitations of these various interventions (Bradley-Springer, Stevens, & Webb, 2010). However, given the diversity of the United States, considerations of interventions to prevent HIV by CDC or the American College of Pediatrics should integrate cultural preferences and differences into the strategies proposed.

The main limitations of this study are the small sample size of participants in the focus groups and the selection of participants. These two limitations will limit any generalization of these results that should be taken as preliminary results and should be subject to further confirmation.

In conclusion, STD clinic attendants in MDC have low rates of MC, particularly in Hispanics, but acceptability of MC as an additional HIV prevention strategy in both male and female Hispanics in STD clinics is relatively high.

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TABLE 1

Circumcision Rate in Miami Sexually Transmitted Disease Clinic

	Circumcised	Noncircumcised	Total	Circumcision Rate (%)
Hispanics	39	197	236	17
Non-Hispanics	93	170	263	36
All	132	367	499	26

TABLE 2

Demographic Data

	Male	Female
Education (mean years)	11.32 ± 2.89	10.4 ± 3.76
Years in the United States (mean)	13.42 ± 10.58	15.5 ± 9.28
Monthly income		
Less than \$500	9 (47%)	5 (25%)
\$500–\$999	5 (26%)	6 (30%)
\$1,000–\$1,999	3 (16%)	3 (15%)
More than \$2,000	2 (11%)	5 (15%)
Marital status		
Single	9 (47%)	4 (20%)
Couple	5 (26%)	8 (40%)
Married	5 (26%)	5 (25%)
Separated	0	3 (15%)
Place of birth		
United States	1 (5%)	4 (20%)
Cuba	10 (53%)	3 (15%)
Caribbean	1 (5%)	1 (5%)
Central America & Mexico	5 (26%)	9 (45%)
South America	2 (10%)	3 (15%)
Health insurance		
Yes	6 (32%)	9 (45%)
No	13 (68%)	11 (55%)
Health care used		
Clinic	16 (84%)	12 (60%)
Office	7 (35%)	7 (35%)
Emergency room	1 (5%)	1 (5%)

TABLE 3**Circumcision Attitudes**

	Males	Females
Circumcision preference for sex partner		
Circumcised		9 (45%)
Uncircumcised		3 (15%)
No preference		7 (35%)
Unsure		1 (5%)
Circumcision preference for children		
Would circumcise	16 (84%)	16 (80%)
Would not circumcise	2 (11%)	4 (20%)
Unsure	1 (5%)	1 (5%)
Cultural acceptability of circumcision		
Acceptable	11 (58%)	9 (45%)
Not acceptable	4 (21%)	6 (30%)
Unsure	4 (21%)	5 (25%)
Willing to be circumcised		
Yes	10 (53%)	NA
No	9 (47%)	NA
Best age for circumcision		
Birth to 1 month	12 (63%)	15 (75%)
1 month to 1 year	4 (21%)	1 (5%)
2–5 years	1 (5%)	0%
5–15 years	0 (0%)	1 (5%)
Never	2 (11%)	3 (15%)

Note. NA = not applicable.