

Male Genital Mutilation - Circumcision

Last Update: 5/12/13

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1. Prevalence and Reasons for Male Circumcision

Like most people, I used to have no particular view about male circumcision, neither for nor against. I know circumcised men who seem content with their condition. Why make a big deal of it? One reason is that in the vast majority of cases the men themselves had no say in whether they were circumcised. The operation is frequently carried out on new born babies. The other most common time is when a boy is pubescent, or immediately after puberty, at perhaps 12 to 15 years old. Though such a boy is old enough to exercise choice, he is invariably not permitted choice. Where circumcision is the norm it is because it is a religious or societal obligation. In Israel, for example, a mother will be fined heavily for refusing to circumcise her son, see for example, <http://www.japantimes.co.jp/news/2013/11/29/world/israeli-woman-is-fined-for-not-circumcising-son/#.UpjMHXBFBes>.

Both the Jewish and the Islamic religions regard circumcision as obligatory, which is part of the reason why the practice is so widespread. The World Health Organisation (WHO) has estimated that about 30% of the total world population of men over 15 are circumcised, i.e., about 900 million men. 70% of these are Muslim (but a negligible percentage are Jews). However, to my great surprise, ~56% of men in the USA are circumcised despite Jews and Muslims accounting for only ~2.7% of the population (and not long ago more than 70% of men in the USA were circumcised).

Other than the arbitrary, and primitive, dictats of religions, you will hear people claim that there are health benefits to circumcision. Do note that this is a *post-hoc* rationalisation. The religious requirement for circumcision is hundreds, or thousands,

of years old. The claim that there are health benefits was posited only in relatively recent times as a defence against accusations of unwarranted mutilation. *Post-hoc* or not, if there are truly significant health benefits then this might reasonably sway one's view of the desirability, or otherwise, of circumcision. But are there? The overwhelming majority view of medical bodies worldwide is that any claimed preventative medical benefits do not motivate circumcision (§8).

But the most serious lie that is still widely believed about circumcision is that it is benign, resulting in no loss of sexual function. This is flatly contradicted by the reports from circumcised men themselves (§12). If you only read part of this essay, read §12. The truth that has been suppressed (successfully, I did not know this myself until I started this research) is that circumcision was, from the start, specifically intended to diminish sexual function. This was the case amongst Jews in ancient times, and it was also the motivation for the sudden popularity of circumcision in the West in Victorian times. This practice, which is monstrous enough as 'merely' a physical mutilation, was always intended to do harm in respect of sexual function. This being the case any doctor performing non-therapeutic circumcision on a child too young to give meaningful consent should be struck off. This is how Moses Maimonides, the Jewish intellectual and physician, expressed it as early as 1135,

"With regard to circumcision, one of the reasons for it is, in my opinion, the wish to bring about a decrease in sexual intercourse and a weakening of the organ in question, so that this activity be diminished and the organ be in as quiet a state as possible. It has been thought that circumcision perfects what is defective congenitally...How can natural things be defective so that they need to be perfected from the outside, all the more because we know how useful the foreskin is to that member? In fact this commandment has not been prescribed with a view to perfecting what is defective congenitally, but to perfecting what is defective morally. The bodily pain caused to that member is the real purpose of circumcision. None of the activities necessary for the preservation of the individual is harmed thereby, nor is procreation rendered impossible, but violent concupiscence and lust that goes beyond what is needed are diminished. The fact that circumcision weakens the faculty of sexual excitement and sometimes perhaps diminishes the pleasure is indubitable. For if at birth this member has been made to bleed and has had its covering taken away from it, it must indubitably be weakened. In my opinion, this is the strongest of the reasons for circumcision. Jewish men, sexually subdued and readily controlled by their wives, don't stray into mischief. The power of his member has been diminished so that he has no strength to lie with many lewd women."

The remarkable thing about this is the clarity of Maimonides' understanding, many of today's physicians, and society at large, being sadly lacking in comparison.

2. Rwanda - An Example

In November 2013 the government of Rwanda announced that it intends to circumcise the entire adult male population (700,000 men). Rwanda is a predominantly Christian country with only ~10% of men currently circumcised. The motivation to carry out wholesale circumcisions is the perceived benefit in terms of reduced rates of HIV transmission, see, <http://somalilandsun.com/index.php/regional/4348-rwanda-health-ministry-aims-to-circumcise-700-000-adult-males-by-2026-to-prevent-hivaids->

They plan to have achieved this by 2016, i.e., in 3 years. The method of circumcision to be used is via an Elastic Radial Compression Device (ERCD). This device has been

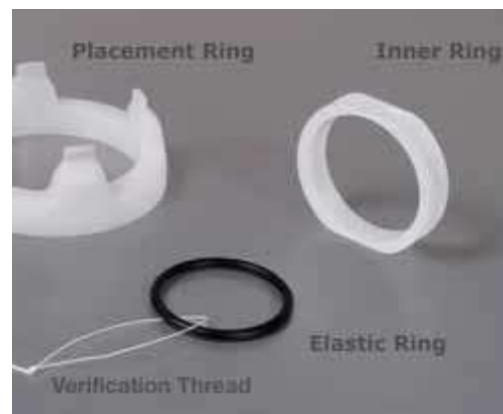
recommended by WHO, see ,

http://www.who.int/hiv/pub/malecircumcision/devices_conclusions/en/

The ERCD device (illustrated below) causes necrosis of the foreskin over one week through radial compression with an elastic ring after which the device is removed. Imagine tying a tight elastic band around the base of your finger until it turned black and fell off. That's about it. I exaggerate, of course. A finger contains a bone whereas the foreskin does not. Doing this to a finger might well lead to gangrene. Field trials with the ERCD have apparently been successful, though it remains to be seen how common medical complications might be when the device is used over an entire population.

Would you volunteer to have this done to you? I would not - and certainly not for a relatively paltry 50% reduction in the probability of HIV. I ask you, wouldn't it be easier to wash your dick after sex? I think so, and the benefits must be at least as great. And, of course, the use of a condom is far, far more beneficial.

The ERCD Circumcision Device



But is there in fact any health benefit at all from circumcision? As regards issues other than HIV this is addressed in §8. As regards HIV, the matter is highly contentious. I humbly suggest that the circumcision of entire populations of males (and it is happening in more African countries than Rwanda) is not sufficiently motivated by a claim which is highly contentious. However, if there *is* a benefit it would appear to be predominantly a benefit to men, with little benefit to women (see [New Data on Male Circumcision and HIV Prevention: Policy and Programme Implications](#) (PDF), World Health Organization, 2007). It is therefore interesting to note that HIV is far more prevalent amongst women in Rwanda than amongst men. Data taken from <http://measuredhs.com/> specific to Rwanda are given in Table 1, below, and show a very clearly greater prevalence of HIV in Rwandan women,

Table 1: Prevalence of HIV in Rwanda: Men and Women Compared

Regional Name in Rwanda	HIV Prevalence (percentage of men 15-24)	HIV Prevalence (percentage of women 15-24)	HIV Prevalence (percentage of men 15-49)	HIV Prevalence (percentage of women 15-49)
East	0.0	0.9	2.1	2.9
Kigali city	1.4	4.2	5.2	8.0
North	1.1	0.8	1.1	2.6
South	0.0	0.5	2.0	3.1
West	0.4	2.2	2.4	3.7

<http://measuredhs.com/> also indicates that 2.1% of intact Rwandan men have HIV whereas 3.5% of circumcised Rwandan men have HIV, data which hardly support the contention that circumcision is beneficial. In fact a study into risk factors associated with the prevalence of HIV infection among pregnant women in Rwanda, carried out by the National University of Rwanda-Johns, concluded, "*This study evaluated risk factors associated with prevalent HIV-1 infection among pregnant women in a semi-rural but densely populated area surrounding the town of Butare in Rwanda. ... Factors associated with higher seroprevalence of HIV-1 includedpartners who were circumcised*". Consistent with this finding, a USAID report stated, "*There appears no clear pattern of association between male circumcision and HIV prevalence. In 8 of 18 countries with data, HIV prevalence is lower among circumcised men, while in the remaining 10 countries it is higher*". In the face of such contra-indications of benefit, why has the government of Rwanda proposed to circumcise the entire male population?

3. The WHO Recommendation on HIV and Its Detractors

Well, despite the above quoted studies there are also many studies which report a beneficial effect of circumcision on HIV transmission. An influential randomised controlled trial has been reported by Bailey, et al, "[Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial](#)". *The Lancet* **369** (9562): 643–656, February 2007. It concluded, "*The two year HIV incidence was 2.1% (95% CI 1.2-3.0) in the circumcision group and 4.2% (3.0-5.4) in the control group (p=0.0065); the relative risk of HIV infection in circumcised men was 0.47 (0.28-0.78), which corresponds to a reduction in the risk of acquiring an HIV infection of 53% (22-72)*." Largely on the strength of this study the World Health Organisation (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS) have recommended that male circumcision is an efficacious intervention for HIV prevention.

However, this study has come in for severe criticism on methodological grounds, largely because its monitoring boards terminated the study prematurely. For example, Mills and Siegfried, *The Lancet* **368** (9543): 1236, concluded that "*The inferences drawn from the only completed randomised controlled trial (RCT) of circumcision could be weak because the trial stopped early. In a systematic review of RCTs stopped early for benefit, such RCTs were found to overestimate treatment effects. When trials with events fewer than the median number (n=66) were compared with those with*

event numbers above the median, the odds ratio for a magnitude of effect greater than the median was 28 (95% CI 11--73). The circumcision trial recorded 69 events, and is therefore at risk of serious effect overestimation. We therefore advocate an impartial meta-analysis of individual patients' data from this and other trials underway before further feasibility studies are done". Nevertheless, the joint WHO/UNAIDS recommendation still stands. However, the recommendation notes that circumcision only provides partial protection from HIV and should never replace known methods of HIV prevention.

But even if there were a factor of 2 reduction in HIV transmission rates, is this enough to motivate the genital mutilation of entire populations of males? Would this be done to women?

The Bailey, et al, study is not the only study which has reported a benefit to circumcision (though it is the only one based on a randomised controlled trial). Typically the reduction in the risk of infection that is reported is of the order of a factor of ~0.5. But there are also many studies which indicate that circumcision is not beneficial, even disbeneficial. The WHO/UNAIDS recommendation has come in for severe criticism from Gary Dowsett and Murray Couch in their review "Male Circumcision and HIV Prevention: Is There Really Enough of the Right Kind of Evidence?" in *Reproductive Health Matters* 2007;15(29):33–44. They are far from convinced that enough evidence exists to motivate wholesale circumcision as an HIV preventative. Some of the studies which contra-indicate any benefit of circumcision are listed in §4, below, with relevant quotes. The matter is pressing because it is not only Rwanda who are planning mass circumcisions. Public health leaders aim to circumcise 20 million men by 2015 in 14 nations in Sub-Saharan Africa.

4. Studies Reporting No HIV Benefit to Circumcision

Thomas, A.G.; , L.N. Bakhireva, S.K. Brodine, R.A. Shaffer (11–16 July 2004). ["15th International AIDS Conference"](#). *Prevalence of male circumcision and its association with HIV and sexually transmitted infections in a U.S. navy population*. [Bangkok, Thailand](#): reported that "male circumcision is not associated with HIV or STI prevention in a U.S. Navy population."

["Risk behaviors and patterns of HIV seroprevalence in countries with generalized epidemics: Results from the Demographic and Health Surveys"](#). APHA Scientific Session and Event Listing. 2006: "No consistent relationship between male circumcision and HIV risk was observed in most countries."

Way, A.; V. Mishra, R. Hong, K. Johnson (7–12 July 2006). ["AIDS 2006 - XVI International AIDS Conference"](#). *Is male circumcision protective of HIV infection?*. [Toronto, Canada](#): International Aids Society: "With age, education, wealth status, and a number of sexual and other behavioral risk factors controlled statistically, in only one of the eight countries were circumcised men at a significant advantage. In the other seven countries, the association between circumcision and HIV status was not statistically significant for the male population as a whole."

Brewer, Devon; Potterat, JJ; Roberts Jr, JM; Brody, S (February 2007). ["Male and Female Circumcision Associated with Prevalent HIV Infection in Virgins and Adolescents in Kenya, Lesotho, and Tanzania"](#). *Annals of Epidemiology* 17 (3): 217–26. "[circumcised] male and female virgins were substantially more likely to be HIV infected than uncircumcised virgins. Among adolescents, regardless of sexual experience, circumcision was just as strongly associated with prevalent HIV infection.

However, uncircumcised adults were more likely to be HIV positive than circumcised adults."

Van Howe, Robert; J. Steven Svoboda, Frederick M. Hodges, (November 2005). "[HIV infection and circumcision: cutting through the hyperbole](#)". *Journal of the royal society for the promotion of health* **125** (6): 259–65: "We contend that the rush to intervene has little to do with preventing HIV infection in Africa and may have more to do with a conscious and/or unconscious impulse to help perpetuate and promote the practice (*of circumcision*) in North America. There is ample indirect evidence to support this contention. Why are circumcision proponents expending so much time and energy promoting mass circumcision to North Americans when their supposed aim is to prevent HIV in Africa? The circumcision rate is declining in the US, especially on the west coast; the two North American national paediatric organisations have elected not to endorse the practice, and the practice's legality has been questioned in both the medical and legal literature. 'Playing the HIV card' misdirects the fear understandably generated in North Americans by the HIV/AIDS pandemic into a concrete action: the perpetuation of the outdated practice of neonatal circumcision."

Connolly, Catherine; Leickness C. Simbayi, Rebecca Shanmugam, Ayanda Nqeketo (October 2008). "[Male circumcision and its relationship to HIV infection in South Africa: Results of a national survey in 2002](#)" (PDF). *South African Medical Journal* **98** (10): 789–94: "Circumcision had no protective effect in the prevention of HIV transmission. This is a concern, and has implications for the possible adoption of the mass male circumcision strategy both as a public health policy and an HIV prevention strategy."

Sidler, D.; J. Smith, H. Rode (29 September 2008). "[Neonatal circumcision does not reduce HIV/AIDS infection rates](#)" (PDF). *South African medical journal* **8** (10): 762–766: "Using neonatal non-therapeutic circumcision to combat the HIV crisis in Africa is neither medically nor ethically justifiable. Furthermore, promoting circumcision might worsen the problem by creating a false sense of security and therefore undermining safe sex practices. Education, female economic independence, safe sex practices and consistent condom use are proven effective measures against HIV transmission."

Boiley, MC; K Desai¹, B Masse, A Gumel (October 2008). "[Incremental role of male circumcision on a generalised HIV epidemic through its protective effect against other sexually transmitted infections: from efficacy to effectiveness to population-level impact](#)". *Sexually Transmitted Infections* **84** (Supplement 2): ii28–34: "The protection of circumcision against STI contributes little to the overall effect of circumcision on HIV."

5. Is There a Correlation between the Prevalence of Circumcision and HIV?

Data for the prevalence of HIV by country has been taken from WHO/UNICEF and may be obtained from <http://apps.who.int/gho/data/node.main.562?lang=en>, and, <http://apps.who.int/gho/data/node.main.620?lang=en>, and, <http://apps.who.int/gho/data/node.main.623?lang=en>.

5.1 Africa

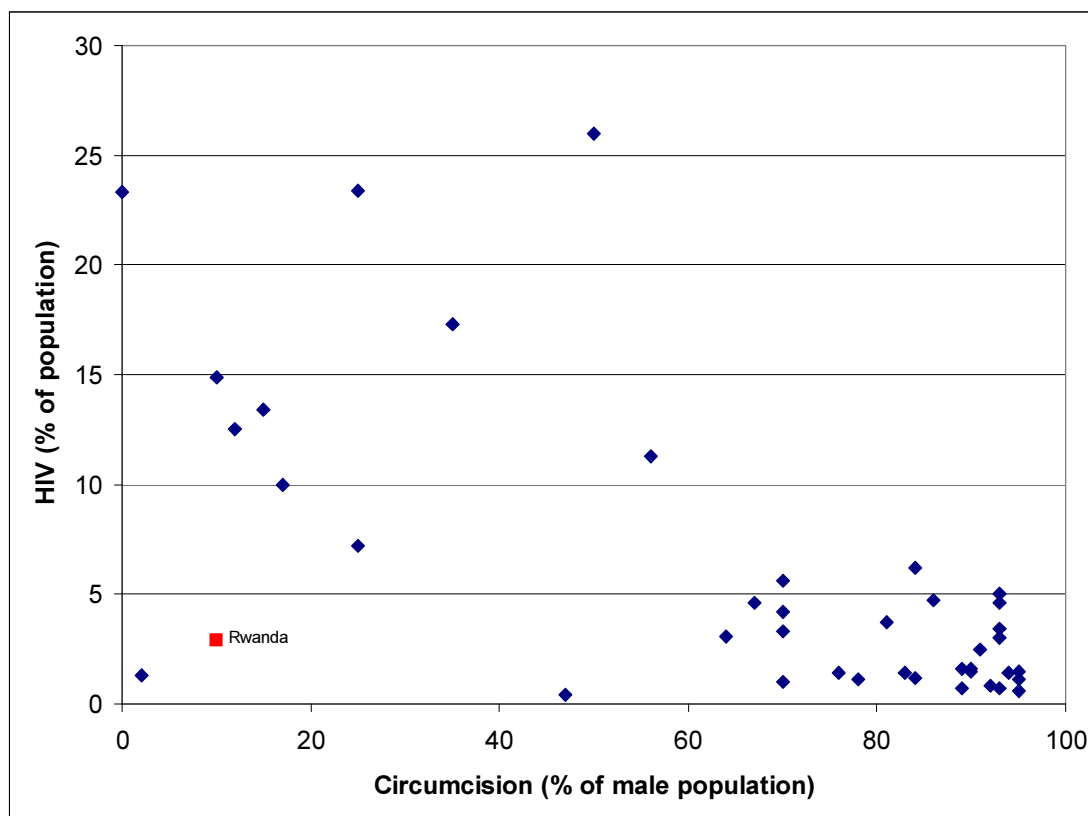
Data for the prevalence of male circumcision by African country has been taken from Williams, B G; *et al.* (2006). "The potential impact of male circumcision on HIV in sub-Saharan Africa". *PLoS Med* **3** (7): e262.

The data for African countries is tabulated in the Appendix, and shown in graphical form in Figure 1 below. The correlation coefficient between the prevalence data (expressed as a percentage of the population) for circumcision and HIV is -0.63. This does indicate a *potential* significant benefit of circumcision, though the distinction between correlation and causality must be born in mind. In other words, it may not necessarily be the circumcision which produces the health benefit but could be some other factor which is correlated with both. For example, circumcision is strongly correlated with Islam, and Muslims do not drink alcohol - and alcohol consumption is known to be correlated with HIV. So it could be useless to circumcise men who remain consumers of alcohol when the benefit would be to reduce alcohol consumption whilst leaving their foreskins alone. I am not suggesting that this is necessarily the case, only warning of the perils of assuming a correlation implies causality. (There is a strong correlation between top cyclists and the wearing of Lycra pants, but if I adopt Lycra pants I will still be a crap cyclist). However the negative correlation between circumcision and HIV is certainly noteworthy.

This correlation arises mainly from the ten countries in Figure 1 which have HIV rates greater than 7%. If attention is confined to countries with more than 60% of men circumcised then the correlation with HIV is greatly diminished (to -0.32). The cluster of data above a circumcision rate of 60% in Figure 1 still retains a substantial rate of HIV. For example, Kenya, with 84% of men circumcised has a high HIV rate of 6.2%. Similarly, Gabon, with 93% of men circumcised, has an HIV rate of 5%. The average HIV rate for African countries with circumcision rates greater than 60% is 2.6%.

One has to question, therefore, whether the government of Rwanda has been well advised. Rwanda currently has only 10% of men circumcised, but its HIV rate is quite low for an African country, 2.9% - barely different from the average HIV rate for African countries with approaching 100% circumcision rates. It is clear from Figure 1 that, even assuming that the circumcision-HIV correlation is causal, Rwanda is an example of a country which is unlikely to benefit. Unfortunately the Rwandan government appears to have been swayed by the WHO recommendation. Someone should have showed them Figure 1.

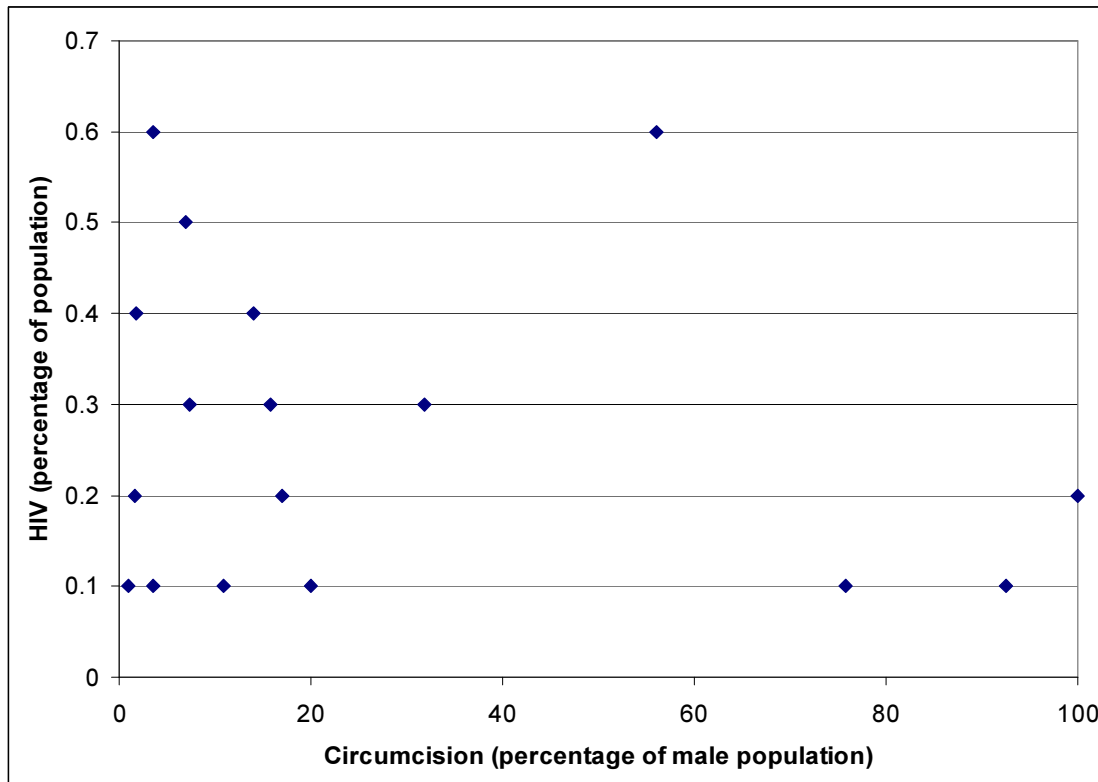
Figure 1: HIV versus Circumcision in Africa



5.2 Other Countries

Figure 2 plots HIV prevalence versus the prevalence of circumcision in a selection of countries other than African countries. The selection was random and determined by the countries for which I readily obtained both HIV and circumcision data. The countries in question are listed in Appendix A. The most striking difference with the African data is an order of magnitude difference in HIV prevalence. For African countries 1% was a very low HIV prevalence. None of the 'other countries' plotted in Figure 2 exceeded 0.6% HIV prevalence. There is very little correlation (or inverse correlation) between HIV and the prevalence of circumcision in the data of Figure 2, and the correlation would be zero if two of the right-most points were omitted.

Figure 2: HIV versus Circumcision: Countries Other Than Africa



6. Circumcision versus Condoms

From the data in §5 it is feasible, though unproven, that wholesale circumcision *might* reduce HIV prevalence in *some* African countries where the HIV incidence is high (>7%), specifically Uganda, Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Zambia and Zimbabwe. Rwanda is not one of them.

However, as we have seen, there is plenty of evidence which conflicts with the claims that circumcision is beneficial. Nevertheless, let us assume that it *is* beneficial, and the claimed factor of ~0.5 on HIV transmission probability is correct. This compares with the benefit of using a condom of around a factor of ten reduction in transmission probability. There is therefore a real risk that wholesale circumcision will lead to *increased* HIV prevalence even if circumcision is theoretically beneficial for the country in question.

This would occur if men regard themselves as protected by having been circumcised and hence become less likely to use a condom. The swapping of an effective protection (a condom) for a less effective protection (circumcision) would then lead to increased HIV prevalence. Note that there is a distinction between a population which is deliberately circumcised as an HIV preventative and a population which happens to be largely circumcised already for other reasons (e.g., religious). Consequently the empirical data presented in §5 (Figure 1) which shows a negative correlation between existing levels of circumcision and HIV prevalence, does not guarantee that the adoption of preventative circumcision will have the same beneficial effect - even in countries with currently very high levels of HIV incidence.

Since I wrote the above paragraph I have discovered, from the comments circumcised men have made in surveys (§12), that circumcised men are often so desensitised that

the wearing of a condom allows them to feel nothing at all. Such men will not wear a condom. So the threat that mass circumcision might increase HIV prevalence by reducing the use of condoms is very real.

7. Would Female Circumcision be Beneficial against HIV?

If male circumcision is effective in reducing the rate of HIV transmission (predominantly from women to men) then it is likely that female circumcision (removal of the prepuce) would also be effective in reducing the rate of HIV transmission from men to women? Since women have a higher prevalence of HIV in sub-Saharan Africa, this would seem to deserve consideration, the benefits being potentially even greater than male circumcision.

The reason why the effectiveness of male circumcision (if indeed it is) would likely imply that female circumcision would also be effective has been described by Dowsett and Couch, *Reproductive Health Matters* 2007;15(29):33–44: "*there is some evidence of a possible anatomical explanation for the epidemiologically observed protective effect of male circumcision, concerning the susceptibility to HIV in Langerhans cells in the inner foreskin, and a protective keratinisation that occurs after circumcision. Yet, Langerhans cells occur in the clitoris, the labia and in other parts of both male and female genitals, and no one is talking of removing these in the name of HIV prevention*".

You see, female circumcision is usually called genital mutilation, and female genital mutilation is absolutely unacceptable. Period. It's not even up for discussion. I agree, it should not be. But the hypocrisy is clear. Female circumcision will not even be contemplated whatever the health benefits might be, whilst universal male genital mutilation is regarded as perfectly fine. Why?

In the same month that Rwanda announced its intention to genitally mutilate the entire adult male population, *The Guardian* ran an article "UK Must Act to Halt Mutilation of Girls" (4/11/13) and the *New Scientist* had a similar article "Call to end mutilation", (9/11/13) concerned only with females. I wrote the following letter to both these august organs and was unsurprised that it was not published,

Personally I think that any decent person must be opposed to female genital mutilation. But I wonder how many of your readers would be content if the mutilation in question were restricted to Type 1a circumcision, that is removal of the clitoral hood (or prepuce) only? Not many, I suspect. And yet this is the exact counterpart of what is tolerated for nearly a billion men worldwide. Why?

The question "why?" is not rhetorical. It demands an answer. As far as I can see the answer is universal anti-male sexism. Women must be protected from something as nasty, as oppressive, as enforced genital mutilation. Men need not be. In fact, circumcision was from the start a deliberate act of oppression.

8. Are There Other Health Benefits of Circumcision?

One of the unspoken reasons why mothers might opt to have their baby sons circumcised is that their husband is circumcised, and as a consequence they have a squeamish opinion that the uncircumcised penis is not right - and even unhygienic, "gross" or "unsanitary". This is probably a specifically female view and is trashed by the following quotes from two contributors to a debate in a medical journal.

Without wanting to sound too preachy, let me reiterate - there are no credible and scientifically proven benefits to male circumcision. The cleanliness argument is

frankly laughable and insulting to men. The female inner labia is comprised of similar fleshy folds yet you would be ridiculed if you suggested excising this from women to improve their hygiene. If I removed all your teeth and therefore the possibility of decay, your breath would smell much fresher. If I sewed up your butt cheeks and gave you a colostomy bag, your butt would be a significantly nicer place. See what I'm getting at? Circumcision for hygiene reasons is laughable. In addition, any supposed "benefits" in terms of cervical cancer rates in females with circumcised partners are highly contentious. Anyway, can you imagine the routine circumcision of females for male health reasons being acceptable? What I'm getting at is that circumcision is not necessary at all.

And the second,

I would recommend NOT circumcising your son. The benefits do not outweigh the risks. One analysis found that for every 9 boys who might be spared a UTI by circumcision, another 12 boys at the least (the upper estimate was 40 boys) will experience severe complications from the circumcision. UTIs can be treated by antibiotics quite effectively. Botched circumcisions are much more difficult to fix. It's also worth noting that 99% of intact boys will never get an infection, compared to 99.9% of cut boys. That means you would have to cut 100 boys to save just one of them from infection. That's 99 boys cut for no reason at all.

You should know that infant boys are easier to care for when they are intact. The foreskin does not retract until late childhood or even puberty, so you do nothing special, just wipe the outside of his penis clean and leave it alone. Furthermore, to prevent painful and bleeding erections later in life on circumcised men, doctors are now commonly leaving more skin behind. In a cut boy this means you may have to push the left over skin back at every diaper change and clean beneath it to prevent it from adhering or infecting. The very thing that mother's think they avoid by circumcising! In short, the risk of infection in a infant can be increased by circumcision. Here is an excellent tutorial on the basics of intact care and circumcision.... <http://www.lactivistintactivist.com/?pag...>

Another factor in your decision is that circumcised boys experience a 12% increase in their risk of MRSA infection. MRSA is commonly picked up in hospitals (where circumcision is generally performed in non-sterile conditions) and has been known to kill adults. I wouldn't want to deal with it in an infant. 12% is a BIG risk, the risk of a boy "needing" a circumcision later in life is well below that - under 1%. <http://www.nocirc.org/publish/12-Answers...>

You should also know that studies have shown that the most sensitive parts of the male anatomy are on the foreskin - not the head of the penis. By cutting off the foreskin, you remove a man's most erogenous genital tissue. Here is a study about that.... (note that other studies found no difference, but they neglected to test the sensitivity of the foreskin - they only tested the glans of intact and cut men and didn't pay any attention to the foreskin at all) <http://www.nocirc.org/touch-test/touchte...>

Next, it is VERY painful to an infant. Most doctors still don't use any anesthesia, those that do rarely offer adequate anesthesia because the only stuff that works is not safe enough to use in infants for such a "minor" procedure. Some doctors argue that it has been done "for thousands of years" without anesthetic- what they neglect to tell you is that a medical circumcision can take over 15 minutes to complete. Here is some info on the pain.....

<http://www.cirp.org/library/pain/>

<http://www.circumcision.org/response.htm>

<http://www.cirp.org/library/pain/taddio2...> (note in this one that even infants offered pain meds for the procedure showed signs of post traumatic stress!).

The so called "benefits" of circumcision are generally trumped up. A big one now is that it "prevents" AIDS. All the studies showing "benefits" like this have been poorly designed and inconclusive. Also, for every study that finds a "benefit" there are more studies that find no benefit. <http://www.icgi.org/> (see also §5).

8.1 Worldwide Medical Bodies' Views

A summary of the position of worldwide medical authorities on male circumcision can be found at <http://www.cirp.org/library/statements/>. Some of the quotes from this site are as follows,

- The Royal Australasian College of Physicians (2010): *"After reviewing the currently available evidence, the RACP believes that the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision, do not warrant routine infant circumcision in Australia and New Zealand."*
- The RACP, Australian Association of Paediatric Surgeons, New Zealand Society of Paediatric Surgeons, Urological Society of Australasia, Royal Australasian College of Surgeons, and Paediatric Society of New Zealand have corroborated the Canadian Paediatric Society (2004), declaring that circumcision of newborn males should not be routinely performed. The statement firmly declares: *"There are no medical indications for routine male circumcision."*
- Canadian Paediatric Society (1996): *"The overall evidence of the benefits and harms of circumcision is so evenly balanced that it does not support recommending circumcision as a routine procedure for newborns."* Here the word "routine" means "in the absence of a medical reason". Note that the cost-benefit analysis in this Canadian report ignored diminished sexual function, probably the most serious effect of circumcision (see §12).
- The Central Union for Child Welfare, Finland (2003): *"Circumcision of boys that violates the personal integrity of the boys is not acceptable unless it is done for medical reasons to treat an illness. The basis for the measures of a society must be an unconditional respect for the bodily integrity of an under-aged person. Circumcision intervenes in the sexual integrity of a male child causing a permanent change in organs and has consequences pertaining to both health and quality of life. The circumcision of girls is rightly considered as inhuman mutilation of the genitals and is punished abuse. Also boys must be guaranteed a similar protection by law. According to the opinion of the Central Union for Child Welfare in Finland nobody has the right, on behalf of the child, to consent to operation, violating the bodily integrity of the child, if it is not done to treat an illness."*
- The Royal Dutch Medical Society (2010): *"There is no convincing evidence that circumcision is useful or necessary in terms of prevention or hygiene. Partly in the light of the complications which can arise during or after circumcision, circumcision is not justifiable except on medical/therapeutic grounds. Non-therapeutic circumcision of male minors is contrary to the rule that minors may*

only be exposed to medical treatments if illness or abnormalities are present, or if it can be convincingly demonstrated that the medical intervention is in the interest of the child, as in the case of vaccinations. Non-therapeutic circumcision of male minors conflicts with the child's right to autonomy and physical integrity. There are good reasons for a legal prohibition of non-therapeutic circumcision of male minors, as exists for female genital mutilation."

- British Medical Association (2006): *"In the past, circumcision of boys has been considered to be either medically or socially beneficial or, at least, neutral. The general perception has been that no significant harm was caused to the child and therefore with appropriate consent it could be carried out. The medical benefits previously claimed, however, have not been convincingly proven, and it is now widely accepted, including by the BMA, that this surgical procedure has medical and psychological risks. It is essential that doctors perform male circumcision only where this is demonstrably in the best interests of the child."*
- The British Association of Paediatric Surgeons advises that *"there is rarely a clinical indication for circumcision."*
- American Academy of Family Physicians (2002) emphasizes the lack of therapeutic benefit and likens neonatal circumcision to a "cosmetic" procedure and expresses ethical concerns about non-therapeutic neonatal circumcision.
- The American Medical Association (1999) has called for the re-training of American physicians and improved information to parents in hopes of reducing the unacceptably high rate of non-therapeutic neonatal circumcision.
- [United Nations Convention on the Rights of the Child \(1989\)](#) states that children have a right to grow up free of traditional practices that are prejudicial to health
- Doctors Opposing Circumcision web site, <http://www.doctorsopposingcircumcision.org/DOC/statement0.html> contains a great deal of information. Amongst other things are these quotes: (1) *The claims of "potential benefits", allegedly provided by medically unnecessary, non-therapeutic circumcision, lack any real support from medical science. United States medical literature, as compared with the medical literature of other nations, is highly biased in favor of male circumcision. The word "potential" means to exist in possibility but not in actuality. The scientific literature that supports such "potential" benefits is written mostly by doctors who were reared in circumcising cultures.* (2) *American medical societies, thus far, have been unable or unwilling to acknowledge the human rights and medical ethics issues inherent in the non-therapeutic circumcision of children. Similarly, they have not recognized the long-term adverse effects reported in this chapter.* (3) *Removal of the nerves of the foreskin by circumcision produces a deficit in sensory input into the central, parasympathetic, and sympathetic nervous systems. One, therefore, would expect to find alteration in sexual response. Several recent studies have found this to be the case. Denniston (2004) surveyed men who had experienced sexual intercourse before and after circumcision. 58% of the men felt that the pleasure of intercourse was lessened and they would not have circumcision again.*
- The American Academy of Pediatrics (AAP) (1989) issued a statement reaffirming their previous position that there is no medical indication for neonatal circumcision. However in 2012...

8.2 The American Academy of Pediatrics Policy Statement 2012

The American Academy of Pediatrics (AAP) issued a revised Policy Statement in 2012 which immediately drew widespread condemnation. The Policy Statement was this:

"Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV".

In the background material supporting this Policy, obtainable from <http://pediatrics.aappublications.org/content/130/3/e756.full.html> you will find this odd statement: *"Parents should weigh the health benefits and risks in light of their own religious, cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families"*. What on earth does this mean? It seems to mean that if you have any religious, cultural or personal preferences not to circumcise, then you should follow your preference because, actually, the medical benefits are too small to rationally persuade you otherwise. I cannot read it any other way. So it flatly contradicts the above Policy Statement.

This 2012 AAP review crucially also claims that,

"The literature review does not support the belief that male circumcision adversely affects penile sexual function or sensitivity, or sexual satisfaction."

This claim is so wildly at variance with the survey of circumcised men's own views which I report in §12 that, to my mind, it just undermines the credibility of this AAP review. The barrage of criticism of the 2012 AAP Policy Statement and its supporting review include the following,

- Staff. (2012) [Commentary on American Academy of Pediatrics 2012 Circumcision Policy Statement](#). Doctors Opposing Circumcision. Seattle.
- Young H. (2012) [Comment](#). The Intactivism Pages. New Zealand.
- Svoboda JS. Van Howe RS. [Out of step: fatal flaws in the latest AAP policy report on neonatal circumcision](#). *J Med Ethics* 2013;00:1–8. doi:10.1136/medethics-2013-101346. Published on line ahead of print
- Frisch M, Aigrain Y, Barauskas V, et al. [Cultural bias in the AAP's 2012 technical report and policy statement on male circumcision](#). *Pediatrics* 2013;131(4):1-5. doi:10.1542/peds.2012-2896 Published on line ahead of print

Quotes from these papers are as follows,

"The policy statement 'is full of equivocations, hedging, and uncertainty; and the longer report upon which it is based is replete with non-sequiturs, self-contradiction, and blatant cherry-picking of essential evidence.' And as argued in a forthcoming international statement criticising the AAP's new policy, both documents exhibit cultural bias in favour of circumcision, and seem to put the AAP firmly out of step with world medical opinion on this issue."

"Over 100 boys die each year from this needless procedure, even when performed under optimal conditions in a medical setting, yet the AAP fails to attach much significance to the deaths stemming from the practice. Rather than objectively evaluating all available evidence, the AAP selectively quotes and references highly

contested and controversial studies to attempt to justify an entrenched, yet outmoded, cultural—not medical—practice."

"The policy statement and technical report suffer from several troubling deficiencies, ultimately undermining their credibility. These deficiencies include the exclusion of important topics and discussions, an incomplete and apparently partisan excursion through the medical literature, improper analysis of the available information, poorly documented and often inaccurate presentation of relevant findings, and conclusions that are not supported by the evidence given."

"Only one of the arguments put forward by the American Academy of Pediatrics has some theoretical relevance in relation to infant male circumcision; namely, the possible protection against urinary tract infections in infant boys, which can easily be treated with antibiotics without tissue loss. The other claimed health benefits, including protection against HIV/AIDS, genital herpes, genital warts, and penile cancer, are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves".

"There is growing consensus among physicians, including those in the United States, that physicians should discourage parents from circumcising their healthy infant boys because non-therapeutic circumcision of underage boys in Western societies has no compelling health benefits, causes post-operative pain, can have serious long-term consequences, constitutes a violation of the United Nations' Declaration of the Rights of the Child, and conflicts with the Hippocratic oath: primum non nocere: First, do no harm."

We are left wondering why the AAP produced this Policy Statement, going against not only the clear worldwide consensus but reversing their own former position. It has been suggested that the motive might be financial gain, since funding and fees will no doubt follow from widespread circumcising.

9. Why is Circumcision Done?

9.1 Religious or Sexual Reasons?

I will take it as read that the semitic/Abrahamic religions, i.e., Judaism and Islam, carry an obligation for male circumcision. For Jews this is traditionally carried out on the eighth day after birth. For Muslims it is usually carried out on a boy between the ages of 8 and 15, i.e., prior to, or around, puberty. If you wish to read how the practice arose in the Jewish religion I recommend Leonard B. Glick's book "Marked in Your Flesh: Circumcision from Ancient Judea to Modern America".

Here, though, I am more interested in the non-religious, non-therapeutic reasons for circumcision. These are the majority in English speaking countries. This is most extreme in the USA in which ~56% of men are circumcised (and it used to be >70%) compared to about 2.7% of the population being Jewish or Muslim. In the UK about 15.8% of adult males are circumcised (roughly 5 million men or boys) compared with about 5% who are Jewish or Muslim. So, in the UK too, circumcision is predominantly not related to religion. (The practice is, thankfully, declining in the UK. The current annual rate of circumcisions is now in percentage single figures, compared with more than 30% of UK men over age 60 who are circumcised). The same picture emerges in Canada, with 32% of men circumcised compared with 3.8% being Jewish or Muslim. In Australia, infant circumcision rates are running at around 15-19%, compared with 2.4% of the population being Jewish or Muslim.

In cultures, or individual circumstances, where masturbation is unacceptable, circumcision can be and is used to inhibit self-arousal, though it is unlikely to prevent masturbation entirely. Some of our ancestors, the Victorians especially, went to great lengths to prevent masturbation. Fear of Divine Retribution coupled with a belief that lassitude, feeble-mindedness and insanity were an inevitable consequence of Onanism led to extreme measures to prevent self-stimulation of the genitalia by either sex. It is a fact that masturbation is more difficult if the penis is circumcised (though it is not prevented, contrary to the Victorians belief). Why did the belief develop that circumcision prevents masturbation?

A possible answer to this question goes like this. At birth, the glans and the inner foreskin are adhered to each other. An uncircumcised boy must, at some stage of his sexual development, undergo separation of the two. Liable to occur at any age before puberty, this natural process takes weeks and is often accompanied by a pronounced itchy sensation below the surface of the penis. Understandably a boy experiencing this discomfort will seek to relieve the irritation by touching (usually by squeezing) his glans even if that means feeling himself through his clothing in the presence of others. Such behaviour, which may be repeated every two or three minutes, gives the impression of sexually-motivated public masturbation. But this usually occurs at an age before the boy has taken to masturbating, or even knows what masturbating is.

I recall exactly this happening to me when I was about 10 or 11. My sisters, four to seven years older than me, were constantly complaining, "Mum, **** is touching himself again". This caused me acute embarrassment. And, of course, I had no clue as to the cause of the itching because no one had warned me. Can you imagine if no one warned a girl about menstruation, nor explained to her when it happened that it was normal? But instead she was made to feel guilty about it, that it was unclean and something that nice girls did not do? In respect of the separation of the glans and foreskin, I was made to feel that I was dirty, indulging in some disgusting practice - and at an age when I had no understanding of such things. I was made to feel at fault for a natural process of sexual maturation. I expect this is the universal male experience. It's another fine example of equality. Anyway, I digress...

If, upon such behaviour being observed, the boy is immediately circumcised then the itchiness will cease because the act of circumcision completes the separation between foreskin and glans. Likewise, a boy circumcised at birth will never experience the irritation in the first place. To our forebears, such pseudo-masturbation would have been enough to ring alarm bells about moral, medical and religious issues. The discovery that circumcision cured this pseudo-masturbation would, it is suggested, be adequate to lead to a belief that all masturbation was thereby reduced. They may well have had a point. In the absence of intervention the boy's experience of self-manipulation might lead to discovery of pleasant sensations, with "Onanism" setting in after the itchy phase had passed. This irritation-triggered learning process might, at least in part, explain why uncircumcised boys masturbate earlier than their circumcised counterparts. That they masturbate more frequently is simply explained by the greater mechanical difficulty of masturbation with no foreskin - often requiring (or, at least, making desirable) some lubrication.

What the Victorian's never even dreamt, and became known only quite recently, is that masturbation is medically beneficial. Done in moderation and with a proper degree of privacy, it should be encouraged because of the health implications. Far from being harmful, modern medical science suggests that sexual climaxes achieved

through masturbation are beneficial in two entirely separate ways, one physical and one psychological.

Firstly, let's consider the potential effect on the health of the prostate gland. The prostate sits at the junction of the plumbing associated with urination and reproduction. Epidemiological studies (Giles et al., 2003) show a (negative) correlation between frequency of ejaculation in the early years after puberty and the incidence of prostate cancer in later life. The precise causal mechanism is unclear, but is thought to relate to the accumulation of carcinogens in the prostate if they are not 'flushed out' regularly by ejaculation. The risk period for this accumulation may well commence years before sexual intercourse takes place, implying that regular masturbation to climax should be encouraged in those too young to be otherwise sexually active.

Secondly, there is a psychological issue. Observational studies suggest that masturbation increases self-esteem, especially in instances of depression. Again the precise mechanism is unclear, but may relate to our primeval past. Before early humans adopted a social norm based on monogamous relationships, the dominant "Alpha Male" had sole breeding rights in the tribe. Such behaviour persists and can easily be observed in several of the Great Apes. The consequence is that only the Alpha Male ejaculates frequently because only he has sexual intercourse with the females of the tribe. Thus there is a link between status and frequency of ejaculation. Status and self-esteem themselves being linked, it appears reasonable to postulate the existence of a subliminal or hormonal connection between self-esteem and frequency of ejaculation.

So we have three potential reasons for circumcision: religious, medical or to deter masturbation. But there is a fourth - or rather a generalisation of the third: the deliberate imposition of reduced sexual function in males (for which see §1 and §9.2, below).

9.2 Why is Circumcision so Common in the USA?

Some light is shed on the odd predilection for circumcision in the USA by the article "Circumcision Decision: Prominence of Social Concerns" by Mark Brown and Cheryl Brown, <http://pediatrics.aappublications.org/content/80/2/215.abstract>, Pediatrics 80, 2, 215 -219, August 1987. Contrary to what you might have thought, the motivation is not generally a perceived health benefit. The abstract of the paper reads: "*Despite policy statements against routine circumcision of newborns by the American Academy of Pediatrics and the American College of Obstetrics and Gynecology more than 10 years ago*, there has been virtually no change in circumcision practices in the United States[@]. In addition, controlled trials of programs to educate parents about the lack of medical indications for routine newborn circumcision have shown that parental education has little impact on the circumcision decision. We hypothesized that parents based their circumcision decision predominantly on social concerns rather than on medical ones. We prospectively surveyed parents of 124 newborns soon after they made the circumcision decision to learn their reasons for the decision. The strongest factor associated with the circumcision decision was whether or not the father was circumcised. The survey also showed that concerns about the attitudes of peers and their sons' self concept in the future were prominent among parents deciding to circumcise. The circumcision decision in the United States is emerging as a cultural ritual rather than the result of medical misunderstanding among parents. In counselling parents making the circumcision decision, the health care provider*

should provide a knowledgeable and honest discussion of the medical aspects of circumcision. Until information is available that addresses parents' social concerns about circumcision, it is unreasonable to expect a significant change in circumcision customs in the United States".

* which would be 1977; @actually there has now, it is reducing somewhat, though still at a high level

Other studies of the reasons behind non-religious, non-therapeutic circumcision also identify "being like the father" as the key motivation. In other words, once the practice has become widespread it will tend to persist from generation to generation even though the original motivation might no longer apply. In other words, it is a social ritual. But what was the original motivation for non-religious, non-therapeutic circumcision, especially in English speaking countries? The answer appears to lie in the Victorians' neurotic obsession with masturbation and their belief that masturbation would be prevented by circumcision. This was further enhanced between the late 19th century and the mid 20th century by madly unscientific claims that circumcision can prevent just about any medical malady you care to mention. In particular, 19th century physicians were struggling to get venereal diseases, gonorrhoea and syphilis, under control. There being no effective treatment prior to the discovery of antibiotics, suppressing the sexual urge was perhaps the only course available. So, circumcision became popular through pseudo-science and Victorian repression, and, once established, tended to persist as a society norm.

Further details of this, most odd, cultural adoption of a previously 'foreign' (i.e., Jewish) practice, so long regarded in the Christian world as repugnant, can be found in Leonard B. Glick's excellent book, "Marked in Your Flesh: Circumcision from Ancient Judea to Modern America". Some extracts from this book are,

"By the final decades of the (19th) century in Britain, disease prevention and sexual discipline were so thoroughly conflated that many physicians viewed circumcision as a double barrelled weapon in the battle for public health and public morality. Prophylaxis for rampant sexuality and its frightful medical consequences was an urgent responsibility. The solution was to cut penises down to size."

"By 1910 more than one-third of all male infants in the USA were being circumcised, and the rate was steadily rising. Claims for miraculous cures were no longer popular; now it was prevention, first of one disease then another, that held centre stage. When one claim proved insupportable, there was always another to take its place."*

* so much harder to disprove, do note

"With hospitalization (of labour) came medicalization of newborn infant management. rather than resting at its mother's breast after birth, the infant now lay alone in a bassinet, located in a separate nursery, where it might cry or not as it pleased. And before long infant circumcision took its place as another hospital procedure, a routine operation performed very soon, sometimes immediately, after birth, often by the very obstetrician who had just completed the delivery. Parents, including women in labour, were asked to sign circumcision consent forms at the hospital (if they were consulted at all), and most did so on the not unreasonable assumption that anything that was medically recommended must be medically advisable. One parental signature sufficed."

The ever-shifting, but always spurious, claims of medical benefit of circumcision is illustrated by this paragraph,

"The decades between 1880 and 1910 had seen circumcision often touted as a cure for illnesses that seemed especially tenacious and resistant to treatment: epilepsy, paralysis, and so on. But by 1920 few physicians still subscribed to the reflex neurosis theory or to extravagant claims for cure of orthopaedic and neurological ailments. Faith in circumcision as protection against sexually transmitted diseases persisted to a degree, although eventually, with the advent of antibiotics in the 1940s, syphilis and gonorrhoea became less frightening and moved off centre stage. But the title holding disease of the twentieth century, unchallenged as the most fearsome, was cancer. so it is hardly surprising that the century's most resolute circumcision advocates discovered evidence that the procedure conferred benefits more wonderful than ever. It was, they believed, the weapon against cancer that everyone longed for: a readily available preventive procedure."

Glick's book contains a thorough debunking of the vociferous claims made, especially in the USA in the period 1910-1950, that circumcision was an effective preventative of cancers of the penis, prostate and, in woman having sexual relations with circumcised men, of the cervix. The latter is a sensible tactic if your objective is to bring the public around to universal circumcision: claiming protection of women will gain you far greater public interest and support than merely protecting men. To this day most people continue to believe that a woman has a lower risk of cervical cancer if her partner is circumcised. It is not true, but belief in this (and so many other) spurious claims was all part of the culture of acceptance of a procedure which was always, in truth, a shameful violation.

9.3 It Isn't Phimosis, Dammit!

Phimosis is a medical condition in which the foreskin is too tight to retract fully. However, to recap, in infants the foreskin is naturally adhered to the glans. No attempt should be made to retract the foreskin of an infant. In young boys, even once the foreskin and glans are no longer adhered, the foreskin will initially often be too tight to fully retract over an engorged, erect penis. Erections commonly occur before the foreskin has become slack enough to fully retract. I recall my own being so as a young boy. This natural condition is widely misdiagnosed by doctors as phimosis. It is not. The overwhelming majority of cases of a foreskin not fully retracting in a pre-pubescent boy will not be phimosis. Full retraction will occur naturally in due course.

The average age at which full retraction occurs is between 10 and 11 years. According to Huntley et al ["Troubles with the foreskin: one hundred consecutive referrals to paediatric surgeons"](#), *J R Soc Med* **96** (9): 449–451 (2003), non-retractibility may be considered normal for males up to and including adolescence.

It is another instance of the disadvantage of males in the health issues that this simple medical fact is almost unknown, even to most doctors. Can you imagine if the presence of the hymen in girls was regarded as a medical condition which required surgical removal? Women, and medical science, know how the hymen matures naturally with age and can explain this if necessary to a young girl. But no one explains the natural maturation of the penis to boys, partly because so few people seem to know what is normal and what is a reason for circumcision!

The ignorance of parents about this issue is illustrated by my own experience. I recall as a young boy (perhaps nine or ten years old?) hearing my parents talking outside the bathroom as I took a bath. My mother was exhorting my father to check that my foreskin retracted properly ("it's your department not mine!"). Reading between the

lines I suppose my mother had heard something, perhaps on Woman's Hour, that the foreskin was supposed to retract and there could be problems if it did not. My father probably knew no better. He duly did his duty by checking me out. I took pity on his embarrassment by showing him quickly that I could retract, no problem. It is rather fortunate that I was fairly early in being able to do so, otherwise my parents would no doubt have concluded I had a problem - and the prevailing medical establishment may have had me circumcised. A narrow escape on my part.

Really it is shocking that males suffer from such ignorance in society as a whole. The contrast with the concern and understanding offered to females is stark.

Actually, even genuine phimosis does not necessarily need to be treated with circumcision. There are other effective treatments which do not involve tissue loss which should always be tried first.

10. Medical complications from circumcision?

Dowsett and Couch, *Reproductive Health Matters* 2007;15(29):33–44, give the data in the Table below. Make of it what you will. Clearly there can be immediate adverse effects from circumcision operations (infection, for example). However, these statistics do not address the even more important issue: a range of problems which occur later in life, including the degraded sexual experience of men who have been circumcised. This is discussed in §12.

Table 1. Review of articles on male circumcision indexed in Medline, compared with appendectomy and hysterectomy, 1996–2006

	Appendectomy		Hysterectomy		Male circumcision	
No. of articles	2,020		5,719		1,095	
No. that address:	No.	%	No.	%	No.	%
Adverse effects	282	14	818	14	306	28
Ethics			3	.05	42	3.8
Ethnology					43	3.8
History	18	0.89	26	.45	38	3.5
Legislation and jurisprudence	2	.099	6	.10	17	1.6

11. The Ethics of Enforced Circumcision

The British Medical Association (BMA) has issued "The law and ethics of male circumcision, Guidance for doctors", June 2006. Here are some extracts,

- Male circumcision that is performed for any reason other than physical clinical need is termed non-therapeutic (or sometimes “ritual”) circumcision.
- There is a spectrum of views within the BMA’s membership about whether non-therapeutic male circumcision is a beneficial, neutral or harmful procedure or whether it is superfluous, and whether it should ever be done on a child who is not capable of deciding for himself. The medical harms or benefits have not been unequivocally proven but there are clear risks of harm if the procedure is done inexpertly. The Association has no policy on these issues. Indeed, it would be

difficult to formulate a policy in the absence of unambiguously clear and consistent medical data on the implications of the intervention.

- In the past, circumcision of boys has been considered to be either medically or socially beneficial or, at least, neutral. The general perception has been that no significant harm was caused to the child and therefore with appropriate consent it could be carried out. The medical benefits previously claimed, however, have not been convincingly proven, and it is now widely accepted, including by the BMA, that this surgical procedure has medical and psychological risks. It is essential that doctors perform male circumcision only where this is demonstrably in the best interests of the child. The responsibility to demonstrate that non-therapeutic circumcision is in a particular child's best interests falls to his parents.
- Competent children may decide for themselves.
- There are, therefore, limits on parents' rights to choose and parents are not entitled to demand medical procedures contrary to their child's best interests.
- The British Association of Paediatric Surgeons advises that there is rarely a clinical indication for circumcision.
- Male circumcision is generally assumed to be lawful provided that: (i) it is performed competently; (ii) it is believed to be in the child's best interests; and, (iii) there is valid consent (see below). The Human Rights Act may affect the way non-therapeutic circumcision is viewed by the courts. There has been no reported legal case involving circumcision since the Act came into force.

This advice is rather woolly in that it is not clear what constitutes the child's "best interests". However it seems clear that the BMA's view is that there is no globally applicable medical reason for circumcision, i.e., only if the child is suffering from a particular medical condition might circumcision be in the child's best interests. However, it is not clear whether conformance with religious or societal norms would constitute a valid consideration of the child's "best interests". The final bullet point, however, raises doubt about the legality of circumcision without clearly defensible medical motivation. This point was taken up by the papers below.

M Fox, M Thomson, "A covenant with the status quo? Male circumcision and the new BMA guidance to doctors", *J Med Ethics* 2005;31:463-469: *This article offers a critique of the recently revised BMA guidance on routine neonatal male circumcision and seeks to challenge the assumptions underpinning the guidance which construe this procedure as a matter of parental choice. Our aim is to problematise continued professional willingness to tolerate the non-therapeutic, non-consensual excision of healthy tissue, arguing that in this context both professional guidance and law are uncharacteristically tolerant of risks inflicted on young children, given the absence of clear medical benefits. By interrogating historical medical explanations for this practice, which continue to surface in contemporary justifications of non-consensual male circumcision, we demonstrate how circumcision has long existed as a procedure in need of a justification. We conclude that it is ethically inappropriate to subject children—male or female—to the acknowledged risks of circumcision and contend that there is no compelling legal authority for the common view that male circumcision is lawful.*

J Steven Svoboda, "Circumcision of male infants as a human rights violation", *J Med Ethics* 2013;39:469-474: *Every infant has a right to bodily integrity. Removing*

healthy tissue from an infant is only permissible if there is an immediate medical indication. In the case of infant male circumcision there is no evidence of an immediate need to perform the procedure. As a German court recently held, any benefit to circumcision can be obtained by delaying the procedure until the male is old enough to give his own fully informed consent. With the option of delaying circumcision providing all of the purported benefits, circumcising an infant is an unnecessary violation of his bodily integrity as well as an ethically invalid form of medical violence. Parental proxy 'consent' for newborn circumcision is invalid. Male circumcision also violates four core human rights documents—the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the International Covenant on Civil and Political Rights, and the Convention Against Torture. Social norm theory predicts that once the circumcision rate falls below a critical value, the social norms that currently distort our perception of the practice will dissolve and rates will quickly fall.

12. Circumcised Men's Views of their Condition

Whilst I believe many men have no difficulty with their circumcised state, it is very clear that many do. Simply by Googling I quickly found a vast number of adverse comments from circumcised men - far too many to record. But here are a few random examples. Many of the comments confirm the reduced sensitivity of the circumcised glans (though this will be discernable only by men who have been cut at a sufficiently late age). Some of the comments relate to embarrassment at the appearance of their penis due to the circumcision. Some comments refer to the greater difficulty in self-stimulating (masturbation) on a circumcised penis, particularly circumcision of the Jewish or surgical kind which leaves no foreskin at all. In such cases the application of a lubricant is either necessary or preferred, hence making masturbation more problematical. There are also widespread problems associated with the keratinisation (both scarring of the penis where the cut was made and drying of the glans resulting from being unprotected).

- I wish I was never done when I was a child (7). Have a look at the lengths some men take to get back their foreskin: <http://www.restoringmen.net>
- I was cut at the age of 15 for religious reasons. I have to say it was the worst thing that happened to me as it not only marked the end of any solo sessions but I was left too embarrassed to show it to my girlfriend at the time, and I still feel so embarrassed I am reluctant to get into a relationship with a girl! In addition to my misfortune exposure of the glans (head), and possibly a few severed nerves, had led to it becoming highly desensitized. And the problems get worse...I was cut by a (supposedly) qualified religious doctor who performed the operation regularly. However, in my case they cut too much skin leaving no excess skin in the erect state and somehow caused damage to the fibrous tissues of the shaft of the penis. As a result the damage has caused curving of the penis when erect (Peyronie's disorder...I think) and a rather unsightly scarring of the skin where the cuts were made (hence the embarrassment). Direct stimulation of the head may seem fun at first, but the sensitivity is short-lived!
- I was cut at four years of age and have no loose skin but masturbation has never been a problem other than perhaps too often at one stage. I find if you lubricate your dick and use your hand as normal taking it over the head of the shaft and back you will still enjoy yourself! Because I was cut at a young age I do resent

that fact and envy those with foreskins. I suspect that was because it was taken forcibly.

- I was circumcised at the age of 27 for foreskin problems. Although my shaft skin is now stretching forward again I cannot masturbate and get the same feelings that I did pre op. Initially I had to directly stimulate my head and use a lubricant. It's interesting that you say the condom problem causes you lack of sensation, as this is exactly what has happened to me through circumcision. My head is now much less sensitive. So it's not really the solo sessions that I am worried about, it is the sex sessions. Lots of guys are happy being cut, and lots are not.
- You will definitely feel less sensitive after circumcision. I was circumcised at three years old due to infection and now at 44 years old can't ejaculate through intercourse unless I ram away for hours on end due to the insensitivity. This may sound good to you and your lady now but after months of this she will be bored or worn out.
- I'm 27 and was circumcised in January. I am now tightly circumcised so no extra skin when I'm flaccid. Everything works fine, sex is amazing, there is just one problem... masturbation is just not the same... has anyone else had this problem? Yeah there is always lube but not good when you want a quick unplanned one!

Are men ever so dissatisfied with being circumcised that they try to restore a foreskin? The answer is Yes. There are no reliable data on the proportion of men that attempt this, but methods of partial restoration exist and devices to assist in doing so are marketed. It seems safe to say that at least tens of thousands of men have attempted restoration (see <http://www.cirp.org/pages/restore.html>). So there are clearly a substantial number of men who dislike being circumcised so much that they go to a great deal of trouble to attempt restoration. There is a web site specifically for men attempting restoration, <http://www.norm.org/>. In December 2013 this site had had nearly 830,000 hits, so this may indicate the level of interest, i.e., the level of men's discontent with their circumcised state.

A survey carried out by <http://www.circumcisionharm.org/> reported the following top physical problems with circumcision,

- Insensitive glans 67%
- Dry, keratinized glans, needs lubricants before sex 75%
- Excess stimulation needed to achieve orgasm 59%

Plus some specific comments from individuals contributing to the survey,

- Frequent ripping of what is left of my frenulum;
- Wooden stick feeling during sex;
- Scar is too tight to accommodate a full erection comfortably;
- Glans is sensitive but in a sandpaper sort of way, not pleasurable;
- Complete sexual dysfunction with no feeling whatever;
- No pleasure and feeling of envy towards intact boys;
- Cut into urethra causing fluid filled cysts;

- Penis bent on erection, will not straighten (this is a well known syndrome resulting from circumcision);
- Pain when erect;
- If I wear a condom I feel absolutely nothing;
- Pubic hair growing at scar (several individuals referred to hair abrasion causing discomfort to their female partner - I did not initially understand why, but this appears to be the reason. One person said, "I am celibate, my girlfriend's vagina would be damaged").

And much, much more - hundreds of such comments in this one survey alone. It makes distressing reading. It really does make one angry at the blithe assurances many people offer that circumcision is entirely benign. The situation of men in the USA is truly shocking. With condoms being *de rigour* in many cases, and with more than half of men circumcised, these guys feel nothing. Sex has been completely wiped out for them with a condom.

One of the things I'd not thought of is - as a circumcised boy, just when do you realise that you are not intact? The survey revealed that by age 13 only 25% of boys had discovered the fact. About a further 35% discovered between age 13 and 19. So 40% of men only find out remarkably late in life, at or after age 20. Another instance of lack of compassion for men in the medical arena.

The survey reported the following top feelings / psychological problems,

- Anger 71%
- Frustration 72%
- Betrayed by mother/father/doctor for lack of protection 55% / 50% / 58%
- Dissatisfied with my condition 77%
- Mutilated 61%
- Violated / raped 55%
- My human rights were violated 73%

A few men announced themselves content, but they were massively outweighed by the severely dissatisfied. The above survey results are the final, absolute, condemnation of non-elective male circumcision. Let no one tell you that it's OK because the men don't mind. I'll end with this final quote from a survey respondent,

"No freedom of speech, others will think I'm anti-Semitic. Sad to see newborn family members automatically circumcised, their parents think its hygienic. I can't discuss it with them because I don't want to accuse them of mutilation, but that IS how I feel about them. It seems evil and barbaric."

Appendix A: Tabulated Circumcision and HIV Data

AFRICA	Percentage of male population	
Country	Circumcision	HIV
Central African Republic	67	4.6
Chad	64	3.1
Republic of the Congo	70	3.3
Democratic Republic of the Congo	70	4.2
Gabon	93	5.0
Burundi	2	1.3
Djibouti	94	1.4
Eritrea	95	0.6
Ethiopia	76	1.4
Kenya	84	6.2
Rwanda	10	2.9
Somalia	93	0.7
Sudan	47	0.4
Tanzania	70	5.6
Uganda	25	7.2
Botswana	25	23.4
Lesotho	0	23.3
Malawi	17	10.0
Mozambique	56	11.3
Namibia	15	13.4
South Africa	35	17.3
Swaziland	50	26.0
Zambia	12	12.5
Zimbabwe	10	14.9
Benin	84	1.2
Burkina Faso	89	1.6
Cameroon	93	4.6
Equatorial Guinea	86	4.7
Gambia	90	1.5
Ghana	95	1.5
Guinea	83	1.4
Guinea-Bissau	91	2.5
Côte d'Ivoire (Ivory Coast)	93	3.0
Liberia	70	1.0
Mali	95	1.1
Mauritania	78	1.1
Niger	92	0.8
Nigeria	81	3.7

AFRICA	Percentage of male population	
Country	Circumcision	HIV
Senegal	89	0.7
Sierra Leone	90	1.6
Togo	93	3.4

OTHER THAN AFRICA	Percentage of male population	
Country	Circumcision	HIV
UK	15.8	0.3
USA	56	0.6
Colombia	6.9	0.5
Brazil	7.4	0.3
Canada	31.9	0.3
Cambodia	3.5	0.6
Japan	1	0.1
S.Korea	75.8	0.1
Philippines	92.5	0.1
Israel	100	0.2
Finland	3.5	0.1
Germany	10.9	0.1
France	14	0.4
Spain	1.8	0.4
Denmark	1.6	0.2
Australia	17	0.2
New Zealand	20	0.1

Appendix B: Letters to The Journal of Medical Ethics

B.1 Michael Glass, Teacher, "The double standard for male and female suffering" In response to M Fox, M Thomson, J Med Ethics 2005;31:463-469.

Fox and Thomson found it "striking" that male and female genital cutting are treated so very differently in law. One explanation for this is that men are expected to endure pain whereas women should be sheltered and protected. Such an assertion is easy to dismiss as academic theorising. However, the effect of this cultural blindness can be demonstrated in the reports of the Sydney Morning Herald to the forcible circumcision of men, women and children in Ambon, Indonesia, on 27 January 2001 <http://www.cirp.org/news/morningherald01-27-01/>. Dominating the Herald report was a courageous woman, Christine Sagat. She revealed the atrocities that she and others had suffered at the hands of the fanatics, and was even willing to be photographed.

"They told me to undress and sit on a chair which was covered with white cloth. "Open your legs," they said. I saw under the chair a coconut shell filled with water and a kitchen knife. I said, "Oh My god, what would happen to me?" I was so scared, upset too. But I did not dare to resist them. I didn't want to be killed. "At first the woman soaked her fingers in the water and then inserted them into my vagina as she looked for the clitoris. After she found it she pulled it out, took out the kitchen knife and cut it. That hurt very much. I shed tears. They left just like that without giving me any medication."

She was not the only one who suffered this brutal assault. Her niece, who was eight months pregnant, and her mother who is in her 70s were also circumcised. Christine's body healed, but the emotional scars remained: "I was lucky. I had some money and went to the store immediately to get antibiotics. My scar healed quite fast, but the sad, humiliated feeling stayed until today." She elaborated: "I feel like I'm no long 'complete' both as a person and a woman." However, she also acknowledged something else: "I know the men suffered more than us women. The circumcision hurt them more than it did to us because their scars could not heal fast. Several of the men I knew got serious infections after suffering from severe bleeding."

What happened to Kostantinus Idi was much less prominently reported, tucked in an article entitled, 'Terror attacks in the name of religion'. "I could not escape," he said. "One of them held up my foreskin between pieces of wood while another cut me with a razor ... the third man held my head back, ready to pour water down my throat if I screamed. "But I couldn't help but scream and he poured the water. I kept screaming aloud and vomited. I couldn't stand the pain." However, there was another indignity. Idi said one of the clerics urinated on his wound, saying it would stop infection.

"All of the men at the house were cut using the same razor," he said. "That night they circumcised about 60 men. I was bleeding all over and had nothing to cover my wound. I was told to take a bath but it kept bleeding until the next day. I could not imagine any greater pain. One of my friends got infected and was taken to hospital when we arrived in Ambon". Without doubt, men and women and children suffered terribly at the hands of their assailants. All suffered physical, emotional and sexual assault. All were exposed to infection. However, the men had the added danger of excessive bleeding, for the human foreskin has an exceptionally rich blood supply.

While no one should minimise the sufferings of women, the reporting of this atrocity consistently underplayed the suffering of the men. Both Christina Sagat and,

Kostantinus Idi showed enormous courage in telling their story to Herald reporters. Christina was exceptionally brave in agreeing to be photographed. However, Christina's story was told in an article of that name with a heading an inch high, Kostantinus's story was tucked into a secondary article on the same page entitled 'Terror attacks in the name of religion'.

The Herald's leading article began: "Islamic extremists are committing atrocities against women and children" An illustration of Christine Sagat praying before a statue of Jesus had the caption: "Fear and pain, Christina Sagat, one of hundreds of Christians forcibly circumcised by Muslim clerics." Almost the entire attention has been directed towards Christina, so forced circumcision was presented as an outrage against woman rather than an abuse of both sexes.

Letters published the following Tuesday (30 January) didn't even mention the men's suffering: '[W]hen "religious" action means forced female circumcision we need to ask whether this is religious freedom or criminal behaviour.' (Dave Burrows, Marrickville). 'The most vile and abhorrent act must be female circumcision in the name of religion, happening on our doorstep in Ambon.' (Alastair Browne, Cromer Heights). This last comment so impressed the editor, that it was used as a caption for all the letters about the situation in Ambon.

Christine Sagat stated that the men suffered even more than the women did. However, this point was not followed up. Why?

One reason could be that the acceptance of infant circumcision blinds us to atrocities such as the forced circumcision of the men in Ambon. Infants are frequently circumcised without anaesthesia when only a few days old. Like Kostantinus Idi, these tiny babies also scream and show other signs of distress. And, despite our best efforts, some suffer infections, too. If we allow this to happen to tiny babies, what moral ground have we to protest against the same thing happening to grown men?

In our society, there is an enormous indifference to men's health. Male death rates during the working years are double and even triple the comparable female death rates. Male suicide rates are much higher than comparable female suicide rates. Enormous efforts are made to prevent, treat and cure breast, uterine and ovarian cancer in women. By comparison, prostate cancer is a poor relation, and testicular cancer, though it mainly afflicts young men, is almost ignored in the media. There is far more attention to road fatalities (a general problem) than to workplace fatalities (a predominantly male problem), even though workplace incidents kill more people overall.

Thus, the reporting of forced circumcisions in Ambon, Indonesia, threw a harsh light on our cultural blindness, and of our disregard of male health and welfare. It is this cultural indifference to men's suffering that helps to account for the vast difference in our view of male and female genital cutting.

B.2 John W. Travis, President, Wellness Associates, "Circumcision not equally balanced between harms and benefits" In response to M Fox, M Thomson, J Med Ethics 2005;31:463-469.

Fox and Thomson's critique of infant male circumcision and the BMA's updated guidance to doctors rightly focuses on the "harm/benefit assessment which lies at the heart of the male circumcision debate." A common error made by circumcision proponents is that the benefits and harms are so equally balanced that it's a toss up. This is incorrect. To count a medical intervention as having benefit or therapeutic

value requires that the "benefit" greatly outweighs the risks and harms necessary to obtain it. Further, that the intervention is the only rational way to obtain these proffered benefits and that they are necessary to the overall health of the child. Infant circumcision does not fill any of these criteria. Neither does it take into consideration the obvious fact that the prepuce has a valid, beneficial, and evolutionary purpose and justifiably belongs to the owner, not his parents, his religion, his peer group, the medical establishment or anyone else. Under these circumstances, we are no more justified in amputating an infant's foreskin against his will than we are in cutting off an ear, nose or limb unless there is clear medical necessity and the amputation is the least invasive treatment available.

B.3 John D Dalton, Researcher and Archiver, NORM-UK, "Male circumcision should no longer masquerade as medical treatment", In response to M Fox, M Thomson, J Med Ethics 2005;31:463-469.

Fox and Thomson have injected a note of rationality into debate over male circumcision with their conclusion that there is no compelling legal authority for the view that the practice is lawful. They have presented a thorough critique of the BMA's 2003 guidance document*. It is however instructive to examine the statement from the BMA guidance that "Male circumcision in cases where there is a clear clinical need is not normally controversial" against the advice "to circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate".

* see §11 of this essay.

The evidence for the efficacy of conservative treatment is, in most cases presently treated by circumcision, overwhelming. As this deviates from the standard teaching of the medical curriculum, it is appropriate to outline the evidence in respect of what have recently been considered the main clinical indications for male circumcision.

Uncomplicated phimosis can be treated by potent topical steroids or by simple conservative surgery.[3-5] Clearly it is inappropriate to remove histologically normal tissue since this is amenable to plastic correction. Paraphimosis too can be treated by an overwhelming array of conservative treatments.[6] Balanitis should be treated in accordance with clinical guidelines.[7] Recurrent balanitis can be managed by restriction of washing with soap.[8]

Current medical teaching has it that preputial lichen sclerosis, otherwise known as "BXO",[9] is an "absolute" indication for circumcision. Lichen sclerosis should however be treated according to clinical guidelines.[10] At least one controlled trial has confirmed that topical steroids will effectively treat "BXO" in a percentage of cases.[11] A greater number of less rigorous studies have shown that potent topical steroids are effective for phimosis involving lichen sclerosis.[12-17] The percentage effectiveness appears to be directly related to the potency of the steroid used. A success rate of 70% has been reported by Jorgensen for clobetasol dipropionate.[12]

Three recent studies undermine the Law Commission's argument for stating that circumcision is not, by their definition based on reducing sexual pleasure, a mutilation.[18-20] Decreased sexual satisfaction secondary to circumcision has been demonstrated in 17%,[18] 27%[19] and 38%[20] of patients. Moreover, since it comprises a wound under section 20 of the Offences against the Person Act, 1861, male circumcision's lawfulness must be in serious doubt. Indeed it may arguably constitute grievous bodily harm.

Male circumcision would be ethical and appropriate only in cases of severe preputial lichen sclerosus which do not respond to conservative treatment; or in rare cases where the prepuce is irredeemably damaged due to necrosis or malignancy. The time has come for medical associations to caution their members that the removal of normal tissue from normal unconsenting children is always unethical. The medical school curriculum must urgently be updated to remove spurious clinical indications for this outmoded form of treatment.

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