On June 28, 2012, I attended a half-day symposium sponsored by the Royal Dutch Medical Association (KNMG). The topic was “the doctor and the foreskin,” and the conference program asked: “Circumcision: Forbid, Deter, Encourage?”

Gert van Dijk, a bioethicist who holds an appointment with the KNMG, graciously invited Marilyn Milos (from NOCIRC) and me to dinner the night before. We had a lovely meal in a Spanish restaurant in Rotterdam, during which Gert talked about the politics of circumcision in the Netherlands and, particularly, about the KNMG being a “Royal” organization and thus compelled to act with great decorum. He also emphasized that he is not an “intactivist,” with an emphasis – I believe, in retrospect – on the activist part of the word. (Gert, like pretty much every Dutch person we spoke with – and when you’re with Marilyn, that’s a lot of speaking to people – believes that children’s genitals should be left alone.) After saying goodnight to Gert, I said to Marilyn, “You know, he was putting us on notice that we should behave ourselves tomorrow at the conference!” 😊 (I believe we didn’t disappoint him.)

The conference itself was divided into two sessions – the first about circumcision and HIV-prevention in Africa, and the second about medical and human rights aspects of circumcision. Here is my report. I have liberally used the conference abstracts and also the very fine notes composed by John Warren, John Dalton, David Smith and Richard Duncker – all from NORM-UK – who also attended the conference.

The first speaker was Gabriela Gomez, a young Venezuelan researcher in infectious disease epidemiology at the Amsterdam Institute for Global Health and Development, where Catherine (Cate) Hankins (a well-known proponent of circumcision as a means to reduce the risk of HIV transmission) is also employed. Ms. Gomez’s support of the African circumcision campaign was unequivocal. What struck me in particular, listening to her remarks, was that the “science” of the three clinical trials (now several years old) is still being accepted by the circumcision-as-HIV-prevention proponents, with absolutely no current confirmation that this strategy is working and – equally important – no method in place to study the efficacy of the campaign.

Ms. Gomez repeated the international HIV campaign’s party line – including the statement that male circumcision should be voluntary, that the campaign should be culturally sensitive, and that there should be no stigma attached to being intact. She also repeated that men should be encouraged to know their HIV status before being circumcised. When she was informed by members of the audience of numerous
reports in the African media of men being harassed into circumcision, being excluded from organized sports activities, and otherwise being stigmatized for refusing to get with the program, she seemed sorry that this is true, but appeared to believe that these real-world events were simply a distraction from the fundamental validity of the campaign. Similarly, she repeatedly said that men should get tested before circumcision, but did not acknowledge both the methodological and health consequences associated with the fact that many are not. Finally, in both her talk and in conversations we had with her during the break, Ms. Gomez deplored the medical imperialism and human rights arguments against mass circumcision as being “not helpful” and as sabotaging this important campaign for the public health. During the break between sessions, an attendee from NORM-UK told Ms. Gomez that he had personally experienced circumcision as mutilation; she repeated that she thought the term “mutilation” also was not helpful.

The second speaker was Michel Garenne, a researcher at the Pasteur Institute in Paris. Garenne’s presentation dismantled many of the theories underlying the circumcision campaign being carried out in Africa, with scientific, ethical, and sociopolitical arguments.

From a scientific standpoint, Garenne demonstrated that there is no epidemiological correlation in Africa or elsewhere in the world between HIV prevalence and circumcision status of the male population. He also emphasized that even if circumcision might slightly decrease the chance of HIV transmission in a single sexual encounter (from, say, one chance in 1000 to one chance in 2000); with repeated exposure this advantage disappears. He likened circumcision-as-preventing-HIV to the rhythm method of contraception, and contrasted these with the proven demographic impact of successful vaccines against, e.g., cholera, polio, measles, rubella, whooping cough, smallpox).

Garenne also criticized the African circumcision campaign from an ethical perspective. He was critical of the campaign’s proponents as having failed to track and publicize negative consequences, such as short- and long-term complications. He described male circumcision of children as a violation of their rights because the harms outweigh the benefits and because they cannot consent. As for adults, Garenne questioned whether the informed consent process is being carried out properly in Africa.

Garenne concluded by asking why international health organizations are spending so much money on something that is not going to work, when there are pressing social and medical needs in the countries being subjected to these campaigns. He emphasized the lack of true debate in the scientific literature, the influence of the pro-circumcision lobby, and the one-sided media coverage on the issue of circumcision.

A Muslim surgeon in the audience commented that in his community, circumcision is deeply ingrained, and that those who fail to conform are stigmatized socially.

Here is a link to a 2008 article by Garenne: http://www.icgi.org/2008/05/male-circumcision-as-hiv-prevention-found-ineffective-says-pasteur-institute-researcher/

The third speaker was Anton van Niekerk, a philosopher who directs the Centre for Applied Ethics at Stellenbosch University in South Africa. Van Niekerk focused on the fact that the current adult circumcision campaign is being expanded to convince African countries to promote the circumcision of male infants on a large scale.

After citing the ethical problems and scientific weaknesses of the pro-circumcision lobby, van Niekerk argued that even if the scientific evidence on HIV prevention were more compelling, it would not warrant imposing circumcision – a procedure with lifelong, irreversible effects – on children, who are not at risk of sexual transmission for many years. He also highlighted the fact that there is no evidence of circumcision
having any benefit in HIV transmission for men who have sex with men, or in male to female transmission.

Van Niekerk pointed out that breast cancer in women could be prevented entirely by removing breast tissue of girls before the age of 20; however, this would be seen as clearly unethical and unacceptable, in contrast with the current enthusiasm for circumcision. Finally, van Niekerk asked why it is assumed that Africans are incapable of practicing safe sex, when we know that only safe sex practices – not circumcision – are effective means of curbing the sexual transmission of HIV.

The second half of the program addressed the medical and human rights aspects of circumcision.

The first speaker in this session was Tom de Jong, professor and head of Pediatric Urology at the Pediatric Renal Center, WKZ/UMC Utrecht and EKZ/AMC Amsterdam.

De Jong focused on the medical issues related to circumcision, emphasizing that only the uncommon condition of lichen sclerosis of the inner prepuce (BXO) was once considered to be a strict medical indication for circumcision, and that alternatives are now available for this condition. Narrow foreskin in adults can be cured by steroid cream coupled with gentle retraction. (Narrow foreskin in children is normal.)

De Jong stated that “In the literature, not one advantage of pediatric circumcision has been documented, whereas long-term complications have been described in up to 20% of cases of infant circumcisions,” and concluded that, “from a medical point of view, circumcision should be abandoned from daily practice in urology.” He urged that urologists should learn to perform a foreskin-sparing preputioplasty for the rare complaints of urinary reflux and persistent narrow foreskin.

With regard to ritual circumcision, de Jong mentioned the recent New York cases where infant boys contracted herpes simplex infections as a result of an ultra-Orthodox Jewish practice in which the mohel sucks the blood from the circumcision wound. He said that no circumcisions should be done except by a surgeon under hygienic conditions.

The next speaker was Morten Frisch, a consultant with the Department of Epidemiology Research, Statens Serum Institut, Copenhagen, Denmark, and author of a recent article on male circumcision and sexual function: http://www.ncbi.nlm.nih.gov/pubmed/21672947

Frisch reviewed the findings from a study of 5500 Danish adults, which showed that on most measures of sexual satisfaction, there was no difference between circumcised and intact men. However, there was an increased risk of orgasm problems in circumcised males, and an increased risk of sexual difficulties (painful intercourse, incomplete sexual needs fulfillment) in their female partners. Frisch commented that in the ongoing circumcision campaign being conducted in sub-Saharan Africa, men are being led to expect that circumcision will make them better lovers (in addition to reducing their risk of acquiring HIV), and stated that many of them will be disappointed.

He recommended thorough research on the impact of circumcision in countries where – unlike in Denmark – male circumcision is more common.
Frisch then turned to a report on how difficult it was for him to get this study published. Despite the fact that he is a well-published author in scientific journals, and despite the fact that the paper in question was a dispassionate report of the findings of a scientific survey, it was rejected by a number of journals and subjected to highly critical peer reviews. For example, one reviewer wrote 17 pages of severe criticism, considerably more than the paper itself, and supplied five pages of references, calling the paper an ideological rant against circumcision. A subsequent revision of Frisch’s paper was characterized by the same reviewer as promoting “extremist” views and as “unpublishable by any journal.” The *International Journal of Epidemiology*, however, did choose to publish the paper. After the article was published, the Journal printed a letter in response, written by Professor Brian Morris of Sydney University, his associate Jake Waskett of Manchester UK, and Ronald Gray (the latter one of the authors of the African RCTs), couched in the same language as the peer review described above. Frisch subsequently learned that Morris had circulated his (Frisch’s) manuscript and the review to his closed mailing list with a request that they bombard the *International Journal of Epidemiology* with letters.

Finally, Frisch also mentioned that, whereas research he has done in other fields of medicine have readily attracted grants to fund them, it was impossible to attract any grants to pay for this research on circumcision. He worried that “undeclared, yet strongly held personal views of medical journal reviewers may delay, manipulate or possibly prevent the dissemination of new research on male circumcision.”

Frisch’s paper and the reviews in their entirety can be obtained by emailing info@intactamerica.org with your request.

**Trond Maarkestad**, Professor of Pediatrics, University of Bergen (Norway), and Chairman of the Ethics Committee of the Norwegian Medical Association was the next speaker. Markestad discussed the controversy surrounding male circumcision in Norway today.

Essentially, circumcision has never been part of Norwegian culture. The influx of Muslims has changed that, with a demand for child circumcision coming from that community. Arguments against child circumcision in Norway focus both on the cost to the national health service and the ethics of the procedure.

The May 2012 death of a three-week-old boy following his circumcision resulted in further debate, and in the decision of a couple of private clinics to stop performing the procedure. After this, the families started bringing in circumcisers from outside Norway. In response, the Norwegian government recently suggested that ritual male circumcision should be offered free of charge in public hospitals. This has caused a heated public debate, and responses from various institutions in public hearings have varied from agreement with the suggestions to a call for a ban.

Markestad stated that the Norwegian Ethics Committee has asked religious leaders if they could provide alternative rituals; none have been suggested. The debate in the media has been intense, with people using the same arguments to reach opposite conclusions. He noted that religious communities, including the Church of Norway, have concluded child circumcision should be permitted, whereas the human rights organizations have concluded that it shouldn't. Markestad said he believes that politicians are loathe to antagonize minority groups in Norway.

Three different proposals have emerged:

1. **Prohibit circumcision under age of 16** – supported by the Centre Party, Humanists and the Children’s Ombudsman.
2 Permit circumcision of children by anyone – supported by Jews, Moslems and the Church of Norway.
3 Permit circumcision of children, but only by a doctor, supported by Norwegian Medical Association, who are concerned that a ban would drive the practice underground, thus resulting in more harm to children.

The final speaker of the day was Arie C. Nieuwenhuizen, internist and President of the Royal Dutch Medical Association (conveners of this conference). The question he addressed was whether circumcision should be prohibited or – alternatively – simply discouraged.

Nieuwenhuizen stated that, as published in its position paper in 2010, the Royal Dutch Medical Association believes the medical benefits of circumcision are unproven, whereas complications are underestimated. The organization’s official position is that non-medically indicated circumcision of underage boys amounts to a violation of a child’s physical integrity, and so contravenes Article 8 of the European Convention on Human Rights and Article 11 of the Dutch constitution. Nevertheless, because he believes that change will come “from the bottom up” in religious communities, the organization recommends doctors follow a policy of discouragement rather than prohibition.

CONCLUSION

I feel privileged to have been able to attend this conference. The tone of all speakers and almost all audience participants was measured and respectful. There were a couple of people in the audience who seemed intent on characterizing child circumcision opponents as anti-Semitic or anti-Muslim. But what struck me was that the European medical community – like our host Gert van Dijk – is not explicitly “intactivist,” but (1) does not for one moment believe that circumcising children confers any medical benefit, and therefore (2) believes that the practice has no place in legitimate medical practice.

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