Attorneys for the Rights of the Child

Newsletter

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Protecting Children's Bodily Integrity

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arc@post.harvard.edu

Getting it Right: Single-Payer Universal Health Care and the End of Circumcision as We Know It in America.

by
Georganne Chapin

Georganne Chapin is President and Chief Executive Officer of the Hudson Health Plan, Tarrytown, New York. She is also the Founder of the Hudson Center for Health Equity & Quality in Tarrytown, New York, and Secretary and Technical Advisor, Attorneys for the Rights of the Child.

Most people who know me know that I am an advocate for universal health care under a single-payer system. The nearly twenty years I have spent working with federal and state programs designed to give health insurance to low-income people have only

Georganne Chapin

polished my diamond-hard conviction that abolishing the current non-system and moving to universal health care funded by a single payer is the only path to continuous, equitable high-quality health care for all.

People who know me also know that I'm passionately opposed to removing healthy body parts from babies or children who have no say in the matter. In other words, I object to routine infant circumcision and I want to see it abolished.

Those of us committed to ending routine infant circumcision don't necessarily agree on other issues. We differ in our religious beliefs, our attitudes toward the war in Iraq, our positions on abortion, and almost any other subject you can suggest. As a group, we are anxious to bring into the intactivist movement people whose causes we respect, and who we think would be influential if they embraced intactivism – but it doesn't always work out smoothly. A good example of this is our ongoing effort to work with breastfeeding advocates, some of whom are reluctant to take an official position against circumcision for fear of offending others in their group. Another, perhaps more complex, example would be the ACLU, which despite its advocacy for individual rights, has taken the position that circumcision is a religious freedom issue (in this case, the religious freedom of the parent) rather than a children's rights issue. Finally, sometimes the conflicts are due to expedience – e.g., many midwives who do not believe in routine circumcision nonetheless perform the surgery, because it's part of the "complete package" of obstetrical services that they must provide if they are to compete with obstetricians. Furthermore, returning to my opening statement, I think it's fair to say that although, like most Americans, most intactivists would agree that there's something really wrong with our health care system, not everybody who believes in ending routine circumcision is also an advocate of single-payer health care.

I'd like to take this opportunity to explain why I think the two are related and, indeed, why I believe that a universal health care system is one of our best hopes for bringing an end to rou-

tine infant circumcision.

A recent study by the Commonwealth Fund compared the performance of the health care systems of six nations – Australia, Canada, Germany, the United Kingdom, New Zealand, and the United States.[1] The report, which includes data from patient surveys, information from doctors, and comparative national expenditures, found that "the U.S. health care system ranks last or next-to-last on five dimensions of a high performance health system: quality, access, efficiency, equity and healthy lives." Adding insult to illness, the report also shows that the United States spends per person nearly double on health care what the next most expensive country, Canada, spends, and three times what is spent by the lowest cost country, New Zealand. Finally, the report notes: "The U.S. is the only country in the study without universal health insurance coverage . . . ."

Unsurprisingly, the Commonwealth Fund does not talk about the fact that the United States is the only one of the six nations studied that embraces routine medical infant circumcision. If it did talk about circumcision, it would have to tell us that the residents of Australia, Canada, Germany, the United Kingdom, and New Zealand are doing quite well, thank you, without spending government health care dollars to hack off the healthy foreskins of newborn babies. In general, Americans have shorter life expectancies than people in the other five nations, they contract and die of AIDS at higher rates, and the care they receive is less safe. The citizens of these countries have similar or longer life expectancies than Americans and they manage to die of AIDS at lower rates than Americans despite the fact that they are generally not circumcised! In fact, in Britain, only about one percent of infants are circumcised at birth; in Australia, only ten percent of baby boys are circumcised while in Canada, rates have fallen to under 10 percent; in Germany, circumcision is very rare; and, finally, in New Zealand the once-popular surgery is virtually extinct. So am I suggesting that when the United States finally adopts a universal, single-payer health care, routine circumcision will just cease? Well, … yes.

Coincidentally, I recently visited New Zealand, one of the countries Commonwealth studied, where I had the good fortune to meet with health care officials and policy-makers, clinicians, and administrators. All of them obviously were also "consumers" of their country's health care system. What struck me most, in contrast with the American non-system, was the rational, orderly and transparent way medical decisions in New Zealand were made. Whether the treatment being considered is a drug, device, or surgical procedure, consideration as to whether it will be paid for with public funds is based on evidence as to its efficacy, its necessity, and its cost-effectiveness across the population as a whole. Routine circumcision, as we know, clearly fails under these criteria. And the government doesn't pay for it.

The history of circumcision in the Britain is also illustrative. As most of my readers know, the United States and Britain share a history of medical circumcision, a history tied to 19th century Victorian attitudes about sex and sexuality, the development of successful biological and surgical techniques, and the emergence of the physician as the preeminent authority on all such matters. Supported by a host of sociocultural and pseudo-scientific ideas, the popularity of foreskin removal increased in a parallel fashion in Britain and the United States until World War II, when its incidence diverged. In order to conserve medical resources, the British government curtailed circumcisions both within its military and among civilians. In contrast, the American military actually supported the practice among the troops, clearly helping to legitimize its status in the civilian population.

Following the war, the newly constituted British National Health Service set about to examine systematically the costs and benefits of a wide range of medical procedures. Possibly because of the lack of observable ill effects resulting from the natural experiment afforded (as it were) by the War, and because resources continued to be limited, circumcision was determined to be outside the scope of coverage. This decision was reinforced by the publication in 1949 of a seminal article by Douglas Gairdner, a British pediatrician who documented, in a systematic and scientific way, the essential role of the foreskin in male health and sexuality, the extreme rarity of medical indications for circumcision, and its inherent risks.

In the United States, where circumcision was well on its way to becoming a national sacrament, Gairdner's work was virtually ignored. And as the fragmented, privately funded, competition-based insurance system evolved in this country, opportunities for collective cost-benefit analysis were lost. What we have today is essentially a medical free-for-all. Despite rhetoric to the contrary, most Americans are encouraged (often by advertising) to believe that resources are infinite; doctors often default to over-treating patients who have a third-party payer behind them; and there is a general belief that if you have "insurance" (and this applies to Medicaid, too, where many states have been reluctant to deny a "benefit" provided routinely through private insurance), you should be entitled to essentially unlimited services – and whether or not they provide any benefit is actually a secondary consideration. Procedures like circumcision are sanctioned by custom; they are done because they have always been done, and because they are paid for. To remove them would require a degree of political and economic will that decision makers in a competitive, fragmented system just don't have the stomach for.

However, if the U.S. were to move to single-payer, universal health care, such procedures would be subject to an efficacy test, and cost-benefit analysis.

I think it was Winston Churchill who said, more or less, "You can trust the Americans to get it right – but only after they've tried everything else." A single-payer system that provides health care to everybody in the United States is still some time off in the future. But it will happen. There is simply no way that we can continue to in-

crease spending on ineffective health care, and there's no way we can afford to provide health care to everybody if we do it in the same mindless, market-driven manner that characterizes today's approach to medicine. Rather, our society would have to do what Britain did after World War II, and what I saw in New Zealand: consider the evidence and the value of what we are being asked to pay for, and make decisions accordingly. Getting the most benefit for the most people would become the criterion for deciding what services would be funded under a national health care system. And routine medical circumcision would not meet the test.

[1] Davis, Karen et al., Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care. New York: Commonwealth Fund, 2007. Further references to sources used for this article may be obtained from the author.

"Halving A Foreskin Is Wrong; Having One Is Not": My Experience Protesting At The AAP Conference
by Robert Blissitt

I can happily report that this year's AAP demonstration at San Francisco's Moscone Center was a success. On average, there were five of us outside at any given time. We took turns holding signs, resting our feet, or grabbing a quick bite in the beautiful public space nearby. Anyone intimidated by the thought of demonstrating at a conference should seriously consider attending one for the AAP. If they were any more peaceful, they wouldn't be demonstrations.

On Dan Bollinger's advice, I was prepared to thank each and every physician for not recommending circumcision to parents, whether they did so or not. I soon realized that I would quickly lose my voice saying such a mouthful, so I resorted to "Good morning," "Good afternoon," and the occasional "Howdy!" I found this had two benefits: It showed us as being approachable, and after being warmly greeted, few doctors would say anything negative in response. Many of the doctors smiled back and offered greetings of their own – at least on the first day, while they were still fresh.

Several doctors agreed with us and took time to speak with us, or even to thank us for being there. A couple of doctors spoke with us at length, providing suggestions on how to engage other doctors. Canadian, Mexican, and Indian doctors were very much in agreement with us and were sometimes very vocal in their opinions. Word from inside the convention was that doctors are becoming more polarized on circumcision. There is less middle ground, with circumcision opponents becoming more numerous and circumcision supporters becoming more vocal.

Robert Blissitt, Outside AAP Conference, October, 2007

On four separate occasions, I was challenged by doctors regarding our "Circumcision Will Not Stop AIDS" signs. The docs said literally "Who is saying that circumcision does stop AIDS?" I explained to them was that the African HIV studies were all over the media, but these doctors were unimpressed. They responded that the studies from Africa were "not convincing" and, "Doctors rely on hard data, not the media." I wasn't sure whether to feel good that they didn't believe the flawed African studies or feel bad that the signs we were holding might have been better suited for a different audience. In any event, their responses were encouraging.

In three days' time, I got negative feedback from only three doctors. One such doctor was confused that I "didn't have anything better to do." I assured him that I had a full-time job (Editor's Note: in the information technology division of Southern Methodist University) and took a vacation to be at the conference. He remained unconvinced, so in parting I told him that I believed children's advocacy to be more important than anything else I could be doing, and I added that a good doctor would know that.

One seemingly sympathetic and rather gregarious doctor informed us that circumcision was due to "Moses, Mohammed, Mama, and Money." He elaborated: "Moses and Mohammed" for Judaism and Islam, respectively; "Mama" because she's never seen an intact male herself; "Money" because doctors earn several hundred dollars per procedure.

Many thanks to all that stood outside the convention center for three or four days, holding signs and engaging doctors and passersby.

Standing in front of the convention center, fellow demonstrator Michael Keith came up with a slogan that conveyed what I find to be a striking thought: "The foreskin is the only part of your body that you don't own; it belongs to society." Always looking for another bumper sticker idea, I came up with an expression of my own: "Halving a foreskin is wrong. Having one is not."

A View from the Exhibitor's Booth at the AAP
By Aubrey Taylor

I have worked in the exhibitor's booth with NOCIRC at the American Academy of Pediatrics (AAP) convention for two years now. Previously I have been outside demonstrating on three occasions. Every year seems about the same: A large percentage of the doctors take your written materials and walk away. Some ignore you. Only from the group that is willing to talk to us can we gain a perspective on our impact; they're not necessarily representative of the whole group.

A major part of these physicians are receptive to our message. Naturally there is an occasional angry doctor who thinks that we are doing the world harm. To my memory there were only

two this time. A good number of them stop just to let us know they agree with us.

Here's the problem. Educating doctors that circumcision is not necessary hasn't turned out to be a magic pill. Doctors have turned out to be a lot like parents in that regard. The principle of the matter unfortunately doesn't hold enough weight to counter the situational pressures of our economy, laypersons' pro-circumcision perspectives, and the doctors' work structure.

Aubrey Taylor

What I hear (and we've all heard) is that the doctors "don't like doing it, but the parents insist". We counter, "But as a physician, you can let them know that it's dangerous," and they answer us with the crux of the problem: "But I do educate them, they want it anyway, and if I don't do it, they will go somewhere else and I won't have a practice".

Can this all be lies? We hear from the parents that the doctors are insistent enough to do it without consent in some cases, then we hear from these doctors that the parents are ready to walk out of their office if they don't agree to do it. Our first instinct as passionate humanitarians is to feel that these doctors are just greedy and it all comes down to money for them. We hear of an example of this or that doctor who won't do it, and that's the standard we hold everyone to. We think of the amount the circumcision costs by itself and imagine a crazed scalpel wielding cartoon character with dollar signs in his eyeballs. Unfortunately, if the world were that simple, our job would be easier than it's turning out to be.

It all does come down to money, but to these doctors, it isn't the question of optional leather seats and a longer lunch; it's all or nothing. To them, you either have a practice that provides circumcision, or you don't have a practice. Some of this could be a bravery issue. Some of it could be misperception. One thing is certain: a LOT of them are saying it, so what can we do?

There is a dynamic that we need to fully understand if we want them to stop and that is: what is it that can alleviate or counter client pressure on their particular profession? Without knowing all the intricate details of each physician's medical community and even the lay community's perception of circumcision, this is hard to figure out. How much pressure needs to be removed for a doctor to refuse circumcision is also going to change from one physician to another. Finding other sources of pressure may help as well.

One doctor who came by our booth was very much on our side, and had even had a hand in getting a law passed to prohibit harassment of breastfeeding women. He still felt he had to circumcise to keep his job. Quit and move to another community isn't the answer because after all, someone has to be in these communities, and preferably someone on our side. This doctor's input was that if insurance didn't pay for it, people would be less likely to get it. Well, we have that plan in action too, so this is at least encouragement that our activities on different fronts are bound to collide and the impact is expected to be positive. Needless to say, I invited him to help us with our work.

I think that it may be time to change the angle of our message. The doctors get it, and they are possibly a resource waiting to be utilized. More communication and feedback is a must. We are already working on so many different fronts that perhaps figuring out where to put a little more pressure will help bring the edges to a seam. This pressure could come from the threat of legal action, but we may have to bring that to a higher place than the individual doctor. The pressure could be support from an "official" authority like the AAP. It could be insurance, and not just private insurance or Medicaid, but malpractice insurance. It could be comrade support. It could be conscientious objector legislation to protect the jobs of medical people who don't want to circumcise. The answer might include all of the above, so we better get to it!

Intactivism as Part of Broader Social Change

By Ryan McAllister

Creating significant social change, such as stopping the practice of circumcision, presents enormous challenges because it brings together custom, taboo, strong feelings, limited vocabulary, and both intellectual and emotional misunderstandings. I believe that such change may therefore be accomplished more effectively and efficiently if we explicitly consider two points when presenting our messages. First, utilizing unifying themes, rather than relying solely on single issue approaches, can help create common ground with listeners and make it easier to convey how circumcision relates to their lives. Second, striving to transcend typical relationship power dynamics and to communicate not just our message, but first and foremost an authentic interest in the needs and feelings of the other person. While this effort naturally helps frame the discussion in a way that touches the other person and enhances the possibility for effective communication, it also fundamentally represents a deeper and more fundamental social change.

My own painful experience with circumcision led me to start the nonprofit organization NotJustSkin. We advocate for the end of child circumcision by educating parents, publishing

accessible articles, and facilitating interactive workshops. However ending circumcision is not our sole focus. In our view, the practice of forcibly altering children's bodies reflects the violence prevalent in our society, and the end of forced circumcision and other such procedures is one of many essential steps toward our overarching goal of a more compassionate and peaceful culture.

Many organizations and individuals want clarity of message, and so restrict their discussion and work to single issues. While this can help keep messages clearer, I believe an overly rigid separation of causes leads to a division of resources that ultimately diminishes our efficacy. As a community of social changers, we simply do not have the time and funds to build networks and approach each audience over and over for each relevant social change issue.

Ryan McAllister

We can have clarity of message another way. I think that integrating causes along sensible, consistent themes brings more efficiency, a greater sense of meaningfulness in our work, and a more intelligible and coherent story to share with our intended audiences.

For example, at NotJustSkin, our unifying theme is supporting the wellbeing of parents, children, and community. We have done the research and understand how forced child genital modification (circumcision) harms children and society. Yet we do not set this topic in isolation. We simultaneously work to improve the lives of parents and children around a number of other issues, including communication, handling strong feelings, breastfeeding, cosleeping, pregnancy, childbirth, and chemicals in the household.

Addressing circumcision, birth, and other delicate topics alongside each other sets them visibly in the larger framework of supporting parents and children. This contextualization makes it easier for people to hear what we have to say and to connect it to their own lives.

Certainly, not all topics mix. In order to find those which do, look for a unifying theme that you believe most people value deeply. For example, most people in the U.S. may be confused about circumcision, thinking it harmless or beneficial in some way. These same people will, however, grasp the value of supporting the wellbeing of parents and children. Coming from this context makes the discussion about circumcision easier.

The second issue I want to discuss relates to the actual manner in which we communicate with others, as I believe that truly effective social change depends on building caring relationships.

Our society presents us with the idea that there is a spectrum along which people interact (particularly with children), ranging from permissive to authoritarian. The only difference among the various positions along this spectrum is who we believe has more power over whom. When we communicate from anywhere within this framework, the communication tends to disconnect both parties, reduce the quality of the relationship, and interfere with the joy of relating.

I propose that transcending power dynamics in our relationships with everyone, and especially young people, is a key investment in both a joyful life and in long-term, positive social change.

I believe we can communicate authentically and compassionately when we are aware of our own and the other person's needs and feelings. This allows us to view any discussion as dialogue about what needs are present and how to get everyone's needs met. Nonviolent Communication is a framework and method for thinking about communication developed by Marshall Rosenberg and others. I have found it has helped me understand needs, and how to place my attention more consistently upon them. In short, I have come to think of needs as abstract things that all people share a desire for (such as safety or consideration), and which manifest in the present moment through more specific desires (such as the importance of respect for someone's religion when talking about controversial topics). This understanding has helped me to look for needs in conversations and to bring them into the explicit conversation rather than leaving them implicit, where they are less likely to be met.

In the last few years, much of NotJustSkin's work has been accomplished through interactive workshops using and sharing approaches for effective, connected communication. Often, I focus on how we can communicate authentically and compassionately with young people without the use of power dynamics.

I think these ideas and approaches to communication can benefit all social change efforts. In fact, simply having a Nonviolent Communication-style intention when talking with others represents social change. At the same time, Nonviolent Communication may help make us more effective. When we are talking with anyone about sensitive issues, we are relying on the relationship, however brief, to carry the weight of the communication. This intention to relate with the other person -- that is, to grasp the other person's needs in the conversation and not just our own need to spread information about social change -- naturally helps us to frame our discussion in a way that touches the other person.

I am quite grateful for all of the work and progress accomplished by the many highly-focused organizations. I believe they continue to contribute significantly to their causes and the greater shift to a more peaceful society. I am especially grateful for the work of NOCIRC and ARC, because it means much to me personally. I think it makes a great deal of sense to have at least one organization presenting the issue of

forced genital modification mostly on its own.

At the same time, I want to encourage many of us to work on themes instead of single issues. I believe we can be most effective when we bring together many issues that share commonality via a unifying theme. This approach is especially important for intactivists, because we need to create context before many people will even be able to open up enough to think carefully about what forced circumcision really means doing to a child.

Thank you for all that you do.

My Intactivism
By Lori Hanna

I feel so blessed. When I was pregnant with my first child, and discovering that 'it' was a male child, I asked my OB/Gyn about circumcision. He promptly informed me that routine infant circumcision (RIC) wasn't medically necessary. Then I asked my local priest, who let me know RIC wasn't a requirement in my Christian faith. I spoke briefly to my mate, who was cut, and together we decided not to inflict this surgery on our son – especially so soon after his birth when we had to get to know each other and establish our various relationships.

My mother remained quiet while my own father lectured me on how he saw the guys that had been cut during his reign in WWII, and how I would regret my decision and how my son would hate me for not having it done. Now that was some pressure, but really it wasn't a huge issue, as not many other people were changing and/or bathing my firstborn. I just didn't have much support or for that matter I really didn't have much information on proper intact care either!

That was until I caught a rerun of the Phil Donahue Show with Marilyn Milos on it! I had to call this woman in California that connected to my soul here in Michigan! That was the start however quiet and slow it was. I gathered information on the foreskin and proper care – if nothing else to place in Keith's baby book for him to review or us to discuss later in his life.

Seven years later, I had another son, this one born 3 months premature. The day of his birth I wasn't able to see my baby until 8 hours after delivery; they finally allowed me to see him. The staff informed me about the roller coaster ride that was ahead of us. They gave much information about my son's status, testing that would occur, and explained how unstable his condition was, so much so that I wasn't allowed

Lori Hanna and sons
Keith (15) and Kevin (8)

to even touch him – yet, I was appalled that the nurse approached me for 'consent' of his circumcision following all this information! She misunderstood my reaction, thinking I thought they would do the surgery soon and tried to reassure me they would wait until right before his discharge. I was adamant and had to keep repeating that, No I wasn't signing the consent because he wasn't going to get circumcised! We spent the next 7 weeks in the neonatal intensive care unit (NICU), where I witnessed several NICU baby boys being circumcised. I cannot ever describe in words the screams and cries I heard, yet they have always remained in my mind. It is a sound that comes and goes to the core of a being. I don't understand how 'medical professionals' can ever say or imply it isn't painful. I remember one distinct RIC – it was obvious that it was the first for the resident, as the senior resident said, "Here, let me clean this up for you" and proceeded to remove even more of the child's foreskin.

I had close friends that finally had a son, which they consented to RIC, only to discover that the paternal grandfather was intact. They regretted having their son cut but even more so when they discovered the original cut had removed too much foreskin and had buried the penis which required additional surgery years later.

Within 4 months, I started talking to anyone and every one I could that would listen. I looked for opportunities to reach more people. I spoke with doctors, nurses, therapists, expectant parents, new parents, young people, schools, went to my local health departments, WIC offices, looked for health fairs, baby fairs, conferences – where ever, it didn't matter! I've been speaking out about RIC now for 8 years.

I have discovered that pure strangers are more open to listen, as we haven't saved any of the male children in my own family other than my own sons (or at least none that I know of). It's not that we haven't tried, as now my own mother, after her own guilt over having my brothers cut, agrees with me. We have spoken to siblings, nieces, nephews, and grandchildren and even total strangers. My own sons have already thanked me for not having them cut. Yet it has given me great satisfaction to know that many babies have been saved, as I've had people let me know it's only because of the information provided, via phone, in person, email, or even giving websites, and the internet – that have helped educate. Sometimes, parents that didn't choose RIC have proudly announced that their son is intact – possibly only for the first time finding the support for their decision and 'permission' to let it be known.

I sometimes have to chuckle, when I hear the concern of 'my son is … (fill in the blank) months and/or years and isn't retracting yet. (This is getting more common as fewer circumcisions are being performed.) My oldest didn't retract until puberty while the youngest

just discovered his glans in the bathtub the other night at the ripe age of (almost) 8 years old. They are both normal, and I love to share their stories with others. Neither son has had any type of 'issues' related to their foreskins and I never worried about them not retracting, all because I've learned it's their equipment to play with and discover all in their own time.

I have bumper stickers on all my vehicles, which have traveled thousands of miles and planted seeds or prompted thousands of conversations all without any words from my own mouth. Sometimes resting my voice, and just allowing the bumper stickers, buttons, wristbands, or t-shirts alone will speak loudly enough to inform.

Working as an intactivist is never ending, but the rewards knowing people are learning and yes, even sometimes acting in a loving way to leave their child intact as nature intended, whether intentional or by accident, it doesn't matter. I love to see parents and babies SMILE and so do I….

Attorneys for the Rights of the Child

2961 Ashby Ave.,
Berkeley, CA 94705
Fax/phone: 510-595-5550

www.arclaw.org
email: arc@post.harvard.edu

J. Steven Svoboda…..Executive Director
Albert Fields.....…....Newsletter Editor
Georganne Chapin…….Technical Advisor
Jeff Borg.....Graphic Designer
Art Coons.....…..... Student Coordinator
Gillian Longley.. .....Research Assistance
Rick King……..Webmaster

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Executive Director's Message

We're back. After setting an ARC record by the ten months that passed between our previous two issues, we knew we had to get a second issue of the ARC Newsletter into your hands before the year was out.

Steven with Eli and Sarita

This issue includes articles by Ryan McAllister about his unique approach to intactivism blending and harmonizing many different interests and movements, from ARC Board Member Georganne Chapin about circumcision and universal health care, and from Lori Hanna about her history as an intactivist. Aubrey Taylor has written a report from inside the American Academy of Pediatrics (AAP) Conference, and Robert Blissitt provides a view from outside as he hoisted signs for conference attendees to see. We are reprinting an excellent commentary on HIV and circumcision that ARC Board Member (and premier intactivist attorney) David Llewellyn published in a Ugandan newspaper. I have reviewed a recent book about FGM.

Change is in the air, folks. 2007 has been a very full, busy year. The Africa/HIV elephant in the room clearly can't be ignored. ARC will shortly be applying to present at the 2008 International AIDS Conference in Mexico City. As we went to press, we learned that Peter Kilmarx of the Centers for Disease Control and Prevention (CDC) gave a presentation at the National HIV Prevention Conference on December 4 promoting infant circumcision as an HIV preventive in the US. Then the CDC apparently met with the AAP on December 10 as they prepare an updated position statement on circumcision. (ARC's letter to the AAP, which was also sent with slight variations to the CDC, is reprinted in this issue.)

Good news is reaching us as well. As reported in articles reprinted in this issue, just as we went to press, the Australian Medical Association backed a call for laws banning the non-essential circumcision of infant boys. In September, Victoria became the fourth Australian state to no longer provide circumcisions at public hospitals for non-medical reasons. There now appear to be more boys being left intact in North America than boys who are being circumcised, a momentous moment of paradigm shift. Other exciting upgrades in the movement are in the works.

While not all of his superlative work is yet visible, ARC Webmaster Rick King continues to upgrade and update the ARC website. This effort will be continuing at least through the early months of the New Year. While we have talked about it several times, we finally have a dedicated law student associate, Jordan Parkhurst, who will be working with me to generate a "Know Your Rights" brochure for potential plaintiffs.

As I recently announced, Oxford University Press has published Does Feminism Discriminate Against Men?: A Debate (by James Sterba and Warren Farrell with Steven Svoboda). The book is a university-level gender studies textbook structured as a debate between Dr. Warren Farrell and pro-feminist Professor James Sterba. Each chapter of the book addresses a different topic, for example: Why Men Earn More. Does Popular Culture Discriminate Against Men? Are Schools Biased Against Girls or Boys? The Future of Feminism and Men.

Congratulations to Amber Craig for having her letter responding to Time's recent feature on circumcision published by the newsmagazine. (The original Time article by Jeninne Lee-St. John from the print version of the

magazine is reproduced in this newsletter.)

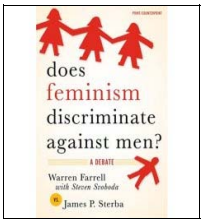
Here at ARC, we always hope and believe we are making a difference, along with our beloved brothers and sisters in the movement, but rarely do we receive concrete news of a specific baby we helped save. Dr. Mark Reiss and I were therefore elated to hear from a pediatrician who attended our August 14, 2006 talk at Kaiser in Sacramento, California that based on our presentation, she elected to leave her baby intact! Such news is truly the best Holiday present I could imagine.

Our next issue will be out in the Spring. Until then, we wish you a Merry Christmas, Happy Hanukkah, Blissful Yule, and a truly Joyous New Year.

Steven Svoboda
Executive Director
Attorneys for the Rights of the Child

New Book Announcement

I am pleased to announce that Oxford University Press has published *Does Feminism Discriminate Against Men?: A Debate* (by Warren Farrell [with Steven Svoboda] and James Sterba). The book is a university-level gender studies textbook structured as a debate between Dr. Warren Farrell and pro-feminist Professor James Sterba. Each chapter of the book addresses a different topic, for example: Why Men Earn More. Does Popular Culture Discriminate Against Men? Are Schools Biased Against Girls or Boys? The Future of Feminism and Men.



Warren is the only man ever to be elected board member of the New York City chapter of the National Organization for Women (NOW) three times. He has gone on to become the most popular and the preeminent author on gender-equal gender studies topics. I first met Warren in 1996 when I interviewed him and since then I have published reviews of a number of his books, tapes, and DVD's. Last year, Warren asked me to work with him on this book, which addresses intact rights at several points.

If you buy a copy of this book (or any item) through amazon.com, your purchase will result in a royalty of about 4% of the price being sent by Amazon to ARC (an Amazon Associate) at no cost to yourself. Here is how to do this: Go to www.arclaw.org, and click on one of the top two book icons on the right side of the page. This will take you to amazon; you should see a URL ending in arc-20. You can then log in, can even use a shopping cart that you filled up previously, and your purchase will help protect babies.

Steven Svoboda
Executive Director
Attorneys for the Rights of the Child

Book Review

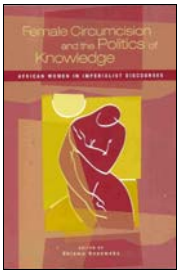
Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses Edited by Obioma Nnaemeka. Westport, Connecticut: Praeger Publishers, 2005. www.praeger.com. No price stated on book.

Review by J. Steven Svoboda

Indiana University Women's Studies Professor Obioma Nnaemeka edited the 2005 book *Female Circumcision and the Politics of Knowledge: African Women in Imperialist Discourses*. Only the rarest works, such as Bettina Shell-Duncan and Ylva Hernlund's superlative 2000 book, *Female "Circumcision" in Africa: Culture, Controversy, and Change* (previously reviewed in these pages) can avoid the pitfalls faced by multi-author essay collections. This book raises some interesting ideas and includes a few noteworthy chapters. Nevertheless, *Female Circumcision and the Politics of Knowledge* proves in the end a bit disappointing and a bit of a muddle.

Several pieces expand upon the growing literature rightfully denouncing the late Fran Hosken, founder of Women's International Network, for her uniquely intemperate and bombastic anti-female genital cutting (FGC) books. Award-winning author Alice Walker suffers repeated (though, it must be said, richly deserved) criticism by many of the authors included here for her profoundly misconceived books and film addressing FGC. Walker assumes that being black somehow gives her the right to speak for all Africans and at the same time decides that a trip to Mexico, of all places, because it is part of the "Third World," will offer her useful insights into the African experience of FGC.

Nnaemeka needed to take a much more forceful editorial role, as an overall unifying vision and coherence is sorely missing here. In addition to repetition, some pieces regrettably read somewhat like poor first drafts of other pieces. The same quotes from the same interviews with Walker are used in multiple articles, and even the same quotes from secondary works like a Keith Richburg newspaper article are referenced multiple times.



Francoise Lionnet regrettably attempts to insulate male circumcision from legal liability in France due to its "cultural acceptance," a misguided attempt that has absolutely no basis in the law and represents a glaring non sequitur. Practically every citation and date she gives regarding French law on mutilation is erroneous, a downright shocking symphony of mistakes that will be difficult for non-French-speakers to deduce.

Editor Nnaemeka's own piece carries a title rife with the sort of academic jargon that characterizes the entire book, "African Women, Colonial Discourses, and Imperialist Inventions: Female Circumcision as Impetus." Nevertheless she introduces a provocative argument that human rights may have become over-inclusive in recent years: "The past decade has increasingly witnessed the tendency to herd all categories of suffering into one battlefield: human rights." Like the book, this essay raises a number of interesting issues but fails to effectively address them. Surely there is some role for absolutes? How does one incorporate human rights into an analysis of genital cutting without ignoring the cultural role the practices play in many of the

places FGC is performed?

The best articles inject fresh perspectives that are sorely missing from the other pieces, and in some cases addressing male circumcision. Kudos to longtime anti-FGC activist Nawal El-Saadawi for her forthright statement in support of keeping males intact. "I am against all types of circumcision including male circumcision, which is not as detrimental as female circumcision, but is still harmful and may cause serious complications."

Omofolabo Ajayi-Soyinka succinctly notes "the arrogance and presumptuousness of mainstream American feminism for positing its experience and derivative critical theories as universal and normative." Later she usefully points to the voyeuristic aspects of the West's focus on African genitalia, and the seemingly "compulsive need to denigrate in their entirety the cultural values of the people that practice" FGC.

The disturbing information Vicki Kirby mentions that several African cultural groups have recently adopted FGC could teach us useful lessons regarding the proposals to introduce male circumcision into currently non-cutting African cultures.

In perhaps the book's standout contribution, Chima Korieh addresses feminism and race in FGC discourse. She provides a fascinating insight: The clitoris has had a tremendous symbolic importance and thus has become an obsessive focus in Western feminism, particularly US feminism. Korieh observes that while the Western woman "knows" that the uncircumcised clitoris plays a critical role in her sexuality, in many African societies a woman "knows" that removal of the clitoris is essential to her proper expression of her sexuality. Moreover, in the Sudan virginity is defined socially and is subject to reversal through performance of genital surgery, whereas the Western definition of virginity treats it as "irrevocably changed by a certain specific behavior." Korieh decries Barbara Walters' facile rationalization of male circumcision on religious and medical grounds.

Jude G. Akudinobi analyzes two movies that address colonialism but are not centrally concerned with genital cutting. Eliose A. Briere intriguingly suggests that focusing on FGC enables the West to view itself in a positive light. Sondra Hale engagingly addresses our own clitoridectomies, mastectomies, and hysterectomies in a brief but very insightful article.

Ange-Marie Hancock writes a lackluster final chapter ranging from the overly theoretical to a superfluous survey of African women's responses to the feminist anti-FGC movement. Most unforgivably, Hancock claims that only four African countries have outlawed FGC, whereas at least fifteen have done so. Hancock and Nnaemeka were asleep at the wheel on this one.

In the end, *Female Circumcision and the Politics of Knowledge* contains a few valuable nuggets but overall the rewards are too intermittent and the errors too important for the book to merit a wholehearted recommendation. Reader beware!

ARC Letter to AAP

Attorneys for the Rights of the Child
2961 Ashby Ave., Berkeley, CA 94705
Email arc@post.harvard.edu
510-827-5771

Renée Jenkins, M.D., President, AAP
Department of Pediatrics and Child Health, Howard University Hospital
2041 Georgia Ave, NW, Room 6B02
Washington, DC 20060
executivecommittee@aap.org

December 14, 2007

Dear Dr. Jenkins:

We have followed with alarm the attention being given to a handful of flawed randomized controlled trials (RCT's) that purport to show a protective effect against HIV of circumcision of adult males in Africa. We have just learned that Dr. Peter Kilmarx of the Centers for Disease Control and Prevention (CDC) recently gave a presentation titled, "Male Circumcision and HIV Infection" at the National HIV Prevention Conference held in Atlanta, Georgia. We understand that the AAP task force on circumcision has reconvened and a new position statement may be issued at some point.

Recent reports indicate that the United Nations and other influential bodies have significantly exaggerated the number of people affected by HIV and AIDS. Moreover, for well over a decade the number of new individuals being infected with HIV has been in decline. Regardless of whether the RCT's are relevant to adults in Africa, they are completely irrelevant to whether infants should be circumcised in the United States. North America and Africa differ radically in demographics and modalities of infection. Moreover, the circumcision experiment has already been tried and failed, as the US has both the highest circumcision rate and the highest HIV rate in the developed world.

Benefits of neonatal circumcision have not been proven to outweigh risks, despite the suggestion otherwise in Slide 29 of Dr. Kilmarx' presentation. The CDC's own research demonstrates that circumcision does not protect males at high risk of contracting HIV. [1] Throughout the world, professional medical organizations, including the AAP and the American Medical Association, have unanimously failed to find that routine neonatal circumcision is medically justified. As ARC has testified before the United Nations (in a presentation that is now part of the official UN record), neonatal circumcision violates several important human rights requirements under US and international law, including the rights to security of the person, to the highest attainable standard of health, to freedom from discrimination based on sex, and to protection from "all forms of physical or mental violence, injury or abuse…."

South Africa is concerned enough about the impact of such a procedure that it recently passed legislation (effective July 1, 2007) to protect males from any form of genital cutting, including circumcision, that is not medically justified.

We ask that the CDC reserve its significant influence to promote measures of proven, not speculative benefit,

and procedures for which the benefit clearly outweighs the harm. Neither is true of male circumcision, and thus this operation is not appropriate for use in the United States.

Sincerely,

J. Steven Svoboda
Executive Director

Cc: Jay Berkelhamer, MD, FAAP, Past-President, AAP
David T. Tayloe, Jr., MD, President-Elect, AAP
Errol Alden, MD, Executive Director, AAP

[1]Millett G et al. Circumcision Status and HIV Infection Among Black and Latino Men Who Have Sex With Men in 3 US Cities. J Acquir Immune Defic Syndr 2007; 46(5):643-650.

The backlash against circumcision

By Jeninne Lee-St. John
Time Magazine
November 12, 2007
http://www.time.com/time/magazine/article/0,9171,1680141,00.html

Expectant parents have loads of decisions to make, from whether to find out the baby's gender beforehand to planning the birth. But recently some have taken up another debate, over a cut that used to be nearly as routine in the U.S. as that of the umbilical cord: circumcision. When Jessica Davis learned she was having a boy, she and her husband assumed that the baby's foreskin would be removed. But when asked why by her obstetrician, who is originally from South Africa, where circumcision is rare, Davis, 28, a college administrator, did research and decided that the risks trumped the benefits. She left her son Aiden, now 20 months, intact--though she says her spouse remains leery of the decision: "He's kind of like, 'Well, I work just fine.'"

On Davis' side are the small but vocal, and growing, forces against circumcision, so-called intactivists: young parents who don't want to alter their perfect babies, men who feel their circumcisions left them psychically scarred and sexually disadvantaged ("I always felt something was missing, not functioning properly," says David Wilson, whose Stop Infant Circumcision Society marches on Washington annually) and even some medical professionals who consider the procedure genital mutilation.

And at least in some parts of the country, opinion is shifting in their favor. According to the National Health and Social Life Survey, the total proportion of U.S.-born males who were circumcised peaked in 1965 at about 85%, dropping to 77% in 1971, the last year of the study. The National Hospital Discharge Survey, which began tallying newborn circumcisions in 1979, shows a downward trend, from 65% that year to 57% in 2005. Much of the decline is attributed to immigration from Latin America and Asia, where the procedure is rare. Additionally, in more than a dozen states, Medicaid no longer covers the surgery routinely, leaving many poor children without the option. But intactivism is also gaining traction among educated, middle-class whites. As University of Virginia sociologist Brad Wilcox observes, "It's these new parents that are unwilling to let kids suffer."

But circumcision partisans say a foreskin causes suffering too. Intact boys are at greater risk for kidney infection as infants, and for penile cancer, foreskin disorders, HIV and other STDs like human papillomavirus later in life, leaving female partners more likely to get cervical cancer. The cost of prevention, proponents say, is the brief trauma of the procedure. Says Edgar Schoen, former pediatrics chief at Kaiser Permanente, who led the 1989 American Association of Pediatrics circumcision task force, which came out neutral on cutting: "A newborn baby is programmed for stress and recovers quickly." Opponents, on the other hand, say foreskin-related afflictions are rare, condoms block STDs, and circumcision has its risks. Michelle Richardson, of Fort Worth, Texas, says her 5-year-old has two genital disorders due to his botched circumcision.

The debate has even extended to the religious practice of Jews. Instead of opting for a bris, the rite in which a boy's foreskin is removed at 8 days old, Theo Margaritov's family welcomed him in April with a brit shalom, a cut-free ceremony. "That's the way God made him," says his mom Deborah, 33, a raw-foods cooking teacher in Brooklyn, N.Y.

Still, religion and health aren't the only concerns parents weigh when making the decision to cut or not to cut; tradition is also a factor. Liz Arnaiz, 30, a Brooklyn architect whose son Lucas was circumcised when he was born last November, says her husband is circumcised, so it made sense for the boy to be like his dad. Besides, she adds, "to imagine your kid in the locker room the odd man out is tough."

Public hospitals to ban circumcision: Snip 'not worth cost'

By Suellen Hinde and Kelvin Healey
Herald Sun (Melbourne)
August 12, 2007
http://www.news.com.au/heraldsun/story/0,21985,22227225

Circumcision will be banned in Victorian public hospitals unless it is for medical reasons.

The State Government has ordered the ban, which starts next month, following medical advice that circumcision of baby boys was unnecessary.

Health Minister Daniel Andrews said circumcisions would be performed only when doctors were concerned about infection or disease.

"Nationally and overseas, doctors agree there is no medical benefit to routine circumcision, and studies show the complication rate is about 5 per cent," Mr Andrews said.

The $2 million a year saved by the ban will be spent on urgent elective surgery.

"It is important to ensure hospital services are prioritised towards treating patients who have a clinical need for surgery to improve their health," Mr Andrews said.

Ministerial Advisory Committee on Elective Surgery chairman Prof Michael Grigg said it was hard to justify spending taxpayers' money on routine circumcision.

"We should be spending relatively scarce health dollars as effectively as we can to benefit the maximum number of people," he said.

Prof Grigg said circumcision had marginal health benefits for some people, but also had a risk of complication.

About 2200 circumcisions were performed by Victorian public hospitals in the 2005-06 financial year.

Parents who want to have their sons circumcised for religious reasons will have to use a private hospital.

Victoria to scrap public hospital circumcision

The Age, Melbourne
August 13, 2007
http://www.theage.com.au/news/

From next month, Victoria will be the fourth Australian state to no longer provide circumcisions at public hospitals for non-medical reasons.

While recent studies of African countries suggested circumcision can reduce the rates of HIV, a report by the World Health Organisation concluded that in countries such as Australia, where HIV rates are low in the general population, limited benefit would result from routine circumcision, according to the Victorian government.

Doctors back call for circumcision ban

ABC Tasmania
December 9, 2007
http://www.abc.net.au/news/

The Australian Medical Association has backed a call for laws banning the non-essential circumcision of infant boys.

The Tasmanian Children's Commissioner, Paul Mason, says non-medical circumcision is a breach of human rights.

The AMA's Tasmanian President, Haydn Walters, says they would support a ban on the practice, except where there are medical or religious reasons. He says there is only rarely a medical need to carry out the procedure.

"There were quite a lot of folk myths around the advantages of circumcision. They've almost all been debunked," Prof Walters said.

"There are some minimal advantages in some circumstances, particularly in some infectious diseases, but they're overwhelmingly balanced by disadvantages in other areas," he said.

ABC, not circumcision, gives best defense against HIV

By David J. Llewellyn
The New Vision
November 5, 2007
http://www.newvision.co.ug/D/8/459/595670

Dr. Myers Lugemwa is to be congratulated on his insightful article on the attempt to circumcise Uganda by US doctors. It is so obvious that Abstinence, Being Faithful and Condoms (ABC) are the only rational defense against the HIV virus, that it is hard to believe that many in the international health community have bought into the ridiculous "circumcise to prevent HIV" theory.

The best way to prevent sexually-transmitted HIV and all other venereal diseases is by ABC. It is that simple.

It appears that there may be more to the push for circumcision than merely the improvement of public health. Some of those pushing this strategy have their academic reputations and careers on the line. Others have familial traditions that emphasise circumcision. For example, Daniel Halperin, one of the foremost proponents of the "circumcise to prevent HIV" movement, admitted in a newspaper article years ago that his grandfather had been a part-time Jewish ritual circumciser. He has also been quoted as saying that women like circumcised men and that sex is better if you are circumcised — two very subjective statements with which most uncircumcised men and their wives would disagree. Others may feel the need to validate their own circumcised status or academic theories by encouraging others to be circumcised.

Two of the primary authors of the recent randomised controlled trials recently have collaborated with long-time proponents of circumcision on the formulation of a pamphlet encouraging women worldwide to push their husbands to be circumcised and to circumcise their sons. One of those proponents, a circumcised middle-aged Australian, the primary author of the pamphlet, has written that circumcision is "an imperative" for the 21st Century!

David J. Llewellyn
Photo by James Loewen

As the Trojans learned, one should always "beware of Greeks bearing gifts," even if those "Greeks" are Americans. Ugandans should know that one of the early proponents of medicalised circumcision in the US, Peter Remondino, M.D., in the late 19th Century advocated circumcising all black Americans to prevent what he called "the Negro rape crisis."

Modern day Ugandans may wish to consider whether or not the US push to circumcise them has any similar patronising, racist overtones or overtones of colonialism.

We know that the foreskin is an in-

tegral part of the penis. A recent study has shown that it is the most sensitive part of the penis. Earlier unrefuted studies proved that it contains most of the fine touch nerve receptors in the penis. It may well mediate the ejaculatory reflex. It makes intercourse easier and more enjoyable for both the man and the woman. No rational man would give up his foreskin if he realized the sexual consequences. It is immoral and unethical to remove normal, sexually-valuable tissue from an infant or child, male or female, without present medical necessity. Ugandans should think twice about what they would be losing before agreeing to circumcision for themselves or their sons.

That Americans may still circumcise the majority of their sons is not an example to emulate.

As Dr. Lugemwa points out, circumcision began in the US in a vain attempt to prevent masturbation. Of course, it did not work. But Americans became invested with their circumcised penises and it has proven challenging to change their minds. Nevertheless, Ugandans should know that the rate of circumcision in the US has been dropping slowly for the last 30 years as the public has learned of the value of the foreskin. In California and some other western states, the circumcision rate for newborn boys is below 35%.

Ugandans should also know that circumcision did not prevent HIV from wreaking havoc in the US. The US has a much higher rate of HIV infection and a much higher rate of circumcision than does Europe. This puts the lie to the hypothesis that circumcision "prevents" HIV. It is not a "vaccine," although its proponents would like Ugandans to believe that it is. One might reasonably wonder what the real motive is behind those who would try to sell a mutilating surgery to others with such hyperbole.

Ugandans wanting more information about the controversy surrounding male circumcision might wish to consult *www.cirp.org* or *www.doctorsopposingcircumcision.org*.

The writer is an Attorney at Law, Atlanta, Georgia, US.

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Thanks!

Steven Svoboda
Executive Director
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