

Brussels, 27 March 2018
Ref. N°. 1803100

Pingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)

Dear Sir/Madam:

On behalf of the European Jewish Congress (EJC), the representative umbrella organization of European Jewry, we would hereby like to express our concerns with regard to the proposed amendment to the Criminal Code no. 19/1940 seeking to criminalise male circumcision.

Religious circumcision of boys (Brit Milah) at eight days old has been a longstanding practice among Jews for more than 3.000 years, regardless of the particular level of religious observance. It is an essential element to our religion, to our cultural and ethnic identity and to our status as free and equal citizens in democratic countries.

We are concerned that the proposed amendment to the Icelandic criminal code will be a disproportionate limitation of the freedom of thought, conscience and religion of Jews in Iceland, taking into account the fact that there is no evidence that Brit Milah poses adverse effects to the health of young boys to justify criminalising an essential religious and cultural Jewish practice (see Annex 1-3). These restrictions would pose an unbearable burden on Jews in Iceland.

Furthermore, we consider it extremely problematic that the proposed amendment seems to equate male circumcision with female genital mutilation, which in terms of risks to public health are not comparable practices by any objective standards.

We fear that this approach not only muddles the debate around the practice of circumcision and around the issue of proportionality regarding restrictions on religious freedom, but that it also may have the effect of stigmatising Jewish communities.

Recalling Resolution 2076 (2015) of the Parliamentary Assembly of the Council of Europe, states should seek reasonable accommodations with Jews in Iceland with a view to guaranteeing equality that is effective, and not merely formal, in the right to freedom of religion.

Therefore, we strongly encourage you to take these concerns into account and to reject the legislative initiative to criminalise male circumcision.

Yours sincerely,



Dr. Moshe Kantor
President of the European Jewish Congress

Annex

1. American Academy of Pediatrics, Circumcision Policy Statement, 2012.
2. Canadian Pediatric Society, Position Statement, Newborn Male Circumcision, 2015.
3. Brady, M., Newborn Male Circumcision with Parental Consent, as Stated in the AAP Circumcision Policy Statement, Is Both Legal and Ethical, The Journal of Law, Medicine & Ethics, Vol 44, Issue 2, pp. 256 – 262, 2016.



POLICY STATEMENT

Circumcision Policy Statement

TASK FORCE ON CIRCUMCISION

KEY WORDS

male circumcision, penis, prepuce, phimosis, sexually transmitted infections, HIV, urinary tract infection, analgesia, parental decision-making, ethics

ABBREVIATION

AAP—American Academy of Pediatrics

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abstract

FREE

Male circumcision is a common procedure, generally performed during the newborn period in the United States. In 2007, the American Academy of Pediatrics (AAP) formed a multidisciplinary task force of AAP members and other stakeholders to evaluate the recent evidence on male circumcision and update the Academy's 1999 recommendations in this area. 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. The American College of Obstetricians and Gynecologists has endorsed this statement. *Pediatrics* 2012;130:585–586

POLICY STATEMENT

Systematic evaluation of English-language peer-reviewed literature from 1995 through 2010 indicates that preventive health benefits of elective circumcision of male newborns outweigh the risks of the procedure. Benefits include significant reductions in the risk of urinary tract infection in the first year of life and, subsequently, in the risk of heterosexual acquisition of HIV and the transmission of other sexually transmitted infections.

The procedure is well tolerated when performed by trained professionals under sterile conditions with appropriate pain management. Complications are infrequent; most are minor, and severe complications are rare. Male circumcision performed during the newborn period has considerably lower complication rates than when performed later in life.

Although health benefits are not great enough to recommend routine circumcision for all male newborns, the benefits of circumcision are sufficient to justify access to this procedure for families choosing it and to warrant third-party payment for circumcision of male newborns. It is important that clinicians routinely inform parents of the health benefits and risks of male newborn circumcision in an unbiased and accurate manner.

Parents ultimately should decide whether circumcision is in the best interests of their male child. They will need to weigh medical information in the context of their own religious, ethical, and

cultural beliefs and practices. The medical benefits alone may not outweigh these other considerations for individual families.

Findings from the systematic evaluation are available in the accompanying technical report. The American College of Obstetricians and Gynecologists has endorsed this statement.

TASK FORCE ON CIRCUMCISION

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Newborn male circumcision

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Abstract

The circumcision of newborn males in Canada has become a less frequent practice over the past few decades. This change has been significantly influenced by past recommendations from the Canadian Paediatric Society and the American Academy of Pediatrics, who both affirmed that the procedure was not medically indicated. Recent evidence suggesting the potential benefit of circumcision in preventing urinary tract infection and some sexually transmitted infections, including HIV, has prompted the Canadian Paediatric Society to review the current medical literature in this regard. While there may be a benefit for some boys in high-risk populations and circumstances where the procedure could be considered for disease reduction or treatment, the Canadian Paediatric Society does not recommend the routine circumcision of every newborn male.

Key Words: *Circumcision; HIV; HPV; HSV; Infant; STI; UTI*

The cultural and religious ritual of male circumcision has been practiced for thousands of years. Circumcision as a medical procedure arose in Britain and the United States in the late 19th century. The historical medical benefits of neonatal circumcision have included ease of genital hygiene, diminished risk of disease and avoidance of circumcision later in life. In the middle of the last century, most Canadian boys were circumcised. However, the rate of neonatal circumcision has declined over time to the current Canadian average of 32%, with significant regional variability.[1] The Canadian Paediatric Society (CPS) published a position statement in 1996 stating that circumcision was not recommended as a routine procedure for male newborns because the benefits and harms were evenly balanced. A similar viewpoint was expressed by the American Academy of Pediatrics (AAP) in 1999 and reaffirmed in 2005.[2] More recent evidence regarding the beneficial role of male circumcision in preventing urinary tract infection (UTI) in infancy and some sexually transmitted diseases (STIs) in adult life has prompted the CPS to review the current medical information on the circumcision of newborn males. The AAP updated its own policy statement in 2012.[3] The goal of the present statement is to provide guidance to health care providers and up-to-date information for the parents of newborn boys, to enable them to make informed decisions regarding circumcision.

Methods

A Medline search using the MESH heading "circumcision, male" was initially performed, which yielded 1596 articles. These articles were subsequently reviewed, as were their references when appropriate. The focus was on neonatal and infant male circumcision and its outcomes.

The hierarchy of evidence from the Centre for Evidence-Based Medicine was applied, using levels of evidence for therapy and prognosis.[4]

The foreskin and circumcision

In the male newborn, the mucosal surfaces of the inner foreskin and glans penis adhere to one another; the foreskin is not redundant skin. The foreskin gradually separates from the glans during childhood. By six years of age, 50% of boys can retract their foreskins, although the process of separation may not be complete until puberty: 95% of boys have retractile foreskin by 17 years of age.[5] Parents may be reassured by their observation of an unimpaired urinary stream in a boy with a nonretracted foreskin. Until this developmental process is complete, the best descriptor to use is 'nonretractile foreskin' rather than the confusing and perhaps erroneous term 'physiologic phimosis'.

Appropriate care for the uncircumcised penis has been well reviewed[6] and should include anticipatory guidance on hygiene and an understanding of the normal nonretractile foreskin.

Circumcision involves the partial or complete removal of the foreskin (prepuce); a number of methods are used.[6] In Canada, the majority of newborn male circumcisions are performed by medical practitioners and most of the remainder by skilled traditional providers. Whatever method is used, strict adherence to hygienic principles and the use of effective analgesia are essential.

Potential benefits of circumcision

Phimosis treatment

Phimosis is defined as a scarring and thickening of the foreskin that prevents retraction back over the glans.[7] Phimosis may occur secondary to recurrent infections, inflammation or lichen sclerosis. Phimosis needs to be differentiated from the normal nonretractile foreskin.

The foreskin can become inflamed or infected (posthitis), often in association with the glans (balanoposthitis) in 1% to 4% of uncircumcised boys.[8][9] The foreskin can also become entrapped behind the glans (paraphimosis) in 0.5% of cases. Both conditions usually resolve with medical therapy but, if recurrent, can cause phimosis.[7][10] An estimated 0.8% to 1.6% of boys will require circumcision before puberty, most commonly to treat phimosis.[7] The first-line medical treatment of phimosis involves applying a topical steroid twice a day to the foreskin, accompanied by gentle traction. This therapy serves to thin the tissue and release adhesions, allowing the foreskin to become retractable in 80% of treated cases, thus usually avoiding the need for circumcision.[11][12] Topical steroid treatment is also useful to hasten foreskin retraction in boys with nonretractile foreskins.[12] A number of steroid preparations have been used, including betamethasone 0.05% to 0.1%, triamcinolone 0.1% and mometasone furoate 0.1%.

Other dermatoses of the penis can occur in childhood and should be considered if the skin over the penile shaft, foreskin or glans is abnormal.[10][13] Such presentations may necessitate referral to a urologist or dermatologist for diagnosis and treatment, which may include circumcision.

UTI reduction

The preputial sac provides an environment for colonization of the urethra with uropathogenic organisms that can cause UTI in infant boys.[14] UTI occurs in approximately one in 100 boys in the first month of life. A meta-analysis that included one randomized trial and 11 observational studies found that UTI was decreased by 90% in circumcised infants, with a significant OR of 0.13 (95% CI 0.08 to 0.20).[15] In a more recent meta-analysis that included 14 studies, the pooled prevalence of UTI in febrile infants <3 months of age was 7.5% for females, 2.4% for circumcised

males and 20.1% for uncircumcised males. The prevalence rate of UTI in febrile males (circumcised and uncircumcised) decreased to 1.7% by six to 12 months of age, but the 10-fold difference related to circumcision status was maintained. [16] Since the publication of this meta-analysis, a further prospective cohort study, in which a series of urine cultures were obtained in boys up to 15 months of age, also found a lower incidence of UTI in individuals who had undergone newborn circumcision (0% versus 2%, $P < 0.001$). [17] The risk of UTI declines rapidly in males after the first few months of life to an incidence of one in 1000 by one year of age. [16] Using estimates of lifetime risk for male UTI, a recent meta-analysis calculated that, over a lifetime, the RR for UTI was 3.65 for uncircumcised versus circumcised males, with 23% of all UTIs attributed to lack of circumcision. [18] However, this conclusion should be questioned because the adult data were limited to a single study of only 78 men.

It has been estimated that 111 to 125 normal infant boys (for whom the risk of UTI is 1% to 2%) would need to be circumcised at birth to prevent one UTI. [15][16] In boys at higher risk for UTI, such as those with recurrent UTI or an underlying urinary tract anomaly (eg, high-grade vesico-ureteric reflux or obstructive uropathy), circumcision may be of greater benefit. In these cases, it is estimated that only four boys would need to be circumcised to prevent one UTI. [15] However, it should be noted that contaminated urines are more common in uncircumcised males, potentially leading to overdiagnosis of UTI; thus, the number needed to treat may be considerably higher than that found in these studies. Childhood UTI leads to dimercaptosuccinic acid (DMSA)-detectable renal scarring in 15% of cases. [19] Although these scars could theoretically have an impact on long-term renal function and hypertension, there is no evidence for this effect, and most experts believe that UTIs in children with normal kidneys do not result in long-term sequelae.

STI reduction

Observational studies performed in Africa and in developed countries since the emergence of HIV/AIDS have suggested that uncircumcised men are at higher risk for HIV infection. [20][21] The inner surface of the foreskin is rich in Langerhans and other HIV target cells that are exposed to infection during sexual intercourse, which is speculated to be one mechanism leading to HIV acquisition. [22] If true, then removing the foreskin could theoretically have a protective effect against HIV acquisition. Conclusive evidence that circumcision is partially effective in decreasing the risk for heterosexually-acquired HIV infection among men in sub-Saharan Africa has been provided by three large randomized controlled trials involving men and adolescent boys in Uganda, [23] South Africa [24] and Kenya. [25] Compared with uncircumcised controls, there was a decrease in new HIV infection by 50% to 60% in the circumcised male participants. In the Kenyan study, this protective effect was sustained for at least 42 months [25] (Level of Evidence 1). Observational studies undertaken in sub-Saharan Africa have also suggested that there is a similar degree of protection when circumcision is performed in the neonatal period [20][26] (Level of Evidence 4).

It remains unclear, however, whether these conclusions can be applied to populations in developed countries, where the HIV seroprevalence rates are lower and common routes of HIV transmission include injection drug use (IDU) and men who have sex with men (MSM). [27]

The Centers for Disease Control and Prevention (CDC, Georgia, USA) recently published an analysis of the cost-effectiveness of newborn circumcision in reducing the lifetime risk of HIV acquisition in American males, assuming 60% efficacy over a lifetime and a risk of HIV acquisition varying from 0.94% for white males to 6.22% for black males. [28] The CDC estimated that the risk of lifetime acquisition through heterosexual transmission was reduced by 16% overall, ranging from 8% in white males to nearly 21% for black males. The analysis, based on a cost of USD\$257 for the procedure, demonstrated cost savings in both Hispanic and black males. The number needed to treat to prevent one HIV infection varied from 1231 in white males to 65 in black males, with an average in all males of 298. The model did not account for the cost of complications of circumcision. In addition, there is a risk that men may overestimate the protective effect of being circumcised and be less likely to adopt safe sex practices.

In 2011, the Public Health Agency of Canada reported that 46.6% of new cases of HIV in Canada for which an exposure category was reported were attributed to MSM and 13.7% to IDU. [29] The proportion of new cases attributed to heterosexual transmission involving individuals not originally from a country where HIV is endemic was 20.3%, while 16.9% of new cases were in individuals originally from HIV-endemic countries. The report noted that the estimated rate of new infection in the latter group was nine times higher than in the general Canadian population. A disproportionate

number of new cases occurred in Aboriginal people (12.2%), a rate estimated to be 3.5 times higher than in the non-Aboriginal population. IDU was the main reported source of exposure (58.1%), followed by heterosexual exposure (30.2%).^[29]

It is presumed that male circumcision, by reducing the burden of HIV in men, will indirectly protect women. There does not appear to be a significant role in decreasing male-to-female transmission in HIV-discordant couples.^{[30][31]}

Evidence obtained from observational studies that male circumcision can decrease the risk of other STIs has been conflicting. Analysis of data regarding subjects enrolled in the randomized sub-Saharan African studies revealed lower rates of herpes simplex virus-2 (HSV-2) seroconversion (adjusted HR = 0.72) and acquisition of high-risk human papillomavirus (HPV) genotypes (adjusted RR = 0.65) in circumcised men during the two-year follow-up postcircumcision.^[32] The rate of HPV infection was also lower in circumcised men in many other countries (OR = 0.37)^[32] (Level of Evidence 2). Circumcision was not found to be protective against gonorrhoea or chlamydia.^[33] No studies have examined the impact of routine neonatal circumcision on STIs other than HIV.

The female partners of men circumcised in the same African studies had a lower adjusted prevalence rate of 0.52 for *Trichomonas vaginalis* infection, 0.60 for bacterial vaginosis and 0.78 for genital ulcer disease.^[34]

Although circumcision can decrease the risk of acquiring and transmitting STIs, it should be emphasized that other preventative measures, including abstinence, use of condoms and other safe sex practices, must continue to be taught and practiced.

Cancer reduction

Female partners of circumcised men have a reduced cervical cancer risk, with ORs ranging from 0.18 to 1.61 depending on the sexual-behavioural risk level of their partner^[35] (Level of Evidence 3). The incidence of cervical cancer in Canada ranges from nine to 17/100,000.

Penile cancer is rare in developed countries (one in 100,000 men). Squamous cell carcinoma of the penis occurs almost exclusively in uncircumcised men, with phimosis being the strongest associated risk factor (OR 11.4 [95% CI 5.0 to 25.9]).^[36] This finding underscores the importance of genital hygiene and of identifying and treating cases of phimosis and residual nonretractile foreskin in all males.

There is a strong association between HPV infection and penile cancer regardless of circumcision status, with 80% of tumour specimens being HPV DNA-positive.^[37] It is expected that routine HPV vaccination for girls will dramatically decrease the incidence rate of cervical cancer. The benefit may also extend to penile cancer, especially as the program is broadened to include young men.

Potential risks of circumcision

Surgical procedures, including circumcision, are painful. Even with procedural analgesia, individuals experience postprocedural pain that must be treated. Newborns who experience procedural pain have altered response to later vaccinations, with demonstrated higher pain scores.^[38]

Acute complications of neonatal circumcision include minor bleeding, local infection and an unsatisfactory cosmetic result. Severe complications, such as partial amputation of the penis and death from hemorrhage or sepsis, are rare occurrences. A recent meta-analysis reporting on prospective and retrospective studies investigating circumcision found a median complication rate of 1.5% in neonates or infants. When circumcision was performed during childhood, the complication rate increased to 6%, a rate similar to that reported in studies of circumcised adolescents and adults.^[39]

The most common late complication of circumcision is meatal stenosis (2% to 10%), which may require surgical dilation.^[40] This condition can be prevented almost completely by applying petroleum jelly to the glans for up to six months following circumcision.^[41] Partial re-adherence of the penile skin to the glans is not uncommon. Such

adhesions often resolve spontaneously by puberty but, when they are extensive, may also benefit from treatment with a topical steroid preparation. Surgical lysis is rarely required.[42]

The foreskin serves to cover the glans penis and has an abundance of sensory nerves,[5] but medical studies do not support circumcision as having a negative impact on sexual function or satisfaction in males or their partners.[43]-[45] It has been reported that some parents or older boys are not happy with the cosmetic result, but no specific data from the literature to quantify this outcome could be found.

Health care providers should be aware of potential contraindications to neonatal circumcision. Hypospadias requires an assessment by a urologist before circumcision is considered. Any risk of bleeding diathesis requires further investigation and discussion with appropriate professionals and decision makers before proceeding with circumcision.

Ethics and legalities of circumcision

Neonatal circumcision is a contentious issue in Canada. The procedure often raises ethical and legal considerations, in part because it has lifelong consequences and is performed on a child who cannot give consent. Infants need a substitute decision maker – usually their parents – to act in their best interests. Yet the authority of substitute decision makers is not absolute. In most jurisdictions, authority is limited only to interventions deemed to be medically necessary. In cases in which medical necessity is not established or a proposed treatment is based on personal preference, interventions should be deferred until the individual concerned is able to make their own choices.[46]

With newborn circumcision, medical necessity has not been clearly established. However, there are some health benefits, especially in certain populations. Furthermore, performing circumcision in older boys, who are able to provide consent, can also increase risk and costs to the individual.[39] Therefore, some parents view circumcision as being in their child's best interest. A complete discussion of ethical and legal issues associated with newborn male circumcision is beyond the scope of this statement. Readers are referred to the July 2013 issue of the *Journal of Medical Ethics* which is devoted to the topic.[47] Both parents and health care providers should be familiar with the legal issues related to consent.

Summary

Current evidence indicates that there are potential health benefits associated with male circumcision, particularly in high-risk populations. Infant circumcision reduces the incidence of UTI in young boys and eliminates the need for medical circumcision in later childhood to treat recurrent balanoposthitis, paraphimosis and phimosis. Circumcised men have a lower risk of developing penile cancer, while the incidence of trichomonas, bacterial vaginosis and cervical cancer in the female partners of circumcised men is also reduced. Circumcision in adult men can reduce the risk of acquiring an STI (specifically HIV, HSV and HPV). Minor complications of circumcision can occur, although severe complications are rare. The risk of complications is lower in infants than in older children. The complication rate decreases significantly when the procedure is performed by experienced health care professionals, with close follow-up in the days postprocedure to ensure that bleeding does not increase. It is important to remember that most data regarding the benefits and outcomes following circumcision come from countries other than Canada, which can make application to our population difficult.

Because the medical risk:benefit ratio of routine newborn male circumcision is closely balanced when current research is reviewed (Table 1), it is challenging to make definitive recommendations for the entire male newborn population in Canada. For some boys, the likelihood of benefit is higher and circumcision could be considered for disease reduction or treatment. Health care professionals should provide parents with the most up-to-date, unbiased and personalized medical information available so that they can weigh the specific risks and benefits of circumcising their son in the context of familial, religious and cultural beliefs. Having the right information will enable them to make the best decision for their boys. Decision aids based on current medical information can be helpful.

Recommendations

- The CPS does not recommend the routine circumcision of every newborn male.
- Physicians and other health care professionals caring for newborns must stay informed about circumcision and assist parents in understanding potential risks and benefits of the procedure.
- The parents of male newborns must receive the most up-to-date, unbiased and personalized medical information available about neonatal circumcision, so that they can weigh specific risks and benefits of circumcision in the context of their own familial, religious and cultural beliefs.
- Parents who choose to have their sons circumcised should be referred to a practitioner who is trained in the procedure.
- Neonatal male circumcisions must be performed by trained practitioners whose skills are up-to-date and strictly adhere to hygienic and analgesic best practices.
- Close follow-up in the early postcircumcision time period is critical. The parents of circumcised boys must be thoroughly and accurately informed about postprocedural care and possible complications.
- At the time of hospital discharge, health professionals should ensure that the parents of uncircumcised newborn boys know how to appropriately care for their son's penis and are aware that the normal foreskin can remain nonretractile until puberty.
- Quality Canadian data are required to understand the clinical and economic issues involved with neonatal male circumcision, including its potential risks, benefits and costs, in the Canadian context.

TABLE 1

Potential risks and benefits of neonatal circumcision

Outcome	Effect size (reference)
Potential risks	
Minor bleeding	1.5% (combined)
Local infection (minor)	NNH = 67 [39]
Severe infection	Extremely rare
Death from unrecognized bleeding	Extremely rare
Unsatisfactory cosmetic results	
Meatal stenosis	NNH 10–50 (<1% when petroleum jelly is used)
Potential benefits	
Prevention of phimosis	NNT = 67 [7]
Decrease in early UTI	NNT = 111 – 125 [16]
Decrease in UTI in males with risk factors (anomaly or recurrent infection)	NNT = 4 – 6 [15]

Decreased acquisition of HIV	NNT = 298 (65 – 1231 depending on population) [28]
Decreased acquisition of HSV	NNT = 16 [32]
Decreased acquisition of HPV	NNT = 5 [32][35]
Decreased penile cancer risk	NNT = 900 – 322,000 [36][37]
Decreased cervical cancer risk in female partners	NNT = 90 – 140 [35]
<i>HPV Human papillomavirus; HSV Herpes simplex virus; NNH Number needed to harm; NNT Number needed to treat; UTI Urinary tract infection</i>	

Selected resources

- Canadian Paediatric Society. Circumcision of baby boys: Information for parents <www.caringforkids.cps.ca/handouts/circumcision>
- American Academy of Pediatrics. Circumcision <www.healthychildren.org/English/ages-stages/prenatal/decisions-to-make/Pages/Circumcision.aspx>

Acknowledgements

This position statement was reviewed by the Bioethics and Community Paediatrics Committees of the Canadian Paediatric Society.

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Newborn Male Circumcision with Parental Consent, as Stated in the AAP Circumcision Policy Statement, Is Both Legal and Ethical

Michael T. Brady

Circumcision is a surgical procedure that removes the foreskin (prepuce) of the penis. While it is a minor surgical procedure, it has generated considerable controversy. There are zealous proponents and opponents of this medical practice. The medical and lay literature has numerous articles and opinion pieces discussing the risks and benefits of circumcision. Opponents of male circumcision have called it “child abuse”¹ and a “human rights violation,”² while proponents feel that the health benefits derived from removal of the foreskin make circumcision a “biomedical imperative”³ and a “cost effective prevention strategy.”⁴ Given this tremendous dichotomy of opinion and the polarization of opponents and proponents, it is unlikely that any rational discussion will sway those who hold extreme views. For that reason, any decision about the role of newborn male circumcision in the delivery of optimal healthcare to children should not be high jacked by those who have emotional or subjective beliefs about this procedure. Rather, determination about whether newborn male circumcision is an appropriate medical option should be based on non-biased review of the evidence relating to the health risks and health benefits of newborn male circumcision.

Background to American Academy of Pediatrics Task Force on Circumcision

The American Academy of Pediatrics (AAP) has played a major role in defining policies and guidelines that have shaped optimal care for infants, children and adolescents. In 2007, the AAP convened a Task Force on Circumcision to update its recommendations on newborn male circumcision. Prior to 2007, the AAP had written three statements on newborn male circumcision in 1975,⁵ 1989,⁶ and 1999.⁷ The purpose of update in 2007 was in large part to address significant new evidence concerning the beneficial effects of circumcision on preventing the acquisition of HIV and other sexually transmitted infections since publication of the 1999 statement. In addition, the 1999 statement provided a very lukewarm description of the identified health benefits. They were characterized as “potential” health benefits that did not provide immediate benefit to the child who was circumcised. The language in the 1999 statement prompted 18 state Medicaid programs to discontinue reimbursement of newborn male circumcision. For these reasons, the AAP brought together experts in areas that they felt would

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be valuable in developing recommendations that were evidence-based and current. Task Force members included the following areas of expertise: general pediatrics, neonatology, bioethics, infectious diseases, obstetrics, family medicine, epidemiology, urology

Embase for the time period of 1995 through 2010. A total of 1430 articles were identified. Case reports, case series, ecological reviews, opinions and articles with an evidence grade of 5 or higher were not accepted. A total of 1031 articles met prior established criteria and

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and public health. The Task Force participants were chosen based on expertise and not whether they had preconceived opinions on the role of newborn male circumcision in healthcare delivery to children.

Methodology and Questions for Review

Task Force members identified eight questions that were relevant to any determination of recommendations concerning newborn male circumcision. These questions were published in the Technical Report.⁸

1. What is the current epidemiology of male circumcision in the United States?
2. What are the most common procedures and techniques for newborn male circumcision?
3. What best supports the parental decision – making process regarding circumcision?
4. What is the association between male circumcision and both morbidity and sexual function/satisfaction?
5. What is the impact of anesthesia and analgesia?
6. What are common complications and complication rates associated with male circumcision?
7. What workforce issues affect newborn male circumcision?
8. What are the trends in financing and payment for elective newborn male circumcision?

AAP contracted a professional medical librarian to search the medical literature for articles that addressed these questions. The evidence from these articles was graded using the American Heart Association's template for evidence evaluation.⁹ Searches were conducted in Medline, Cochrane Database and

were reviewed by the Task Force. A contracted physician epidemiologist and at least one Task Force member with specific expertise in the area in the article reviewed each of the 1031 articles.

Task Force Recommendations

The following are the recommendations developed by the Task Force following a review of the current evidence concerning newborn male circumcision and were included in the Technical Report:¹⁰

1. Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.
2. Parents are entitled to factually correct, non-biased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
3. Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks, and by ensuring that they understand the elective nature of the procedure.
4. 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.
5. Parents of newborn boys should be instructed in the care of the penis at the time of discharge from the newborn hospital stay,

- regardless of whether the newborn has been circumcised or not.
6. **Elective circumcision should be performed only if the infant's condition is stable and healthy.**
 7. **Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management.**
 8. **Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.**
 9. **Key professional organizations (AAP, AAFP, ACOG, the American Society of Anesthesiologists, the American College of Nurse Midwives, and other midlevel clinicians such as nurse practitioners) should work collaboratively to:**
 - **Develop standards of trainee proficiency in the performance of anesthetic and procedure techniques, including suturing;**
 - **Teach the procedure and analgesic techniques during post-graduate training programs;**
 - **Develop educational materials for clinicians to enhance practitioners' competency in discussing the benefits and risks of circumcision with parents;**
 - **Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.**
 10. **The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.**

It is important to understand what the policy statement recommends and what it does not recommend. The policy statement does not recommend routine newborn male circumcision. The policy statement actually does not recommend circumcision of any child. But it does recommend that frank and non-biased discussions of newborn male circumcision be made between healthcare providers and parents of newborn males. These recommendations were endorsed by the American College of Obstetrics and Gynecology.¹¹

While opponents of circumcision have attacked the AAP Policy Statement and Technical Report, there are a number of recommendations that should not be controversial and should be acceptable to everyone. Recommendations that should not be controversial include: (1) Parents of male newborns should

receive instruction on the care of the penis whether the child is circumcised or uncircumcised; (2) Parents are entitled to factually correct, non-biased information about circumcision; (3) Physicians counseling families about elective newborn male circumcision should provide non-biased information about risks and benefits; (4) Elective circumcision should only be performed if infants condition is stable; and (5) Male circumcision should only be performed by trained and competent practitioners using sterile technique and effective pain management.

Controversial Recommendations

Recommendations that have been considered controversial include: (1) Evaluation of current evidence indicates that health benefits of newborn male circumcision outweigh the risks and benefits of newborn male circumcision justify access to this procedure for those families who choose it; (2) Parents should weigh the health benefits and risks in light of their religious, cultural and personal preferences, as medical benefits alone may not outweigh those other considerations for those individuals families; and (3) Preventive and public health benefits warrant third-party reimbursement for newborn circumcision. These last three recommendations deserve specific attention in order to understand how the Task Force developed them.

Evidence of Benefit

The AAP was not first in stating that the medical benefits of newborn male circumcision outweighed risks. In 2007, the CDC had made this exact same statement.¹² The reason that the AAP and the CDC feel that the health benefits outweigh the risks is because there are clear evidence of significant health benefits, particularly relating to reduction in urinary tract infections,¹³ HIV infection,¹⁴ sexually transmitted infections, specifically HPV, HSV and syphilis,¹⁵ penile cancer,¹⁶ phimosis, paraphimosis and balanitis in young males¹⁷ and lichen sclerosis.¹⁸ In addition, female partners of individuals who are circumcised are less likely to be infected with HPV, to develop cervical cancer¹⁹ and to develop bacterial vaginosis.²⁰ The evidence to support these health benefits is clear and supported by multiple well designed studies. These health benefits are irrefutable.

The greatest impact on reduction of urinary tract infections occurs in the first year of life.²¹ Circumcised infants in the first year of life have nearly a ten-fold decreased risk of urinary tract infection as compared to non-circumcised males. While the difference in risk of acquiring a urinary tract infection between circumcised and non-circumcised males declines with increasing age, the benefit remains for life. Children

between the ages of one and 16 years and greater than 16 years who have been circumcised have 6.6 and 3.4-fold less risk of a urinary tract infection, respectively.²² Circumcision is also protective against positive urine cultures and urinary tract infections in all ages of children with vesicoureteral reflux.²³

One of the most compelling health benefits documented by circumcision has been the reduction in acquisition of HIV infection in heterosexual circumcised males. This evidence comes from three randomized controlled trials that were performed in Africa.²⁴ Opponents of circumcision state these studies were not valid because they were performed on a population that is dissimilar to the population in the United States. It is true that the prevalence of HIV-infection in the three African countries where the studies were conducted is significantly higher than in the United States. In addition, the predominant mode of acquisition by males in these African countries is different than in the US. In Africa, most acquisition of HIV infections in males is through heterosexual activity; where as in the United States it is more commonly acquired in men who have sex with men. Since the beginning of the HIV pandemic, there were numerous epidemiologic studies from the United States that identified circumcision as one of the factors associated with reduced acquisition of HIV infection in heterosexual males.²⁵ The three randomly controlled studies in Africa provided a proof-of-principle, i.e. these three studies clearly defined the role of circumcision in the reduction of HIV acquisition in heterosexual males. In order to assess the relevance of the African studies to a United States population, the Centers for Disease Control and Prevention (CDC) performed a modeling study looking at the efficacy and cost-effectiveness of newborn male circumcision in a population in the United States with a lower prevalence of HIV and with a lower proportion of males acquiring HIV infection through the heterosexual route.²⁶ While the impact of newborn male circumcision would be less in the United States than it would be in Africa, the modeling study was able to show that if all of the infants in the US who are currently not circumcised were circumcised there would be a significant reduction in HIV infections despite the differences in the US population and those in the African studies.²⁷ In this model, they were able to project a 15.7% reduction in lifetime risk of acquiring HIV by all males.²⁸ In addition, there would be a medical cost savings for all males, for African-American males, and for Hispanic males.²⁹ For white males, it would be cost-effective.³⁰ These cost savings did not take into account the impact and costs of transmission of HIV to female partners. Nor did this model take into account the costs of reducing

other conditions reduced in circumcised males such as other sexually transmitted infections, urinary tract infections, penile cancer, phimosis, etc. A separate cost-effectiveness study that did include these other health benefits suggested that if the rate of newborn male circumcision in the United States was reduced to the rates seen in Western Europe it would add approximately \$505 million to our healthcare costs each year.³¹ Another study that looked at the impact of South Carolina Medicaid discontinuing to reimburse elective newborn male circumcision determined that for every year of decreased circumcision rates due to Medicaid defunding, there would be approximately 100 additional HIV-infection cases and an additional \$30 million worth of net medical costs in this population.³²

Complications and Risks

Circumcision is a surgical procedure that does have some risks in both the immediate post-surgical period, as well as later. Complications seen in industrialized nations such as the United States and the United Kingdom occur in about 1 in 500 or more infants who are circumcised in the newborn period.³³ The most common complication is bleeding. This occurs more commonly in children who have an underlying bleeding disorder. In more than 60% of children who have bleeding following circumcision, the bleeding can be stopped just by applying pressure. Approximately 40% will need a suture to be placed to stop the bleeding.³⁴ The second most common complication is infection.³⁵ Fortunately, the vast majority of the infections are local and most can be managed by topically applied antibiotics. Penile injury in the immediate period after circumcision can include removal of too much or too little foreskin or by surgically damaging the glans. Fortunately, penile injury is very uncommon. In longer-term studies, penile medical conditions actually occur twice as frequently in uncircumcised males than in circumcised males. Late complications are typically adhesions, meatal stenosis or an unsatisfactory cosmetic result. The risks of complications are higher when the circumcision is performed outside of an accredited medical facility, performed by an inadequate trained practitioner, performed without using sterile technique, performed on an infant who is not medially stable, performed on a premature infant or performed on an infant with a family history of a bleeding diathesis.

Impact on Sexual Health

There has been much said by the opponents of circumcision about the impact of circumcision on sexual function, sensitivity and sexual satisfaction. The litera-

ture contains numerous studies assessing sexual function and satisfaction. Unfortunately, most of the studies are extremely poor due to sampling bias or poor study design. Findings from these numerous studies reveal that circumcision results in: (1) Improved sexual satisfaction and sensitivity; (2) Diminished sexual function, satisfaction and sensitivity and (3) No change in sexual function, satisfaction and sensitivity. The limited number of reasonably designed studies with the greatest evidence suggests that circumcision does not have any significant impact on satisfaction of either the male who was circumcised or their partner. There are two randomly controlled trials that support

US teens.³⁹ Forty-seven percent of twelfth grade students have acknowledged having sexual intercourse; 24% have had more than 4 different sexual partners. In addition, complication rates and costs are significantly higher for circumcisions performed outside of the newborn period.⁴⁰

Conclusions

The AAP and its Task Force on Circumcision felt that it would be ethical for parents to make a medical decision that they felt was in the best interest of their child. The best interest of their child would be informed by their parents' experience, culture, and by evidence and information presented to them by medical providers. Since there is strong evidence to support that health benefits of a newborn male circumcision outweigh the risks, it would be ethical if a parent decided to accept the risks because they are interested in allowing their child to benefit from the reduction in urinary tract infections, sexually transmitted infections, HIV-infection, penile cancer, and other penile disorders. There are some cultures and/or religions that either support or do not support newborn male circumcision. The AAP and its Task Force felt that parents could, in addition to non-biased medical evidence, use these values to assist them in making the decision about what is in the best interest of their child.

The AAP and its Task Force felt comfortable in its recommendations because there were some concerns that not providing parents with appropriate information concerning health benefits of circumcision would actually be unethical. So the question is would it be ethical to withhold evidence from parents relating to the health benefits and risks of newborn male circumcision. Opponents of circumcision would like parents to only know their side of the story.

Would it be ethical to prohibit parents from making a decision that they believe is in the best interest of their child if the evidence supports that health benefits outweigh the risks? Again, the opponents feel that this decision should not be left up to the parents. However, clearly parents consistently make decisions for their children based on what they believe are in the best interest of their child.

Would it be ethical to deny access to preventive health measures based on the source of health care payment? If a parent feels that their child's health would benefit by a medical procedure, the American Academy of Pediatrics and the Task Force did not believe that this healthcare decision should be denied to those individuals who could not afford to pay for it

Opponents of circumcision recommend that any decision about male circumcision be deferred until age 18 years. This deferral would allow the male to participate in the decision making process. However, many of the health benefits that can be achieved by circumcision are lost if the procedure is deferred to age 18 years.

this evidence.³⁶ Another well-designed study sampling men who have and have not been circumcised performed in a random fashion found no evidence of impact of circumcision on sexual health.³⁷

Two recent systemic reviews/meta-analyses concludes that medical male circumcision has no adverse effect on sexual function, sensitivity, sexual sensation no sexual satisfaction.³⁹ Circumcision removes highly innervated erogenous tissue. However, the evidence in circumcised males suggests that residual highly innervated erogenous tissue can accommodate to maintain the expected function, sensitivity and satisfaction.

Optimal Age for Male Circumcision

Opponents of circumcision recommend that any decision about male circumcision be deferred until age 18 years. This deferral would allow the male to participate in the decision making process. However, many of the health benefits that can be achieved by circumcision are lost if the procedure is deferred to age 18 years. As stated earlier, the potential to reduce urinary tract infections is greatest prior to age 18 years. The impact of reducing acquisition and/or transmission of HIV and other sexually transmitted infections is diminished by the high frequency of sexually activity and acquisition of sexually transmitted infections by

on their own. For that reason we feel that third party payers including Medicaid should reimburse for newborn male circumcision. Cost should not be a factor in whether or not parents make their decision to circumcise or not circumcise their child.

At the present time, there is no jurisdiction in the United States that makes newborn male circumcision with parental consent illegal. While there have been attempts to create such legislation, they have failed to date. Given the clear evidence of health benefit, and a benefit that outweighs the risks, and the fact that some religions include circumcision as one of their traditional rites, it is unlikely that legislation to ban circumcision would be passed or upheld as constitutional in the United States.

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