Been There, Done That:

Thoughts on the proposition that yet more circumcision can save the world from AIDS

By Robert Darby

Where a supposition is so contrary to
common sense, any positive evidence of it
ought never to be regarded. Men run with
great avidity to give their evidence in
favour of what flatters their passions and
their national prejudices.
—David Hume

For every problem there is a neat simple
solution, and it is always wrong.
—H.L. Mencken

In ancient times, when doctors were priests, they responded to problems they could not solve by sacrificing something valuable to appease the angry gods. The concept of a propitiatory sacrifice to ward off or achieve recovery from illness was common among pre-scientific peoples. In Homer's *Iliad*, when plague strikes their camp the Greeks learn that the only way to halt it is by returning the beautiful Chyseis to her father and sacrificing one hundred bulls to Apollo. At the height of the Black Death in fourteenth century Germany many people took up vigorous self-flagellation; and when that failed they started murdering Jews, whose relative resistance to the plague (the result of being quarantined in ghettos) was sufficient evidence of their responsibility for its spread.

There are signs that this ethos is not entirely dead. When AIDS appeared in the USA, there were demands for further persecution of homosexuals on the opposite principal that they were the main victims. It seemed proof that they were spreading the disease through their unmentionable sexual practices. AIDS came as a godsend to long-time enthusiasts for mass circumcision, who instantly pushed their favourite surgery as the panacea,[1] a claim requiring some gall in view of the fact that the USA then had not only the highest incidence of AIDS cases, but also the highest proportion of circumcised, sexually active men in the industrial world.

The scare over HIV-AIDS is the main reason why circumcision is on the rise today, even in parts of the world where it had never

been thought of. Advocates of the operation are making strident and widely reported claims that the destruction of supposedly vulnerable genital tissue provides significant protection against the deadly virus, and some people are frightened enough by the spectre of this terrible disease to be willing to try anything: doing something, no matter how harmful, immoral, or ineffective, seems to be better than doing nothing. But in their eagerness to take some action, some medical researchers seem to be treading the same dead-end beaten by nineteenth century physicians who claimed that universal male circumcision was the only way to defeat syphilis, then an equally fearsome and incurable disease. In this article I suggest that it would be a pity to repeat the mistakes of the past.

In the industrial world:

Lies, damned lies and statistics

Whatever the situation in Africa, a glance at the incidence of HIV infection and circumcision in selected western countries suggests that there is no correlation at all between having a foreskin and greater susceptibility to HIV-AIDS. On the contrary, the country with one of the highest proportions of circumcised males (the USA with 75 percent) also has the second highest rate of HIV infection (61 cases per 100,000). The countries with the lowest incidence of HIV infection are Finland and Japan, which also have the world's lowest proportion of circumcised males. In between, patterns are hard to find. Israel, with 95 percent of the population circumcised, has a similar rate of HIV infection to Norway, where not more than 2 or 3 percent of the population is circumcised.

In other countries with low rates of circumcision the incidence of HIV infection varies widely, and it is impossible to offer explanations without knowing the proportions represented by homosexual men, heterosexual men and women, intravenous drug users and others. At first sight the rate seems to be higher in predominantly Catholic countries (Spain, Italy, France, Austria) than in northern Europe (Britain, Germany, Scandinavia), suggesting that opposition to the use of condoms by the Catholic Church could be a more relevant factor than the prepuce. Ireland and Switzerland are surprising departures from this pattern. Other important reasons may be the speed with which governments took action (since delay gives the virus a head start), inadequate resources devoted to safe sex education and other local factors.

Australia has a fairly high (though rapidly falling) proportion of circumcised, sexually active males, but a very low incidence of HIV infection. This is almost certainly a result of the rapidity with which Australian health authorities acted when the danger first became apparent in the 1980s, and it indicates the great success of the consultative approach, the safe sex education campaign and extensive use of condoms. This triumph of good sense and rational science has received international acclaim, yet it has been won in the teeth of continued sabotage attempts by assorted clerical reactionaries who seem to think that using a condom er person with a fatal and incurable disease.

In South America, where circumcision is very rare and the number of male foreskins is much the same in all countries, the incidence of HIV infection varies from 10 per 100,000 in Bolivia to 301 in Guyana: a thirty-fold difference which in itself emphasizes the irrelevance of the foreskin in disease transmission. Figures from Asia show that puritanical Muslim societies with a very high rate of circumcision, such as Bahrain, Kuwait, and the United Arab Emirates, have much the same rate of HIV infection as a liberal society like

Australia, while an authoritarian regime like Malaysia must confess an incidence nearly three times greater. The high rate of HIV infection in Thailand (most males not circumcised) is most probably a consequence of widespread sex tourism.

The most important point to note is that the main reasons for the spread of AIDS are social and cultural, not anatomical or physiological[2]–which is why the resources devoted to laboratory examination of foreskins, revelations about the disturbing qualities of Langerhans cells and all of the rest of it are only marginally relevant to the real problem and a distraction from effective action. These may be physiological facts, but the human genitals must be accepted as nature made them, not as they might have been designed by a committee of medical experts. Micro-organisms have many cunning ways of getting into the body, but the idea of stopping them by amputating all the possible entry points belong not to the world of ethical medicine, but of Dr Frankenstein.

The strategy followed in places like Germany, Britain, New Zealand and Australia has worked, and did not involve waging war on the male genitals. The lack of correlation between high proportion of males circumcised and a low rate of HIV infection, and vice versa, suggests that mass destruction of foreskins will not be effective as a public health measure. Instead of attacking a natural part of the human body, campaigners for AIDS control would be better advised to direct their impressive polemical talents toward safe sex education and against the opponents of condom use.

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Country	Estimated proportion of adult male population (15-49) circumcised (%)	HIV prevalence, adult population (M & E, 15-49), cases per 100,000
INDUSTRIALISED WORLD		
Australia	**55**	**15**
Austria	**<5**	**23**
Belgium	**<5**	**15**
Canada	**45**	**30**
Czech Republic	**<5**	**4**
Denmark	**<5**	**17**
Finland	**<2**	**5**
France	**10**	**44**
Germany	**<5**	**10**
Ireland	**<10**	**10**
Israel	**95**	**8**
Italy	**<5**	**10**
Japan	**<2**	**2**
Netherlands	**<5**	**10**
New Zealand	**45**	**6**
Norway	**2**	**7**
Portugal	**>5**	**74**
Slovakia	**<5**	**1**
Spain	**10**	**58**
Sweden	**<2**	**8**
Switzerland	**<5**	**46**
United Kingdom	**15**	**11**
United States	**75**	**61**
DEVELOPING WORLD: SUB-SAHARAN AFRICA	**65**	**857**
Botswana	**50**	**3580**
Guinea	**?**	**154**
Kenya	**65**	**1395**
Madagascar	**?**	**15**
Nigeria	**70**	**506**
South Africa	**70**	**1994**
Tanzania	**65**	**809**
DEVELOPING WORLD		
OTHER		

Bahrain	**90**	**15**
China	**<5**	**7**
Kuwait	**90**	**12**
Malayasia	**75**	**42**
Mauritius	**10**	**8**
Sudan	**70**	**99**
Thailand	**<10**	**215**
United Arab Emirates	**90**	**18**

Source:UNAIDS data for 2000 - www.unaids.org/epidemic_update/report. (From this page you can read country-specific data as a web page or download it as an Excel file.) No official statistics on circumcision are published; my estimates here are approximate.

In the Third World

Voodoo science and medical imperialism

It is a different story in Africa, where the AIDS crisis is fuelling an international push for universal circumcision as preventive health strategy. The leaders of this campaign include a formidable array of US and Canadian professors, supported by an Australian veterinary scientist and expert in reproductive physiology (Dr Roger Short)[3] and a recent medical graduate (Dr Robert Szabo). Professor Short made a big splash in a TV documentary last year, urging widespread infant circumcision as an essential part of any strategy to control AIDS. He claims to have evidence that non-circumcising African tribes have a rate of HIV infection two to eight times greater than tribes which cut it off.[4]

There are many difficulties with this sort of statistical analysis: as every schoolchild knows, correlation is not causation. One problem is the complexity of Africa social life. Circumcision is a cultural tradition, performed by most Muslims and about half the non-Muslim tribes, each of which has its own cultural/religious practices and different standards of sexual behaviour. Without far more detailed research than has been done there is no way of knowing whether a lower rate of HIV infection is the result of behavioural rather than anatomical differences, or of other factors that ignorant westerners have never thought about.

Another problem is that Africa already has a very high incidence of circumcision. Out of a total population of 767 million, about 311 million are Muslims, most of whom are probably circumcised as a religious rule. Of the remaining 456 million it is estimated that about two thirds of the population is already circumcised. The incidence of HIV infection in sub-Saharan Africa varies so enormously among countries – from 3580 and 2525 per 100,000 in Botswana and Swaziland down to 51 in Equatorial Guinea and 15 in Madagascar – that it would be very surprising if the number of male foreskins in the various regions turned out to be the decisive factor. South Africa, with more than two thirds of the nation circumcised has an HIV infection rate of nearly 20 percent. If circumcision were such an effective tactic against HIV infection you would expect the AIDS crisis to be far less severe than it is, and it seems unlikely that circumcising the remaining third will make much difference.[5]

Why don't we learn from history?

In the nineteenth century English doctors keen to introduce circumcision assured people that it protected against syphilis – then as incurable and even less treatable than AIDS is now. Instead of innocent Africans they used innocent Jews to prove their case, claiming that Jewish

men were highly resistant to syphilis (if not immune) because their foreskins had been removed. A London physician named Jonathan Hutchinson recorded the incidence of venereal cases among his Jewish and non-Jewish patients during 1854 and came up with the following table:

	Venereal	Gonorhoea	Syphilis
Non-Jews	272	107 (39.3%)	165 (60.6%)
Jews	58	47 (81%)	11 (19%)

On the basis of these figures he claimed he had demonstrated a conclusion "long entertained by many surgeons of experience": that the "circumcised Jew is … very much less liable to contract syphilis than an uncircumcised person", and the reason was obvious: circumcision rendered the "delicate mucous membrane of the glans hard and skin-like". Hutchinson provided no elaboration of his reasoning as to why a damaged ("hard and skin-like") glans should provide this protection, nor what non-injurious alternatives might be recommended if it really did, but he showed no reticence at all when it came to the clinical implications, and urged the speedy adoption of routine infant circumcision.[6]

It was a flimsy foundation on which to erect such an ambitious therapeutic edifice. All his observations showed is that, while non-Jewish venereal cases had more syphilis, than gonorrhoea (60.6 to 39.3 per cent), Jewish case had more gonorrhoea than syphilis (81 to 19 percent). Although Hutchinson insisted that the high level of gonorrhoea among the Jews proved that less promiscuity could not have been the reason for the difference, the statistics revealed nothing about the relative susceptibility of cut and normal men to venereal infection, and could as well been cited to show that circumcision increased the likelihood of getting gonorrhoea. If you compare these figures with the Jewish population of London at that time, you actually find that Jews had a higher rate of syphilis than others.

Myths of syphilis

This did not stop doctors from claiming that circumcision could provide immunity to syphilis. For the next century Hutchinson's dubious figures were regarded as the "hard data" needed to prove the health-giving value of preemptive foreskin amputation. In 1900 E. Harding Freeland cited them to prove that "circumcision of every male in infancy" would reduce the incidence of syphilis by 49 per cent.[7] In 1914 Abraham Wolbarst relied on them to support his clarion call for "Universal circumcision as a sanitary measure".[9] As late as 1947 *Newsweek* praised Hutchinson as the first to discover that "syphilis and gonorrhoea were uncommon among Jewish people" and asserted that circumcised men are not likely to contract venereal disease".[9] The myth had become a media truth.

Gradually it was realized that any lower incidence of VD among Jews was the result of cultural and lifestyle factors: the quarantine effect of segregation and a low level of promiscuity and other sexual adventurism. It was also realised (as even Hutchinson had admitted) that the operation, in the days before aseptic surgery, actually infected many babies and children with syphilis, tuberculosis and other diseases, not to mention ordinary gangrene.[10] Circumcision played no role in the eventual conquest of syphilis, which was controlled by the growing use of condom, Metchnikoff's ointment and Salvarsan, and defeated in the 1940's by penicillin.[11] (See appendix.)

The story with AIDS is not likely to be much different. Where it has been controlled, as in Australia, success has been the result of a non-moralistic sex education campaign, and promotion of safe sex and condom use. Little

else can be done until a vaccine is developed. The problem here is that some medical researchers don't like a non-medical approach to disease control because it appears to devalue their expertise; they want a medical and ideally a surgical response in which they, not soft-hearted social works, can play a heroic role.

Female circumcision complicates picture

The possibility of a simple link between circumcision and vulnerability to HIV infection is made more remote by the fact that many of the African cultures which practise male circumcision also practise various forms of female genital mutilation (FGM). This may include excision of the clitoral hood (i.e. prepuce), clitoris, labia minora (or more), and sometimes sewing up the vaginal orifice. How can western researchers know that the reportedly lower incidence of HIV infection among circumcising populations is not the result, or much of the result, of circumcising girls? If, as Szabo and Short assert, the genital mucosa (specialised dermis, especially on the inner foreskin and glans) is the Trojan horse, why wouldn't the mucosa of the clitoral hood, clitoris and labia, not to mention lips, vagina, urethra, and anus, be just as treacherous? And their amputation just as protective?

It would be difficult to amputate the lips and anus, but if it were shown that excision of the clitoral hood or labia made women two to eight times less likely to contract HIV, would Dr Short and others advocate the universal circumcision of girls? When Daniel Hrdy investigated cultural factors in HIV infection, he sought evidence that female circumcision was spreading AIDS, but he actually came up with evidence that HIV was lower in areas with a high incidence of FGM; despite this, he did not conclude that circumcision of girls should be an important part of an AIDS control program.[12] In 1909 a British doctor with the Natal Railways investigated a common disease (then known as bilharzia, now schistosomiasis) caused by a parasitic trematode worm, against which he decided that circumcision would be the perfect strategy. After proving to his satisfaction that the parasite entered the body through the urethra and that its entry was greatly assisted by the non-retracted foreskin of boys bathing in rivers, he proposed that circumcision should be "enforced" in areas where schistosoma were prevalent. He noted that girls also get infected and speculated that their labia probably played the same facilitating role as the boys' prepuce, but he did not suggest that they too should be subject to genital excisons; in their case, vigorous towelling after bathing should be sufficient.[13]

The limits of scientific neutrality

This double standard on the integrity of male and female genitals is where the researchers claim to scientific objectivity breaks down and a cultural bias asserts itself. The west has no tradition of circumcising women, which most westerners regard with horror as an unacceptable mutilation, whether it offered health benefits or not. Experts like Dr Short are not interested in amputating parts of the female genitals, so it would never occur to them to even research the question. It was a different story in the mid-nineteenth century when clitoridectomy was regarded as a legitimate treatment for epilepsy, hysteria and other "nervous" complaints,[14] and it is a different story today in the Islamic and other traditional cultures which practice female circumcision. Its defenders parrot outdated claims about the value of male circumcision, but they also insist on the many benefits from the procedure for women, including improved hygiene and

reduced susceptibility to STDs, genital warts and AIDS.

An Egyptian cleric who fought a government ban on female circumcision in 1997 not only thanked God for preserving a religious tradition handed down by mothers and grandmothers for fourteen centuries, but stated that the operation protected the nation from AIDS by reducing promiscuity.[16] In explaining the link between circumcision and AIDS by reducing promiscuity in behavioural rather than anatomical terms, the priest showed a better understanding of the epidemiology of STDs than some medical researchers. Widespread (hetero)sexual promiscuity, especially with prostitutes and without condoms, in conditions of poverty, malnutrition and unsanitary living conditions, is the main reason for the African AIDS crisis.

Confused messages from the experts

Africans must be getting very confused by the contradictory messages they are receiving from western health experts. One group tells them they must stop circumcising women to improve their health; another group tell them they must circumcise more boys. Either argument might be valid, but it is unlikely that both could be right at the same time. For the reasons mentioned above, reduction of female genital mucosa is likely to be just as effective in combatting AIDS as reduction of male genital mucosa. This would be culturally and ethically acceptable in Egypt, Somalia, and Nigeria, but not to western aid agencies or anyone with a genuine regard for human rights. But why should the human rights of women be different from those of men?

Opponents of female circumcision correctly point out that it is harmful as well as cruel and probably spreads AIDS, either by the operation itself (dirty hands, knives, razor blades etc) or because the scars from the operation bleed during intercourse. But these comments are just as applicable to the circumcision of boys. As the *New York Times* pointed out last year, "In a country where … 1 in 10 are HIV positive even many boys who emerge seemingly unscathed from ritual circumcision face the risk of surgeons' use of unsterilized scapels or spears".[17] It is equally true that circumcision scars on the penis can bleed during sex, and it is not unusual for boys who have been cut tightly to suffer splits and tears in the remaining skin when they have erections.

Circumcision also kills African boys

Circumcision, often carried out in unhygienic settings as part of ritual initiation ordeals, is itself a significant cause of death among African boys. According to recent reports:

- Boy bleeds to death after ritual circumcision in South Africa (African News Service, 26 June 2001)
- Death toll for Northern Provinces initiations reaches eight (http://allafricacom.stories, 12 July 2001
  - — At least 35 South African boys die from circumcision injuries, and many more hospitalised with "horribly injured genitals" (*New York Times*, 6 August 2001, p.A6).
  - — 25 boys admitted to hospital with gangrenous penises following circumcision (South African Press Association, 22 December 2001)
  - — 7 boys die after circumcision in Kenya, and "it is feared the total could be as high as ten" (*The Nation* (Nairobi), 27 December 2001).

These reports may only be the tip of the iceberg. Stopping the circumcision of African boys would save more lives than encouraging the practice.

Real causes hard to isolate:

Infant mortality in nineteenth century Britain

It is always difficult to establish causality in complex multi-causal situations and very easy for interested parties, with their own prior agenda, to assume that their particular barrow is the key to the problem. A good example is infant mortality in nineteenth century Britain, which decreased very little as the century advanced, even though adult mortality fell steadily from the 1870s. Several doctors and health officials who happened to believe that women's place was in the home noticed that infant mortality was particularly high in many places where there was also a high incidence of women working, and they instantly concluded that the problem was maternal neglect. They pressured parliament on this issue, and in 1891 it passed a law restricting employment opportunities for nursing mothers. It was not rigorously enforced and would have made no difference even if it had been. The largest single cause of infant deaths at that time were diarrhoea-related diseases, which were caught from contaminated food, water, utensils, toys and all of the other things babies were always picking up and putting in their mouths. The areas with the highest incidence of working mothers were also the poorest areas and consequently the ones with the worst hygiene (dirty and overcrowded living conditions, contaminated food and water, lack of sewerage etc), thus offering the most opportunity for contracting the viruses and bacteria, as the babies rolled around on the dirty floors.[18]

The decline of disease-related mortality owed little (with one exception) to the discoveries of medical science, but much to the discoveries of sanitary reformers and engineers. English life expectancy increased from 30 to 40 years between the 1730s and the 1820s (despite nobody being circumcised); stagnated from the 1820s to the 1870s as deaths from typhoid, cholera, typhus, tuberculosis and other airborne infections rose during a period of rapid urbanization; and increased again to 48 years between the 1870s and 1900 as sanitary engineers cleaned up the cities, reduced overcrowding, laid on uncontaminated water, regulated the food supply and installed hygienic waste (especially sewerage) disposal systems. The fall in infant mortality came later because it took longer to ensure a clean food supply and to clean up the squalid conditions in working class homes than it did to provide pure water and effective drains in middle class areas.[19]

The second period is similar to the phase through which Third World countries are passing at the moment. Modernisation means rapid population growth and migrations, increased social and geographic mobility, more communication with the outside world, the breakdown of traditional family patterns, and a similar set of problems from rapid urbanization. As with AIDS in Africa the most important factor in the high rate of infant mortality in Britain was poverty, and after that lack of clean water and ignorance of elementary hygiene. Because western medical experts can't do much about these problems, some of them want to attack Third World penises, the only thing many Africans can call their own.

The one disease which nineteenth century medicine was able to conquer, thanks to Edward Jenner's discovery of a reasonably safe method of vaccination, was smallpox. Advocates of circumcision as a preventive measure against HIV are fond of likening their operation to vaccination, forgetting both that a scratch on the arm is not the same thing as amputation of a large part of the penis and even if it did reduce risk, it does not confer anything like immunity. In the 1890s Dr. P.C. Remondino used the example of smallpox to assert that circumcision provided an equal measure

of protection against tuberculosis;[20] if that was quackery, so is the claim that it can do the same for HIV infection. The more sinister point of the analogy of circumcision with vaccination is to insinuate that it should be made mandatory a public health measure, but the belief that circumcision will immunize a man against HIV infection is just as irrational as the common African superstition that he could cure himself of AIDS (or syphilis, as was believed by many eighteenth century Englishmen) by having sex with a virgin. The practical enforcement of these convictions is equally harmful and immoral.

Why not put more effort into safe sex education?

In countries where AIDS has been controlled (Australia, New Zealand, Germany, Britain), success has been the result of safe sex education and widespread use of condoms. This is appreciated by the UNAIDS organization, whole exports to the Barcelona conference last July called for an expanded effort to combat AIDS involving proven methods, focusing on safe sex education and the promotion of genital equality and human rights. Twelve preventive interventions listed included school- and workplace-based education, provision of condoms, outreach programs for sex workers and voluntary counselling and testing. There is not a word about circumcision.[21] Nor has the Royal Australasian College of Physicians been convinced. Its recent statement on routine male circumcision states that the evidence for circumcision providing HIV is inconclusive, but that even if it did there would be no reason to circumcise boys in countries like Australia. It reaffirms its long-standing opposition to the practice.[22] Dr. Short himself seems to be losing interest in the amputation of foreskins: his latest tactic against AIDS is to squirt the vagina with lemon juice (which apparently has powerful anti-viral properties) after intercourse. This is pretty much the principle on which Metchnikoff's ointment worked against syphilis; although the approach was less successful than it might have been because many people did not have the presence of mind to do what had to be done in time, it seems a simple, cheap and benign intervention to which only fanatical citrophobes could object.

Boys' foreskins easier target than opponents of condom use

In focusing on anatomical alternations rather than on education, advocates of mass "preventive" circumcision seem to be saying that in Third World countries a boy's foreskin is a softer target that opponents of safe sex education: traditional tribal custom and male preference, the hostile attitude of many African leaders until very recently, and the policy of the Catholic Church have all made it more difficult to use condoms. HIV could be brought under control of they were more widely used, especially with prostitutes, but it seems much harder to make adult men use condoms than to force babies and little boys to suffer having part of their penis cut off.

Setting aside the issue of medical ethics and civil rights (amputations performed on non-consenting children showing no signs of injury or disease), what about efficiency and effectiveness? Ensuring that all circumcisions were carried out in accordance with the rules of modern surgery (asepsis, anaesthesia, after care etc) would probably be harder and more expensive than educating men to adopt safe sex practices. If a 15-year old boy were shown a condom and a gomco clamp[23] there would not be much doubt which he would choose. Whatever he decided, giving him the right to choose is the ethical approach.[24]

Puritanical moral agenda

In targeting the foreskin rather than promoting education, circumcision enthusiasts (and more recently Dr. Castelsaque's team),[25] do seem to have an agenda to promote circumcision as an alternative to naughty condoms and the sexual promiscuity inevitably associated with them. That Christian churches in the Philippines have tolerated (and even condoned the Islamic-derived custom by which mobs of older males forcibly circumcise boys in the street suggests that they have no dogmatic doctrinal objection to bodily mutilation, despite the opinion of Thomas Aquinas and the decision of the Council of Florence. Non-procreative sex, however, especially if it involves devices associated with contraception, seems to be a different matter.

Despite the pleas of some bishops to relax the ban on condoms (notably Kevin Dowling, Bishop of Rustenburg), the Catholic Church in southern Africa condemns the use as "immoral and misguided" and actually claims that condoms "fuel the AIDS epidemic" by facilitating promiscuity. A conference of bishops in August 2001 stated that the Christian way to overcome AIDS was to "abstain and be faithful".[26] Until recently many African leaders took the same line. Conservative politicians and clerics, both Christian and Islamic, can recommend chastity and strict monogamy till the cows come home, but humans are a randy and promiscuous species, and if you want to be scientific (or even practical) there is no point in fighting the fact.

Been there, done that

There is a direct historical parallel in the work of the puritanical Jonathan Hutchison, whose shonky statistics on the protection which circumcision provided against syphilis cost thousands of boys their foreskins and saved nobody from syphilis. He was the principal nineteenth British Crusader for routine circumcision, particularly as a preventative of masturbation,[27] but he also played the syphilis card. In 1900 he wrote:

> "Most other measures [to control syphilis], such as the inspection of prostitutes, have a collateral influence prejudicial to morality. Professedly making irregular sexual intercourse less dangerous, they possibly increase its amount to an extent which more than counterbalances their supposed advantages. They are also injurious to the sense of decency, to say nothing of modesty, and detrimental to the moral conscience of a community. It is not so with circumcision. Effected in early infancy, and with other avowed objects, it would silently become the means of preventing on a large scale the prevalence of a loathsome and misery-producing disease. The extent to which this diminution of risk might tend to increase sexual folly would probably be infinitesimal."[28]

In other words, in controlling syphilis circumcision was preferable to condoms or health checks because it would discourage pre- and extra-marital sex. Thus western medical scientists who want male circumcision, Islamic clerics who demand female circumcision and Catholic bishops who favour chastity find they have more in common than anyone suspected.

The medical profession took humanity down this blind alley once before. There is no need to make this same mistake again.

Appendix

Syphilis in the early 20th century

Supporters of the idea that circumcision promotes significant protection against HIV infection assume that it has been proved that circumcision does protect against other forms of venereal disease, especially syphilis. This is simply not true. Studies have repeatedly failed to find firm evidence that uncircumcised men are more vulnerable to any forms of VD,[29] and even so conservative an authority as the English Royal Commission on Venereal Disease in 1916 found that syphilis was concentrated

exactly where STDs and HIV are concentrated today among poor and uneducated populations, living in unsanitary conditions and having frequent unprotected sex with multiple partner or prostitutes.

Social distribution of syphilis in Edwardian Britain

Social Class/ Occupation	Death rate per million	Death rate rank
Intermediate	280	4
Skilled labourer	264	5
Intermediate	304	2
Unskilled labour	429	1
Textile workers	186	6
Miners	177	7
Agricultural labourers	108	8

Source: Royal Commission on Venereal Diseases, *Final Report of the Commissioners*, p.19 (British Parliamentary Papers, 1916, Vol. 16)

Circumcision at that time was most prevalent among the urban upper class[30] and lowest among workers in rural areas. Circumcision was also rare among unskilled labourers, but they were the group which lived in the worst urban squalor and exhibited the most sexual promiscuity.

Notes

1 A.J. Fink,"A possible explanation for heterosexual discussion for heterosexual male infection with AIDS", New England Journal of Medicine, Vol. 315, 1986 p. 1167; "Newborn circumcision: a long term strategy for AIDS prevention", Journal of the Royal Society of Medicine, Vol 83, 1990, p. 673

2 The UNAIDS organization has a sensible discussion of this issue, "What makes people vulnerable?", available at www.unaids.org/epidemic_update/report/Epi_report_chap_vulnerable.htm. See also Daniel B. Hrdy, "Cultural practices contributing to the transmission of human immunodefciency virus in Africa", Review of Infectious Diseases, Vol 9, 1987' pp. 1109-19

3 See his personal details at www.unimelb.edu.au/staff/short.htm

4 Robert Szabo and Roger V. Short, "How does male circumcision protect against HIV infection?", British Medical Journal. Vol 320, 2000, pp. 1592-4

5 Robert S. Van Howe, "Neonatal circumcision and HIV infection", in George C. Denniston, Frederick Hodges and Marilyn Milos (eds), Male and Female circumcision: Medical, legal and ethical considerations in pediatric practice (New York and London, Kluwer Academic and Plenum Publishers, 1999) pp. 99-130

6 Jonathan Hutchinson, "On the influence of circumcision in preventing syphilis", Medical Times and Gazette, NS Vol. II December 1855, pp. 542-3

7 E. Harding Freeland, "Circumcision as a preventive of syphilis and other disorders", Lancet, 29 December 1900, pp. 1869-71

8 Abraham Wolbarst, "Universal circumcision as a sanitary measure", Journal of the American Medical Association, Vol. 62 1914, pp. 93-4

9 "Circumcision and VD", Newsweek, 21 July 1947, p. 31

10 Sander Gilman, Freud, race and gender. (Princeton University Press, 1993) 66 60-70; John M. Ephron, Medicine and the German Jews: A history. (New Haven, Yale University Press, 1993 pp. 177, 222-30

11 Milton Lewis, Thorns on the rose: The history of sexually transmitted diseases in Australia in international perspective. (Canberra, AGPS, 1998)

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