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To Cut or Not to Cut? Exploring Parental Decision-making about Neonatal Male Circumcision

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TO CUT OR NOT TO CUT? EXPLORING PARENTAL DECISION-MAKING ABOUT NEONATAL MALE CIRCUMCISION

by

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ABSTRACT

This thesis analyses the narratives of 33 parents in the United States concerning their decisions to circumcise or leave their children intact, and five key informants consisting of medical professionals involved in obstetric and gynecological care and trained childbirth companions. The United States differs from other nations in the Global North due to its comparatively high rates of neonatal male circumcision, a procedure that is performed as a preventative surgery, rather than for cultural or religious indications. However, in recent years, rates of circumcision have begun to decline. This study sought to gain a nuanced understanding of these trends by examining the factors that influenced the parents in my sample. The results show that parents' circumcision decisions were affected by their evaluations of the procedure's medical risks and benefits and their considerations of the relationship between being circumcised, hygiene, and health. Also relevant to their decisions were concerns and expectations regarding their child's future sexual functioning and pleasure, as well as cultural assumptions about bodily autonomy and integrity. Interviews with five key informants, including medical providers and trained childbirth assistants, provide further context to findings regarding the sometimes-unequal power dynamics between providers and parents. The results of this study raise questions about the extent of informed consent for this procedure and shed light on the ways that parents are sometimes "selective" with the information they use to make decisions. Overall, the findings in this research offer valuable insights into the complexities of parents' decision-making processes and contribute to scholarship on the social and medical dimensions of circumcision.

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CHAPTER 1: INTRODUCTION

This master's thesis utilizes an anthropological lens to explore the topic of parental decision-making regarding neonatal male circumcision. In the United States (US), neonatal male circumcision is the most common surgery performed on newborns, though the prevalence of the procedure has declined in recent years (Maeda et al. 2012). Despite its waning ubiquity, the practice is still steeped in a considerable amount of controversy, including attention from activists ("intactivists") who oppose the practice, as well as medical professionals who may stand on either side of the issue. Meanwhile, the American Academy of Pediatrics (AAP)—a trusted source of clinical guidelines for pediatric health care—currently endorses circumcision as a practice with health benefits that "outweigh the risks" (AAP 2021); however, they do not go as far as to routinely recommend the procedure—instead leaving the final decision to parents' consideration (AAP 2012).

The topic of neonatal circumcision is often addressed in various media industries in the US, and in particular, journalistic news sources. Discussions of circumcision in the news occur across partisan lines and encompass reports, commentaries, articles as well as guides constructed by networks and publications to inform readers. Sources of such guides include national television networks such as the Cable News Network (CNN), the FOX News Network, and print publications such as the New York Times. Despite the ideological contrast between FOX News (a conservative network), and CNN and the New York Times (both more liberal sources), each company's guide references the guidelines set in 2012 by the AAP, and overall, present the procedure as one with health benefits that is subject to a parental decision (CNN Wire Staff 2012; Keatley 2020; Relevant 2013). Meanwhile, Breitbart—a news provider leaning even further right than FOX—addresses the controversy surrounding circumcision with inflammatory

articles such as “No One Wants to Live in a World of Uncircumcised Penises” (Deacon 2015) and “Men’s Rights Group Hold Bizarre Anti-Circumcision Protest On International Men’s Day” (Yiannopoulos 2015), both of which possess a very apparent pro-circumcision lean. Intactivists, on the other hand, have been found campaigning on university grounds; for instance, in February 2020, the anti-circumcision group known as Bloodstained Men demonstrated at the University of Central Florida to advocate against the procedure in the presence of students. The framing of circumcision in the news and other public campaigns is important to take into account, as it is very likely that parents may consume information from such sources, and what each source says may impact parents’ perception of the issue.

Given that parents have the final say as to whether their child will be circumcised, an anthropological examination of the factors that influence their decision-making surrounding the practice through qualitative methodologies such as semi-structured interviews functions to shed light on trends such as the procedure’s declining prevalence. Following this introductory section, this thesis is composed of two original research articles and a conclusion chapter. The anthropological study on which the two articles in this thesis are based was driven by the following research questions:

- To what extent are parents aware of discourses and medical information and guidelines about circumcision in the US?
- What are the medical and health factors that influence parents’ agreement to or rejection of the procedure?
- What are the social and cultural considerations that impact parents’ agreement to or rejection of the procedure?

The significance of examining these questions lies in circumcision's simultaneous existence as a cultural practice—including in religious rites like the Jewish *brit milah* ceremony (Silverman 2006)—and as a common medical procedure with health implications. These realities—especially when taken together with critiques of circumcision as a medicalized practice (Gollaher 1994)—underscore the importance of exploring parents' motivations for providing or refusing to provide consent for circumcision. In the past, anthropologists have studied male circumcision as both a rite of passage (Turner 1962) and a medical intervention with protective effects against HIV infections (Soori et al. 1997), but attention to non-religious motivations for the procedure is lacking within the discipline. The research on which this thesis is based also intends to address this gap in knowledge.

Research for this project started in March 2020, with data collection beginning in May and ending in July of the same year. The results of this study are the basis for the two articles introduced below, with the background literature and a detailed methodology provided in each. Both articles adhere to their intended journal's specific formatting and style guidelines and are expected to be submitted in June 2021, following the incorporation of any revisions based on committee feedback.

The first article, entitled "Situating Parents' Circumcision Decision-Making within Health Research, Knowledge, and Experience," addresses how medical information is constructed, interpreted, and utilized by parents in their decisions to circumcise or not circumcise their children. After a review of relevant literature and a presentation of the study's methodology, the first section addresses the medical benefits of neonatal circumcision, and how these benefits can succeed and fail in convincing parents to follow through with the procedure.

The second section of the manuscript is dedicated to exploring pediatric guidelines both within and outside of the United States and captures parents' use of medical knowledge from international sources in their circumcision decisions. Following this section is a consideration of parents' experiences circumcising previous children, and how those experiences affected their decisions about the procedure in later births. The last section of the manuscript draws upon parents' interactions with medical professionals, particularly about the guidance they offered on the topic of circumcision; this section contextualizes these interactions utilizing data derived from interviews with the key informant sample. The first article concludes by arguing that a desire for evidence-based health care drives the decisions of both circumcising and noncircumcising parents. This article was prepared for the *Anthropology & Medicine*[1] journal, a publication curating research that examines the connections between culture, health, illness, and medicine within an anthropological context. As my first article examines parents' beliefs about health, medicine, and medical information, this journal is fitting.

The second article, titled "Social Factors in Parents' Circumcision Decision-Making," explores the influence of social considerations surrounding circumcision on parents' choices about the procedure. After addressing existing research on this topic and presenting the study's methodology, the first section considers the influence—and in some cases the predictive nature—of the father's circumcision status on that of the child. The second section is dedicated to non-circumcising parents' concerns about the potential effects of circumcision on their children's future sexual pleasure and functioning; these concerns are considered alongside current research regarding the effects of circumcision on sexuality. The last section of the manuscript details the way that circumcision is conceived by non-circumcising parents as a surgery that violates the

[1] https://www.tandfonline.com/toc/canm20/current

bodily autonomy of an individual who has not consented. The second article concludes with the argument that parents' circumcision decisions are informed by their sociocultural conceptions of the practice and are influenced by information outside the scope of medical science. This article was prepared for submission to *Culture, Health & Sexuality*,[2] a journal that publishes research on sexual and reproductive health and sexuality, among other topics. As my second article addresses parents' culturally informed justifications for their circumcision decisions, it falls well within this journal's scope.

[2] https://www.tandfonline.com/toc/tchs20/current

CHAPTER 2: SITUATING PARENTS' CIRCUMCISION DECISION-MAKING WITHIN HEALTH RESEARCH, KNOWLEDGE, AND EXPERIENCE

The first section of the thesis, an article entitled "Situating Parents' Circumcision Decision-Making within Health Research, Knowledge, and Experience" and prepared for submission for publication in the *Anthropology & Medicine* journal, is dedicated to capturing the so-called "medical" factors that may compel parents to circumcise children or leave them intact. This article exists in contrast with—but not opposition to—the second article of my thesis, "Social Factors in Parents' Circumcision Decision-Making," which considers the "social" factors that potentially influence parental decision-making regarding the procedure. The first article relates to the thesis in its entirety by discussing results of this research, which shed light on trends such as the procedure's medicalization in the United States.

Article #1:

Prepared for submission to journal: *Anthropology & Medicine*

https://www.tandfonline.com/toc/canm20/current

Situating Parents' Circumcision Decision-Making within Health Research, Knowledge, and Experience

Abstract

This research analyses the narratives of 33 parents in the United States concerning their decisions to circumcise or not circumcise their children. The United States differs from other nations in the Global North due to its comparatively high rates of male neonatal circumcision, a procedure that is performed as a preventative surgery, rather than for cultural or religious indications. However, in recent years, rates of circumcision have begun to decline. This study sought to gain a nuanced understanding of these trends by examining the factors that influenced the parents in my sample. The results show that parents' circumcision decisions were affected by their evaluations of the procedure's medical risks and benefits, their considerations of the relationship between being circumcised, hygiene, and health, as well as their interactions with healthcare providers. Also relevant to their decision were their experiences circumcising previous children. Interviews with five key informants, including medical providers and trained childbirth assistants, provide further context to findings regarding the sometimes unequal power dynamics between providers and parents. The results in this study also raise questions about the extent of informed consent for this procedure. Overall, the findings in this research offer valuable insights into parent's decision-making process, and contribute to medical anthropology critiques of the medicalization of male circumcision.

Keywords: male circumcision, neonatal circumcision, medicalization, informed consent, medical authority, United States

Introduction

Despite a considerable decline in the prevalence of this procedure since 1999, neonatal circumcision is the most common surgery performed on male newborns in the United States (Maeda et al. 2012). A practice with historical basis within certain religious traditions—such as Judaism and Islam—neonatal male circumcision is now performed for reasons outside of religion in populations that do not necessarily adhere to Jewish, Muslim, or any religious customs (Gollaher 1994). In recent years, the medical practice of circumcision has become increasingly contested in the United States (US). Activist groups ("intactivists") such as Intact America,[3] Bloodstained Men,[4] Genital Autonomy America,[5] and MGMbill.org[6]—among others—have formed to oppose male neonatal circumcision. Even within Judaism, circumcision is subject to dispute, as demonstrated by the presence of forums such as Beyond the Bris[7]—an online space for Jewish parents who have doubts about the practice (Greenberg 2017).

Medical professionals have taken their own stances on the matter, as demonstrated by the creation of Doctors Opposing Circumcision – an international network of physicians against genital cutting.[8] In contrast, the American Academy of Pediatrics released an official policy statement in 2012 indicating that the health benefits of circumcision outweigh the risks, but that the decision should ultimately be left to the parents. This statement was later critiqued by European pediatricians and urologists, who suggested that because its efficacy as a preventative

[3] See: https://www.intactamerica.org/
[4] See: https://www.bloodstainedmen.com/
[5] See: http://www.gaamerica.org/
[6] See: http://mgmbill.org/
[7] See: http://www.beyondthebris.com/
[8] See: https://www.doctorsopposingcircumcision.org/

measure against UTIs is questionable, and because potential complications exist, neonatal circumcision violates the non-maleficence principle of the Hippocratic Oath (Frisch et al. 2013).

Given this contested terrain both within the medical community and wider society, questions arise regarding the impact of these debates on parents and their decision about their newborn. Specifically, to what extent are parents aware of discourses and medical information and guidelines about circumcision in the US? What are the factors that influence parents' agreement to or rejection of the procedure? This article presents findings from research examining the motivations of parents who consented for their child to be circumcised at birth (or recently after birth) for non-religious reasons, as well as parents who did not consent to neonatal circumcision. In particular, I argue that parents can utilize medical knowledge, research, and healthcare experiences to rationalize two opposing decisions—circumcising and not circumcising their child.

Understanding circumcision in research

There is diverse research on the topic of circumcision within the discipline of anthropology (Shell-Duncan & Hernlund 2000; Silverman 2004). Much of the anthropological literature regarding male circumcision has been oriented around understanding the practice as a rite of passage, with many accounts addressing circumcision rituals for boys' passage into manhood among indigenous groups in Africa, such as the Wiko and Ndembu peoples (Gluckman 1949; Paige & Paige 1981; Turner 1962), and practices of subincision by indigenous Australians (Ashley-Montagu 1937; Singer & DeSole 1967). Other anthropological analyses of male circumcision include studies of biblical or Abrahamic circumcision as it occurs in the Jewish faith during the *brit milah* ceremony; these studies interpret the practice as a rite to distance

infant boys from femininity and their mothers, and to masculinize them (Bilu 2000; Boyarin & Boyarin 1995; Goldberg 1996; Silverman 2006).

As a practice with health implications, male circumcision is also well-studied in other disciplines and contexts. Naturally, the subject often falls within the purviews of medicine—particularly pediatrics—and public health. Of particular interest are studies that examine parental medical knowledge and decision-making, drawing upon questionnaire and survey data to determine what factors are predictive of whether a child will or will not be circumcised (Binner et al. 2002; Sardi & Livingston 2015; Wang et al. 2010). Binner et al. (2002) found that mothers with a college education consented to neonatal circumcision more often than mothers with grade school or high school education. Furthermore, the father being circumcised made the child's circumcision more likely. Sardi and Livingston (2015) indicated that medical information was less important than parents' pre-existing cultural attitudes toward the practice. Essentially, parents' decision to circumcise their child was influenced by ideas about cancer prevention and hygiene that were not based on scientific research. The authors argue that this finding suggests that parental agreement to neonatal circumcision may not truly constitute informed consent (Sardi & Livingston 2015).

A robust body of public health research conducted in Africa exists regarding the relationship between voluntary male circumcision and the human immunodeficiency virus (HIV). This research can be traced back to a prospective study by Cameron et al. in 1989 in Kenya that indicated a causal relationship between a lack of male circumcision and vulnerability to heterosexually transmitted HIV infection. Since Cameron et al.'s initial study, over 40 more have been conducted in the field of epidemiology that have confirmed the protective effect of

circumcision, and the World Health Organization endorses the practice as an effective intervention against HIV (Szazbo & Short 2000; WHO 2019).

Medical anthropologists have engaged with these studies in research documenting changes in circumcision practices for the purpose of HIV prevention, such as Soori et al.'s study (1997) of adult men in the Sukuma ethnic group in Tanzania, who were traditionally noncircumcising, but began to adopt the practice in hopes of enhancing hygiene and decreasing STI transmission. A wide body of research on female circumcision—a group of practices sometimes referred to by the more politicized term female genital cutting (FGC)—also exists (Hodžić 2016). Similar to studies of male circumcision as a rite of passage in Africa, many anthropologists have explored the symbolic nature of the practice in Muslim communities (Ahmadu 2000; Boddy 1996; Shell-Duncan & Hernlund 2000) while others have questioned its medical repercussions (Gordon 1991; Larsen 2002). As noted by anthropologist Eric Silverman in a comprehensive review of anthropological scholarship on circumcision, opposition to female circumcision is well-documented in anthropology, while opposition to male circumcision is not (2004). Historian Robert Darby and child rights attorney J. Steven Svoboda (2008) offered an important outside critique directed toward anthropologists, suggesting that the discipline's engagement with male and female genital cutting varies due to a tendency to separate them into two different categories—circumcision in the male case, and mutilation in the female one. Darby and Svoboda suggested that this double standard is driven by the West's historical familiarity with Jewish customs through the Old Testament, coupled with wariness regarding the rituals of 'obscure barbarians' who practiced female genital cutting (2008:312).

Other social scientists have also investigated the topic of male circumcision. Of particular interest is the work of sociologist Genaro Castro-Vázquez's on male circumcision in Japan

(2015), where he investigated the rise of adult circumcision procedures in Tokyo. CastroVázquez (2015) draws upon data collected from interviews with men, women, medical professionals, and mothers of male children to argue that these rare circumcisions are sought out by men to enhance their own masculinity in a country with declining birthrates that some suggest are linked to Japanese young adults' loss of interest in sexual activity (Wilford 2017).

My research study builds on this scholarship and expands on existing studies regarding parental decision-making about circumcision from an anthropological standpoint.

Neonatal male circumcision policies in the United States

After decades of performing routine circumcisions because of beliefs that the surgery prevented both disease and masturbation, medical providers in the US began to question the medical value of the surgery in the 1960s (Gollaher 2000), and in 1971, after reviewing medical literature, the American Academy of Pediatrics (AAP) deemed that there were 'no valid medical indications for circumcision in the neonatal period' (AAP 1999:686). In 1975, the AAP reaffirmed their position that neonatal circumcision was not medically necessary, but also added the stipulation that traditional, cultural, and religious factors also play a role in the final decision of the parents (Thompson et al. 1975). However, in the late 1980s, research based in Kenya began to suggest and consistently reconfirmed that removing the foreskin might have a protective effect against HIV in cases of heterosexual transmission (Cameron et al. 1989; Szazbo & Short 2000). Because of these findings, the AAP made an addendum to their 1975 statement in 1989 that considered newborn circumcision to have both medical benefits and risks (AAP 1999). All these statements have been superseded by a policy statement issued in 1999 that referred to newborn circumcision as having 'potential medical benefits', but that data were not sufficient for the procedure to be routinely recommended by physicians, allowing the final say to again fall onto the newborn's

parents (AAP 1999). In 2012, the AAP formally endorsed circumcision, asserting that its protective benefits outweigh any risks to the procedure (Frisch et al. 2013). Despite this endorsement, circumcision on newborn boys remains a complex issue both in and outside medical circles and is one that has been affected by a variety of factors, including its significance as a religious ritual, its historical context in the US as an alleged 'cure' for physical ailments, as well as its validity as a medical intervention against HIV transmission.

Still, it should be noted that the prevalence of neonatal male circumcision in the US varies from that elsewhere in the Global North. For instance, in the United Kingdom, the procedure is not as common, with only six percent of the male population above the age of 15 being circumcised, whereas in US, about 75% of males in the same age range are circumcised (WHO 2007). Indeed, in Europe as a whole, neonatal circumcision is not as widespread (WHO 2007). This is due to the idea among European physicians that the procedure is unnecessary (Frisch et al. 2013), and might also be because circumcision is associated with an increase in operating costs for their nationalized health care systems (Schoen 1997). Overall, however, the US differs significantly in its continued wide-spread practice of circumcision.[9]

Circumcision and medicalization

The theoretical concept of medicalization is highly relevant to the scholarship on circumcision, especially within the US, because of the procedure's historical context. The framework of medicalization posits that human conditions and experiences are categorized by medicine as medical problems, which can then be addressed and controlled within medical institutions, that

[9] The prevalence of circumcision varies regionally in the US; the practice is less common in western states like California—which has been linked to high immigrant populations—and more common in the South, Midwest, and Northeast (Merrill et al. 2008).

are thus granted increasing reach into social life (Howson 2019). The concept of medicalization has its roots in the discipline of sociology, where it was developed by Irving Zola, who utilized it to explore how the process of diagnosis distinguishes the 'normal' from the 'abnormal', thus legitimizing the authority of medical institutions in societies with capitalist economic systems (Howson 2019). Medicalization applies in the context of this article due to the historical background of how circumcision became a normalized medical practice in the United States in the early 1900s, despite medical evidence of its benefits not appearing until almost a century later (Cameron et al. 1989; Gollaher 1994).

Circumcision and experiential knowledge

According to sociologist Thomasina Borkman, who coined the concept in 1976, 'experiential knowledge is truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others' (Blume 2017:94). More recently, experiential knowledge has been applied to recognize the role of the patient in making healthcare decisions (Blume 2017). This application is in line with how it is implemented in this study to analyze parent-provider interactions and the impact of past experiences on parents' decisions whether or not to circumcise.

Circumcision, authoritative knowledge, and scientific motherhood

The concept of scientific motherhood is applicable to research on parental medical decisionmaking overall but is especially pertinent to the topic of circumcision. The idea of scientific motherhood was first conceptualized by medical historian Rima Apple in 1995 to describe an ideology originating in the early twentieth century US that insisted mothers must take responsibility for the health of their children while simultaneously adhering to the

authoritative knowledge of physicians; . This positioned mothers' experiential knowledge as inferior to professional expertise (Apple 1995). The concept of scientific motherhood can be used as a lens through which to analyze parents' deference to provider advice about circumcision due to their own uncertainties about the practice. More broadly, this concept can be applied to describe the lengths to which parents in my sample went to base their circumcision decisions within medical evidence and research.

The first part of my analysis—following the methods section—is dedicated to discussion of the medical benefits of circumcision, and how parents are and are not compelled by them in their choices to circumcise their children. The second section examines the ambiguities of pediatric guidelines in the United States, and how parents seek and utilize sources of authoritative medical knowledge abroad to aid in their circumcision decision. The third section explores the experiences of parents in my sample who circumcised initial children but decided against circumcising in later births. Finally, the last part of this article sheds light on the guidance offered by medical professionals to my sample of parents on the topic of circumcision and incorporates recommendations from my key informant sample. This article concludes by arguing that the decisions of both circumcising and non-circumcising parents indicate a desire for evidence-based healthcare, marking scientific parenting as a dominant parenting archetype in the United States.

Methods

This article draws on semi-structured, qualitative interviews with 38 research participants conducted from May to July 2020. Participants were in two samples: (1) 33 parents, and (2) five key informants. Two interview guides geared toward each sample, but with the shared inquiry

domains of experiences, and perspectives on circumcision provided structure, and contained probing questions to allow for open ended responses.

The inclusion criteria for my sample of parents required participants be (1) at least 18 years old, and (2) the parent of a child born in or after 2013 and have opted for or against circumcision. Of the first sample, 18 parents reported not circumcising their child, eight parents reported circumcising their child, and seven parents reported circumcising an initial child or children, but not circumcising in subsequent births. Thirty-one participants in this sample identified as ethnically white, one identified as Black, and one as Black/Latinx. Overall, the sample of parents was more educated than the national average, with more than half holding an advanced degree (American Council on Education 2021). More than half of my participants had a higher household income than the national median of $68,703 (Semega et al. 2020). All parents in this sample were in the United States at the time of birth, except for one parent who gave birth on a US military base overseas. (See Table 1: Sample characteristics, parents.)

The inclusion criteria for my sample of key informants required participants be (1) at least 18 years of age and (2) be a healthcare professional or a doula/trained childbirth companion who advises and accompanies parents before or after birth. The second sample of key informants was composed of two certified nurse midwives, one labor doula/childbirth educator, one labor doula/nurse, and one obstetrician gynecologist (ObGyn). Participants in this sample assisted with births at different frequencies; the labor doula/childbirth educator attended approximately three to four births per year, while the ObGyn assisted with as many as 100 to 150 births in the same span of time. These births occurred in various settings: hospitals, birthing centers, and at patients' homes. All key informants were educated and practiced within the United States. (See Table 2: Sample characteristics, key informants.)

The interviews lasted on average around 30-45 minutes, and up to 60 minutes, and were conducted via telephone and video conferencing services like Zoom and Skype. All interviews were audio-recorded with participant's permission, and transcribed verbatim. The samples permitted saturation of themes (Saunders et al 2018). Data analysis included systematic coding using the qualitative analysis software Dedoose. The coding process followed the "dynamic and fluid process" of the grounded theory approach (Strauss & Corbin 1998) which allows for both predetermined, *a priori codes* to be explored (e.g., interactions with providers), and the emergence of inductive, not previously considered factors or explanations (e.g., 'mismatched' children) (Coffey and Atkinson 1996). Completion of the coding process generated a detailed thematic dataset. The names of the research participants referenced in this article have been changed to pseudonyms to adhere to confidentiality protocols.

A limitation of this research is the composition of the sample, which included predominantly white individuals with higher income and education levels than the national averages. Other limitations include the sample size, and the lack of data collected about respondents' geographic location. Thus, the interview data collected from my parent sample cannot be used to make any nationally representative claims (though this was not the intent of the research regardless).

Questioning the value of circumcision's medical benefits

To understand the parents' narratives in this study, it is important to keep in mind the formal guidelines of the American Academy of Pediatrics given that this professional association is considered a trusted source of clinical guidelines for pediatric healthcare in the United States (AAP 2021). Therefore, the AAP's statements are taken up by healthcare providers and generally are expected to guide doctors' decisions and doctor-patient interactions. According to the AAP's

Task Force on Circumcision, neonatal male circumcision is a medical procedure that offers many potential advantages for the patient (2012). Specifically, the AAP identified that the surgery had a preventative effect against urinary tract infections and penile cancer, as well as reduced chance for individuals who engage in heterosexual sex to acquire immunodeficiency virus (HIV), and to spread other sexually transmitted infections (STIs) to their partner (2012:585). The AAP contextualized circumcision's benefits alongside the infrequency of minor complications and the considerable rarity of severe ones, but still maintained that these benefits are not great enough to recommend it as a routine surgery (2012). Instead, these benefits merely serve to justify access to the surgery and warrant insurance coverage (AAP 2012:585).

Circumcision to reduce the child's likelihood of contracting UTIs, HIV/AIDS and other STIs

Many parents in my sample were cognizant of circumcision's medical benefits, regardless of whether they had learned of them through or were even aware of the AAP's recommendation. For some of the parents I interviewed who chose to circumcise their child, the preventative effects of circumcision factored into their agreement to the procedure.

For example, when I asked Zoey—a mother of two boys in her late thirties—about the reasons why she circumcised both of her children, she replied: 'Overall safety and health. […] So, it's recommended by many physicians because it reduces the transmission of STDs later in life'. When asked the same question, stay-at-home mom Jordan echoed this exact idea in her response: 'My husband and I were under the impression that it was cleaner and better for them; it would help prevent STDs and infections and everything'. In response to my question about whether she was aware of any benefits to the procedure that may have had an influence on her decision, another mother, Peyton answered: '…just kind of various things you would hear about here and there, like it could potentially help against particular yeast infections or kinds of

diseases, that it would help it stay cleaner'. It is worth mentioning that circumcision does decrease the symptoms—but not the likelihood of transmission—of yeast infections in males (Davidson 1977), however, this particular benefit is not mentioned in the AAP's policy statement (2012).

In contrast, other parents refused to circumcise their child despite having knowledge of the potential medical benefits. Some of parents were less than convinced by the procedure's protective effects against HIV, STIs, and urinary tract infections (UTIs), indicating that condoms were a more reliable—and less invasive—way to prevent those conditions. Andrew, a father I interviewed who was not circumcised himself, said:

> Like, okay; even if it reduces HIV, wearing condoms prevents HIV, and [so does] good sex practice. The number of like, "Oh, well it reduces UTIs". How many boys do you know that have ever gotten a UTI? My son just turned six. He's never had a UTI. The only time I ever had one is when my ex-wife had a yeast infection.

Amanda, another parent and a master's student in her early thirties, felt similarly to Andrew:

> As someone who's prone to UTIs, I just was like, "that's an insane reason to chop off part of someone's body because you can take antibiotics for it". And then in terms of like the HIV and STDs thing, I just felt like that condoms are more effective for that. And also, it's like the risk of HIV and STDs is so far in the future.

Both Andrew and Amanda drew on their personal experiences with UTIs in their evaluations of the risks of not circumcising their children, and neither felt as if the condition justified removing the foreskin. Their perspective does not necessarily exist in opposition to science or clinical guidelines; after all, even the AAP (2012) does not recommend the procedure for all newborns, despite the surgery's demonstrated ability to reduce the prevalence of UTIs in male newborns

(Eisenberg et al. 2018). Because Andrew and Amanda's decisions not to circumcise their children are well-contained in pediatric recommendations to allow the parent(s) the final say, these choices do not exemplify noncompliance or nonadherence (Fineman 1991). Furthermore, both parents' viewpoints demonstrate that they contextualized authoritative scientific evidence within their own experiential knowledge, prioritizing the latter (Blume 2017).

Contextualizing circumcision and African research on HIV/AIDS

Some of the parents that were not compelled by circumcision's medical benefits also took issue with research on HIV and circumcision in Kenya by Cameron et al. (1989) and following studies across the African continent. Amanda, for instance, questioned the applicability of these studies in the context of the US:

> You probably know this, but it's based on studies done in like Sub-Saharan Africa, HIV transmission. And my thought then—I wasn't in social sciences at this point—like, I had a high school degree, I hadn't gone back to school yet, but I just was like, "I feel like that doesn't transfer". Like, if you're studying and looking at HIV transmission in a place where HIV transmission is really different and you're looking at UTIs in a place where people don't have the same access to clean water.

One mother, Rebekah, who is married and in her early thirties, went even so far as to suggest that one of these studies had a flawed methodology:

> I know in particular there's a study that's quoted a lot about lowering the risk of HIV transmission, and that study was later found to be flawed. Like, the methodology of it was somewhat flawed; the way that they conducted the study. So, the results were skewed. That was important to us, to kind of dig deeper into things instead of just, "well, this is what Google said".

Without the name of the author, it is impossible to determine what study Rebekah was referencing, however, criticisms of bias and other methodological issues in African circumcision research are well-documented (Collier 2012). Opponents of circumcision in public health have critiqued three randomized trials—one in South Africa in 2005, one in Uganda in 2007, and another in Kenya that same year—as demonstrating numerous biases; most notably, the researchers allegedly had an expectation bias for positive results and terminated the trials early, before it was determined whether the positive effects of circumcision would plateau (Collier 2012). Speaking from a bioethical perspective, Fish et al. (2020) have suggested that these studies and their resulting campaigns to circumcise African men and boys en masse are a form of cultural imperialism, rather than a justified medical intervention. Fish et al. argue that 'voluntary medical male circumcision' (VMMC) campaigns exist in a context where the racialized power imbalances created during the colonial era are reproduced in the present day by actors such as the World Health Organization (WHO) and the Joint United Nations Programme on HIV and AIDS (UNAIDS) (2020:5).

Overall, parents' willingness to consider the context and criticisms of circumcision research is not indicative of a desire to defy scientific evidence in their decision-making, but rather to make an informed choice about their child's health (Carter and Reyes-Foster 2020). However, the implication that an 'informed' parenting choice must be derived from scientific research is one that serves to prioritize authoritative knowledge production over parental experience (Apple 1995). Next, I will discuss how parents in my sample view circumcision as a hygienic practice, and the relationship between circumcision, hygiene, and health.

Circumcision for hygiene

The relationship between health and hygiene is nuanced. Both the World Health Organization and the Centers for Disease Control and Prevention recognize the influence of clean water, sanitation, and hygiene on human health—particularly as related to hygiene-related diseases such as lice and scabies (WHO 2004; CDC 2020). This being said, the AAP does not establish a relationship between circumcision and penile hygiene in their policy statement, indicating that their endorsement of the procedure is not explicitly based in its benefits to hygiene—though a hygiene-based argument can be made about UTIs (2012). However, for many of the parents I interviewed, health and hygiene went hand and hand. In other words, these parents equated circumcision with better hygiene, and consequently with health, thus necessitating their concurrent discussion. Consider Alison, a mother of two, who responded to my questions regarding her reasons for circumcising her son with the following:

> For us, it was more of sort of a health and cleanliness decision. We have a daughter, so this was our first time having a boy, and just in the research we did, medically, we just felt like that was the best decision for us based on the cleanliness factor, and the health factor, of him moving forward in life. That was our main determinant.

In her reply to my question regarding any benefits to circumcision she had been aware of that may have had some bearing on her decision, Alison elaborated:

> I'd kind of heard people say, “oh, you have to clean it, and that's a lot more work down the road, and you can get infections”, and things like that. So, I had heard that sort of in passing, and just kind of reading up on it more, and knowing my own other child who is a female, cleanliness is something that you're learning as a toddler, among other things. I just was like, “I would rather him be circumcised so that we could take out one element of having to put an extra effort to clean it every day, and really make sure that it's cleaned properly so he doesn't get infections”. I wanted

> to sort of mitigate that as best I could. That was something where I thought, “okay, then it's worth doing, for that reason alone”.

In response to this same question regarding circumcision’s benefits—another parent and college professor—Lindsey said:

> The benefits I've heard are like, it's easier to clean, keep clean, less infections and things like that. But again, when I was reading myself and when I was talking to my friends and all that, I didn't really perceive that it was worth it. Like, I felt like you could still keep clean and he could still be healthy and fine without it [circumcision]. We just, you know, may have to accommodate it [the foreskin].

Though Alison and Lindsey ultimately made different decisions about circumcision, both emphasized a connection between the cleanliness (or lack thereof) of the penis and infection, indicating that these ideas had become linked in an almost cause-and-effect manner. Failing to keep an uncircumcised penis clean would lead to disease; for Alison, protecting her son from infections warranted removal of the foreskin, a tissue that necessitated ‘extra effort’ to keep clean. Even Lindsey acknowledged that the foreskin had to be ‘accommodated’, but unlike Alison, decided that she could keep her son safe from health issues while leaving him uncircumcised.

These parents’ conflation of hygiene and health in the context of circumcision begs the question: where are they acquiring this association? There is a historical basis for the relation of these ideas; in 1912, circumcision was described as a sanitary practice by Victorian urologist Frank G. Lydston, who referred to parents who did not circumcise their children as ‘almost criminally negligent’ for not providing them with what was considered to be proper medical care (Gollaher 1994:23). This association between penile hygiene and health is also emblematic of the

very way that the procedure has been historically and is continuously subjected to the process of medicalization, as historian of science and medicine David L. Gollaher (1994) has noted. Gollaher explains that the importance of cleanliness in late-1800s America elucidates why circumcision gradually became a more accepted practice, but that an affinity for sanitation does *not* clarify why people opted to operate on the penis rather than simply use soap and water. Parents' decision to circumcise rather than cleanse becomes clearer given that during the late1800s, surgery had found a new and important role in public health, and circumcision was a status symbol indicating that the child's parents could afford to pay a physician for the procedure (Gollaher 1994).

The medicalization of circumcision becomes even more apparent when one considers the way that the procedure can have a detrimental effect on the hygiene and health of the penis. Like any surgery, circumcision has the potential for minor complications—such as bleeding, pain, and infection of the surgical site—as well as more serious complications like glandular amputation that require intervention (Krill et al. 2011). Deaths resulting from circumcision have been recorded in the past but are extremely rare (Krill et al. 2011). Aside from complications related to the surgery itself such as excessive bleeding, removal of the foreskin leaves the glans penis and meatus exposed to 'direct friction, abrasion, and trauma', as well as pathogens (Fleiss et al. 1998). Furthermore, the suggested connection between the two separate benefits of health and hygiene exemplifies how the germ theory of disease has contributed to circumcision's prevalence in the modern day (Darby 2003).

The narratives above demonstrate that parents generally view the foreskin as a site of potential disease requiring attention and regulation, and that the effort entailed in caring for an uncircumcised penis can—but does not necessarily—encourage parents to circumcise. In the next

section, I will discuss how parents confront the ambiguities inherent in medical advice from domestic sources, and how they understand literature and research outside of the US.

Doubting 'American' conventions

According to Morris et al. (2016), the United States has a distinctly high percentage of circumcised males (71.2%) when compared to other nations in the global north such as Canada (31.9%), the United Kingdom (20.7%) and Australia (26.6%). The US also differs from these and other global north countries in that their authority on pediatric health, the AAP, endorses—but does not routinely recommend—neonatal circumcision (Hodgson 2020). To some parents in my study, the differences between the US and other countries regarding circumcision did not go unnoticed.

In fact, quite a few of the parents who did not circumcise their children identified circumcision as uniquely 'American', and a procedure that was not endorsed outside of US medicine. Andrew—a father who is uncircumcised himself—desired to make an informed decision for his son, and this inclination motivated him to cast a wide net in his search for medical expertise about the surgery: 'I looked at the American Academy of Pediatrics. I also looked at UK and Australian medical sources since routine infant circumcision isn't as prevalent there. Pretty much every [other] organization says there's not enough benefits to conduct circumcision'. The discrepancies that Andrew noticed between medical recommendations in the US, UK, and Australia reinforced his sense of doubt toward conventions surrounding circumcision in the US.

Indeed, neither the British Medical Association nor the Royal Australasian College of Physicians indicate that the preventative health benefits of circumcision outweigh the procedure's risks, in contrast to the AAP's perspective which does definitively state that

circumcision's protective effects supersede any potential complications (Hodgson 2020). However, it is worth noting that the perspective of both organizations is grounded solely in health data, so their statements are not speaking to circumcision's potential social or cultural benefits or drawbacks.

Teresa, a mother in her late twenties who chose to not circumcise her son, also sought information about circumcision from both domestic and foreign sources—such as the CDC—emphasizing a preference for trustworthiness:

> I mainly went and looked up credible sources online and then I also looked up what other countries were doing. So, I noticed in European countries that circumcision is actually not a huge thing. And so, that kind of made me look more into it and like the reasoning why. And then—I think it was the AAP—they even state it on there that its recommended, but they don't note it as medically necessary for every child. […] It just seemed a little wishy-washy 'cause it was like they recommended it, but then at the same time it wasn't like a definite like, 'Yeah, no, they like have to' kind of a thing. So, that's kind of how I ended up convincing my husband, because once he really looked at it, it was conflicting information.

Teresa's narrative also speaks to certain ambiguities or contradictions in the AAP's grounds for endorsing circumcision. In the AAP's conception of the procedure, circumcision is overall beneficial—but not beneficial enough for a routine recommendation (AAP 2012). The inability of the AAP to take a more definite stance on circumcision was something that occasionally came up when I asked parents whether they were aware of the organization's 2012 policy statement. For instance, Amanda responded: 'Oh, the AAP thing—that most recent AAP paper, which is like the pretty ambivalent one? [laugh] It's the one that's like, "Oh, there's benefits to it, but you know, if you don't want to do it, don't do it" essentially?'

Overall, the perspective that comes across from these participants' narratives suggests that the AAP's relatively ambivalent statement is not extremely satisfying to a parent who is seeking to make a completely informed medical decision for their child, especially when contextualized with different recommendations about circumcision from medical organizations outside of the US. On the other hand, the doubt generated by the ambiguities inherent in the medical guidelines also appear to motivate those parents who became aware of them to pursue further research beyond medicine in the US.

In addition to confronting ambiguities from the healthcare field and the present state of medical evidence, parents' decisions were shaped by prior experiences with circumcision and interactions with medical providers, a topic I explore in the next section.

Parents' experiences with circumcising a previous child

Quite a few of the parents in my sample indicated that their experiences circumcising a previous child had a significant impact on their circumcision decision-making for latter children. Medical experiences make very meaningful contributions to parents own bases of knowledge (Blume 2017). This idea is reinforced by the accounts of parents in my sample, who ended up abandoning the practice after experiencing complications in circumcising their earlier children. By deciding not to circumcise after previous circumcisions that went awry, parents asserted the importance of experiential knowledge—truth derived from personal experience (Blume 2017)—in opposition to the authoritative expertise of the AAP which regards circumcision as a procedure where the benefits outweigh the risks.

Marie, a Christian in her early thirties, circumcised her first son but not her second and third. She confided during her interview that she initially did not know much about circumcision, but after researching the procedure prior to the birth of her first son, she was opposed to it.

However, her husband disagreed; she explained that given 'he was a man and he has a penis, I let him make the decision for my son'. When I asked why she did not circumcise her other boys, this is what she had to say:

> My first son got a botched circumcision that needed reconstruction. […] I mean, we researched, we found a Jewish, what do you call it? We found a mohel[10] to do it. And so, we thought that, you know, we were making the best decision—we thought we were getting the best care that we would. But yeah, he ended up needing to go in and see a urologist and have the foreskin peeled back. It had adhered to the tip of the penis. So, it was awful, to say the least. So that was it. That was it for me. I was never going to circumcise another boy.

Marie's account is emblematic of the way that a negative experience with a procedure such as circumcision can shape a parent's willingness to consent to it later. However it is worth noting that this is not always the case; despite the botched circumcision of his first child, Marie's husband did in fact want to have his following sons circumcised so they would "match" him. She seemed to find this exasperating: 'He wanted them circumcised and I said 'over my dead body.' […] He did, he did! Isn't that crazy? It's crazy. But yeah, he did'. Ultimately, Marie did not circumcise their latter children, despite her husband's wishes. Her experience with her first son's botched circumcision was so powerful that she refused to consent to it again; she couldn't even be swayed by her home birth midwife, who was a proponent of the procedure and had assisted with the birth of her first child. Notably, Marie's use of a mohel for her first son's birth—despite her and her husband's Christian faith—and her employment of a home birth midwife for her first two births—aligned with a preference for low intervention births she mentioned in her interview.

[10] A mohel is a person who performs ritual Jewish circumcisions (Berlin 2011).

Bella, another mother of three boys, offered a similar narrative to Marie. Her first pregnancy was with twin boys, and as a nurse, she looked through her educational manuals before deciding that she didn't want to circumcise them. However, she described her husband as being 'very adamant' about circumcising the twins, despite being 'one of the most passive people [she] knew', so she relented. Her account of what happened after their circumcisions follows:

> I was actually treated for PTSD after the twins were born and were circumcised. It was causing such a disruption in my life that I was in therapy and on medication. […] Things got worse when one of the twins needed surgery for meatal stenosis…meatal stenosis is when the urethral opening scars over because the foreskin isn't there to protect it. Like, the urethral opening—instead of being a slit—was the size of the head of a ballpoint pen. So, he would have pain when he tried to pee. He was almost four when he had finally that surgery. I had suicidal ideations that day.
>
> …They had adhesions where the foreskin remnant was trying to reattach, they had balanitis, they had UTIs. Both of the twins have meatal stenosis, but only one needed the surgery, and they would complain of painful erections and sensitivity in certain underwear. That seems to have resolved at this point.

Aside from the greater number of complications experienced by her circumcised children, Bella's narrative does differ from Marie's in another important way: her husband did not desire to circumcise their third child.

However, it is worth noting that parents may decide not to circumcise latter children for reasons other than, or in addition to, complications surrounding the procedure in initial children.

Consider the case of Skylar, a professor in her late forties who had circumcised her first son but not her second, and like Marie and Bella, was not particularly eager to circumcise her child and disagreed with her husband's stance:

> My husband and I, we disagreed about it. I was like, “I had just had a baby, I already have two kids, I'm kinda overwhelmed”. I'm like, look, “They're not going to do it in the hospital. Our pediatrician said, we can do it. You need to make an appointment. If you really want the kid circumcised, go ahead and do it, honey”. And my husband just never did it. If my husband had been motivated, I think we would have circumcised him. I think my husband felt like our older one is circumcised, he's circumcised; it might be kind of weird that our other son is uncircumcised, but it was one of those things where, we talked about it, it was a little bit hard to get one, so we didn't do it. […] I think one of the other reasons I was more than happy to not circumcise number two, is because number one was uncomfortable! It wasn’t horrible, but his little penis needed special care for probably a week, or something like that. Why cut your kid's genitalia up if you don't have to, right? Why add that risk of infection? So, yeah, I was definitely much more comfortable not circumcising the second time, because I had experienced it the first time.

Skylar’s narrative accounts for parents of multiple children with different circumcision statuses who were not necessarily dissuaded by an adverse medical experience but instead by the inaccessibility of the procedure in certain contexts, such as when it is not offered by a hospital.

Overall, the accounts given by Marie, Bella, and Skylar also speak to the relative lack of importance of having ‘matching’ children as an influence, despite each mother having considered the idea. When the stakes include potential complications, discomfort, or even difficulty acquiring a circumcision, an aesthetic difference between their children’s penises was not compelling enough to ensure their consent.

The role of healthcare providers in shaping circumcision decisions

The parents I interviewed had a range of interactions with medical providers during their or their partners’ pregnancies. Shedding a light on their accounts of these exchanges is crucial for

situating the authoritative influence these providers had on my participants, especially in relation to their circumcision decision-making.

When I asked Jennifer, a mother in her early forties who discussed the circumcision decision with her wife, why they circumcised their first son but not their second, she answered:

> I didn't know any better. I'd never heard anything other than circumcision and the benefits of it. No one spoke up and said anything different. At that time, social media was not a major factor. There wasn't a lot of thought to question things. I was still under the impression that doctors were experts and authority figures, and growing up in the deep South, you learn quickly not to question authority or expert figures. Why would you question it? It's what's been done, you know? It was just my own ignorance, misunderstanding of, and lack of questioning, really. It's probably my biggest parenting regret.

Jennifer's answer to this question is crucial for providing the context to two very different interactions with her sons' respective pediatricians she described later in her interview. Her account of her interaction with her first son's pediatrician perfectly embodies the way medical providers are sometimes regarded authoritatively by parents:

> My oldest son was adopted, so once he came home from the hospital with us and we followed up with our pediatrician, I asked for it to be done. The pediatrician said he recommended it, his own children were circumcised, and that there were benefits to it. He was somebody I trusted and saw as the expert on babies, and children, and what was best. He was an excellent pediatrician, but I don't think he would have pushed it or encouraged it if I hadn't necessarily sought it out.

In her interview, Jennifer stressed that she is confident that her first son's pediatrician did not have an agenda to push circumcision. However, given her answer to my first question and the account above, it is not inaccurate to say that she relied on him, as an authority figure, to lend her his expert opinion on circumcision, including informing her of the risks. She believed that in

doing so, the doctor ‘downplayed’ the possibility that the procedure would cause her son pain or make him bleed. Unfortunately, her son did experience pain and bleeding—among other complications like meatal stenosis—so she was confident in her decision not to circumcise her second son. This confidence was reflected in her approach to circumcision with her second son’s pediatrician, who provided her family with care after she relocated:

> I didn't discuss circumcision [with the pediatrician] because my mind was already made up and I was more educated. I found my voice by that point. I was more confident and understanding of a doctor's role, too; that more or less, they worked for me as opposed to seeing them just solely as the expert, but that my opinion and my thoughts were more valuable too. I let it be known that it was not something we were considering, and it was never pushed at that particular pediatrician's office.

Jennifer’s experiences reflect how parents may rely on the expertise of medical professional when making decisions about their child’s health, especially when the parent has not yet found their ‘voice’ and confidence in their own judgement. Also indicated by Jennifer’s account was a desire for medical providers to educate parents completely to make an informed decision about their child’s health—even if that education contradicted the parents’ assumptions (Kleinman and Seeman 2000).

This sentiment was echoed by Jordan, when I asked her about her knowledge of the risks of the procedure and her experience with circumcising her first son:

> I can honestly say that we never had a doctor talk to us about the risks of it. I think that's part of the reason we went through with it. No one said, “Yeah, such and such can happen in a percentage of these babies, or there's even a risk of death with it”, or anything like that. Nothing like that was ever said. Even talking to the pediatrician before they took him back, nothing was

> said about it. […] We never had anyone sit down and go, “Okay, this is what's going to happen. This is how the procedure works. [These are] the complications that could happen. They're gonna feel pain. It's gonna hurt”.
>
> It was more like he came in just before they took our son. He said, “Okay, we're going to take him back”. He said, “Do you have any questions?”. And I didn't have any. I didn't really know what to ask or if there was anything I should be asking. So, I kind of said, “No, I think we're okay”. He goes, “Okay, well, I'll have him back to you in a little bit”.

Jordan’s narrative raises questions regarding what an informed consent for surgeries like circumcision should look like, and whether existing informed consent procedures are adequate (O’Neill 2003). As noted by Svoboda et al. (2000:61), informed consent for neonatal circumcision presents a conundrum for legal scholars and bioethicists because hospitals do not often supply reliable information regarding the health risks of circumcision when seeking consent. Instead, they simply give parents a paper to sign—as in Jordan’s case. Even when reliable information is provided, Svoboda et al. suggest that parental consent to circumcision is altogether invalid because the procedure ‘causes significant harm while providing no appreciable medical benefits’ (2000:63).

Meanwhile, doctors like Jeffrey R. Brown of the AAP Committee on Medical Liability and Risk Management have called for physicians to revise their consent procedures, to ensure that parents are made aware of the relationship between circumcision, HIV, and other STIs (2013). Brown’s call draws attention to the fact that physicians can sometimes be held legally accountable if they fail to inform patients about the ramifications of not receiving an available medical treatment or procedure, and the patient later experiences harm that could have been prevented (2013:1). This fact lends nuance to interactions between parents and providers, who

may feel obligated to protect themselves from litigation by emphasizing circumcision's benefits in alignment with the AAP recommendation.

Jordan's experience also indicates that in some interactions between providers and parents, the burden of being informed is placed on the parent by the provider, who expects the parents to know what questions to ask. This creates conflict when parents are not particularly confident or educated on topics like circumcision and are relying on the doctor to provide them with enough information to make an informed decision, again assigning the provider an authoritative role.

Whether the provider embraces that role, however, seems to be up to that individual's conception of their position in a parent's pregnancy. Gina, a labor doula and childbirth educator who I interviewed as a key informant, has a particular approach to informing parents who take her childbirth classes about circumcision:

> So, in the childbirth classes we do not so much talk about circumcision itself, but more about, you know, functions of the foreskin, how many nerve endings, then we talk about what is being removed and really educating parents that it's not just a snip, that everybody likes to use that term, making it sound like it's such a tiny, like, "oh, it's nothing, it's a nick", you know? So, we feel that if they actually knew what is being removed and what the purpose of that body part is, then maybe they won't choose that. And so helping them see--what gets a lot of parents I feel like is the, we have like the note card and that's basically a grown man. If you've cut off his foreskin at birth, that's how much you're taking away. And so, when they see that it's like this huge amount, it's like, "wow". People just don't really understand it. And I think once they understand and see, then they're more likely to at least question, "Why are we doing this?". Or "oh, maybe we don't need to".

Gina's goal seems not so much as to instruct parents, but rather to encourage them to question pre-conceived notions surrounding the foreskin. However, her role can nonetheless be described as active and informative.

Despite performing the procedure, Vera's involvement with informing parents about circumcision during her time in residency as an obstetrician/gynecologist was relatively limited. She recounted the procedures she had to follow for circumcising babies: 'I had to ask the mother of any male infant, whether they wanted their child circumcised or not. And then I had to have them sign an informed consent form for the circumcision, which I had to explain the risks and benefits of the procedure. And that was it.'

Vera's somewhat detached approach to the procedure was elucidated when she answered my question regarding what her opinions on circumcision were shaped by. She responded:

> …My experience actually performing it, you know? I found it to be inflicting unnecessary suffering on a person who has not consented for a procedure. So, I really don't see the point. And then I think the most important thing is that I am a woman's health provider. I don't care for males at any other point in their lives, and I don't even know the anatomy of a male really from a medical standpoint. So, I don't see why I should be performing surgery on a male. Completely nonsensical to me. Even just beyond my opinion of the procedure, I just think it is not appropriate for women's health provider to be performing surgery on males.

As an Ob/Gyn, Vera does not view male neonatal circumcision to be within her scope of care. However, obstetricians are a common provider of the surgery alongside pediatricians and other physicians (American College of Obstetricians and Gynecologists 2017), so this is not necessarily a common opinion.

Overall, perspectives of key informants in this study indicate that medical providers and childbirth assistants do have a role in—and in the case of Ob/Gyns, an obligation to—informing parents about procedures such as circumcision. When taken alongside the accounts of parents like Jennifer and Jordan, however, a complex picture emerges wherein parents are sometimes not adequately informed by their providers, despite the trust they illustrate in ceding to their expertise.

Conclusions

This study highlights the way that two different choices—circumcising a child or not circumcising a child—can be rationalized by parents who value evidence-based healthcare, as there exists ample research on both sides of the debate to aid parents as they weigh the risks and benefits of the procedure. Still, parents' emphasis on finding evidence-based healthcare can also be interpreted as a reflection of the concept of scientific motherhood, where the scientific knowledge produced by experts like doctors and research is constructed to be highly valued and the expectation of parents is to seek and use this knowledge.

Two findings from this study may suggest why male neonatal circumcision continues at a relatively high rate in the US. First, the narratives of my participants illustrate that parents' conceptualizations of the connection between penile hygiene and health reinforce the idea of circumcision as a decidedly medicalized procedure. This is evident in parents' vague references to 'cleanliness' and 'infection', rather than an explicit identification of the relationship between those factors in context. Essentially, parents in my sample are aware that circumcision could benefit their children's hygiene, but not *how* or *why*, falling back on an unspecific idea of the procedure as a generally beneficial one. This suggests that long assumed ideas about the

'diseased' nature of the foreskin are enduring in parents' discourses on circumcision, and this association may continue to underpin the choice to circumcise children.

Second, while parents search for evidence-based knowledge, the ambiguities around risks and benefits may still make parents vulnerable to making decisions without feeling fully informed. The narratives of my participants illustrate a lack of satisfaction with 'ambivalent' or 'wishy-washy' guidelines like the AAP's 2012 policy statement, which motivates them to look to sources from Europe and Australia. Parents were also deeply concerned with knowledge credibility, regardless of the source's country of origin. Often, parents' decisions were shaped by the advice and knowledge offered by medical professionals and other providers. For some that were unable to find their 'voice' and unwilling to second-guess or question their providers, this became problematic, and their trust in medical expertise left them without an informed understanding of circumcision's risks. This experience of being left with a sense of incomplete knowledge occurred despite the requirements for informed consent in the US medical system, suggesting a gap in current consenting procedures. Their experiences reveal that fully informed consent is particularly important in situations where there is an ambiguity regarding the benefits of the procedure, therefore providers should ensure that patients take an active role in the process and are empowered.

This study contributes to medical anthropology scholarship regarding medical decisionmaking and male circumcision, particularly in a US context, by illuminating the complex process that underlies parent's decisions for their children. Furthermore, it provides an understanding of how the procedure's historical context has continued to influence this procedure's prevalence in the US. However, the availability of data sources that fall outside of,

and critique mainstream medical literature in the US—as consulted by parents in this study—also reveals why circumcision rates may be gradually declining.

Ethical approval

This research was reviewed and approved by the University of Central Florida's Institutional Review Board in May 2020, study #00001715.

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Appendix

Table 1: Sample Characteristics, Parents

Parent	Circumcised Child?	Age Range	Ethnicity	Religious Affiliation	Approx. Income (Household/Year)	Level of Education	Employment	Marital/Partnership Status	Health Insurance/ Coverag
1	No	31-35	White	None	70,000 - 100,000	Bachelor's Degree	Part-time	Married	Public (AIM, ACA)
2	No	36-40	White	No affiliation - Spiritual	70,000 - 100,000	Master's Degree	Part-time	Married	Private, full
3	No	36-40	White	Pagan	20,000 - 50,000	Master's Degree	Stay-at-home	Married	Private, full
4	No	41-45	White	Unitarian	100,000 <	Master's Degree, Doctoral Candidate	Full-time	Married	Private, full
5	Yes, then No	36-40	White	None	20,000 - 50,000	Bachelor's Degree	Part-time	Married	Private, full
6	Yes, then No	36-40	White	None	50,000 - 70,000	Master's Degree	Part-time	Married	Public (state job), full
7	Yes	31-35	Black/Latinx	Christian	20,000 - 50,000	Bachelor's Degree	Full-time	Married	Private, full
8	Yes	26-30	White	Christian	20,000 - 50,000	Bachelor's Degree	Part-time	Married	Private, full
9	No	36-40	White	None	20,000 - 50,000	Master's Degree, Doctoral Candidate	Full-time	Married	Private, full
10	No	18-25	White	Christian	50,000 - 70,000	Some College	Full-time	Married	Private+ Public, partial
11	Yes, then No	31-35	White	None	100,000 <	Master's Degree	Full-time	Married	Private
12	No	31-35	White	Christian	50,000 - 70,000	Bachelors	Full-time	Married	Private, full
13	No	31-35	White	Unitarian Universalist	50,000 - 70,000	Some College	Part-time	Married	Tri-Care
14	No	18-25	White	None	20,000 - 50,000	Associate's Degree	Full-time	Married	Public (Medicaid)
15	Yes, then no	41-45	White	Christian	100,000 <	Some College	Part-time	Married	Private, partial
16	No	41-45	White	Unitarian	100,000 <	Doctorate's Degree	Full-time	Married	Private, full
17	No	36-40	White	Christian (Non Denominational)	70,000 - 100,000	Bachelor's Degree	Part-time	Married	Private, Full
18	No	36-40	White	Protestant (not practicing)	100,000 <	Doctorate's Degree	Full-time	Married	Private, full
19	Yes	31-35	Black	Christian (Non Denominational)	>20,000	Master's Degree, Doctoral Candidate	Full-time	Married	Public (state job), full
20	No	26-30	White	Catholic (Non Practicing)	70,000 - 100,000	Bachelor's Degree	Full-time	Married	Private, Full
21	No	36-50	White	Christian	100,000 <	Master's Degree	Stay-at-home	Married	Tri-Care
22	Yes, then No	41-45	White	Christian (Non Denominational)	20,000 - 50,000	Master's Degree	Full-time	Married	Private, full
23	No	31-35	White	None	70,000 - 100,000	Master's Degree	Full-time	Married	Private, full
24	No	31-35	White	Christian	20,000 - 50,000	High School Diploma	Stay-at-home	Married	Private
25	No	31-35	White	Agnostic	70,000 - 100,000	Associate's Degree	Full-time	Divorced	Tri-Care
26	Yes	31-35	White	None	70,000 - 100,000	Master's Degree	Full-time	Married	Public (state job), full
27	No	41-45	White	None	50,000 - 70,000	Associate's Degree	Full-time	Single	Private, full
28	Yes, then No	26-30	White	Christian	70,000 - 100,000	Bachelor's Degree	Stay-at-home	Married	Tri-Care
29	Yes	36-40	White	None	100,000 <	Master's Degree	Full-time	Married	Private, full
30	Yes, then No	46-50	White	Atheist	100,000 <	Doctorate's Degree	Full-time	Married	Private, full
31	Yes	31-35	White	Christian (Non Denominational)	100,000 <	Master's Degree	Full-time	Married	Private, full
32	Yes	36-40	White	None	70,000 - 100,000	Doctorate's Degree	Full-time	Married	Private, full
33	Yes	36-40	White	Lutheran	100,000 <	Associate's Degree	Part-time	Married	Private, full

Table 2: Sample Characteristics, Key Informants

Key Informan	Occupation	State of Practice	Time in Current Positio	Approximate # of Births Assisted
1	certified nurse midwife	New Jersey	11 months	20/month
2	doula, childbirth educator	Oregon	4 years	3-4/year
3	certified nurse midwife	Texas	3 years	11/month
4	doula	Iowa	20 years	2-3/year
5	obstetrician gynecologist	New York	5 years	100-150/year

References

Ahmadu, Fuambai. 2000. "Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision." In *Female "Circumcision" in Africa: Culture, Controversy, and Change*, ed. Bettina Shell-Duncan and Ylva Hernlund, pp. 283-312. Boulder, CO: Lynne Rienner Publishers, Inc.

Apple, Rima D. 1995. "Constructing Mothers: Scientific Motherhood in the Nineteenth and Twentieth Centuries." *Social History of Medicine* 8(2):161-178. https://doi.org/10.1093/shm/8.2.161

American Academy of Pediatrics. "About the American Academy of Pediatrics." HealthyChildren.org. 2021. https://www.healthychildren.org/English/Pages/About-AAP.

American Academy of Pediatrics. "Circumcision Policy Statement." *PEDIATRICS* 103, no. 3 (1999): 686–93. https://doi.org/10.1542/peds.103.3.686.

American Academy of Pediatrics. "Circumcision Policy Statement." *PEDIATRICS* 130, no. 3 (2012): 585–86. https://doi.org/10.1542/peds.2012-1989.

American College of Obstetricians and Gynecologists. 2017. "Newborn Male Circumcision." ACOG, 2017. https://www.acog.org/womens-health/faqs/newborn-male-circumcision.

American Council on Education. "Educational Attainment, by Race and Ethnicity." Race and Ethnicity in Higher Education, September 10, 2020.

Ashley-Montagu, Montague F. 1937. The Origin of Subincision in Australia. *Oceania* 8:193–207.

Berlin, Adele. 2011. "Mohel." In *The Oxford Dictionary of the Jewish Religion*. Oxford: Oxford University Press.

Bilu, Yoram. 2000. "Circumcision, the First Haircut and the Torah: Ritual and Male Identity among the Ultraorthodox Community of Contemporary Israel." In *Imagined Masculinities: Male Identity and Culture in the Modem Middle East*, ed. Mai Ghoussoub and Emma Sinclair-Webb, pp. 33-63. London: Saqi Books.

Binner, Sharon L., Joan M. Mastrobattista, Mary-Clare Day, Laurie S. Swaim, and Manju Monga. 2002. "Effect of Parental Education on Decision Making About Neonatal Circumcision." *Southern Medical Journal* 95(4): 457-61.

Blume, Stuart. "In Search of Experiential Knowledge." *Innovation: The European Journal of Social Science Research* 30, no. 1 (2017): 91–103. https://doi.org/10.1080/13511610.2016.1210505.

Boddy, Janet. 1996. "Violence Embodied?: Circumcision, Gender Politics, and Cultural Aesthetics." In *Rethinking Violence Against Women*, ed. R. Emerson Dobash and Russell P. Dobash, pp. 77-110. Thousand Oaks, CA: Sage Publications.

Boyarin, Jonathan, and Daniel Boyarin. 1995. "Self-Exposure as Theory: The Double-Mark of the Male Jew." In *Rhetorics of Self-Making*, ed. Debbora Battaglia, pp. 16-42. Berkeley, CA: University of California Press.

Brown, Jeffrey L. "Medical-Legal Risks Associated with Circumcision of Newborn Males: Need for Revised Consent." *AAP News* 34, no. 4 (2013).

Cameron, D. William, Lourdes J. D'Costa, Gregory M. Maitha, Mary Cheang, Peter Piot, J. Neil Simonson, Allen R. Ronald, Michael N. Gakinya, J.O. Ndinya-Achola, Robert C. Brunham, Francis A. Plummer. 1989. "Female to Male Transmission of Human Immunodeficiency Virus Type 1: Risk Factors for Seroconversion in Men." *The Lancet* 334(8660):403-407.

Castro-Vázquez, Genaro. 2015. *Male Circumcision in Japan.* New York, NY: Palgrave MacMillan.

Centers for Disease Control and Prevention. "Water, Sanitation & Environmentally-Related Hygiene." Centers for Disease Control and Prevention. Centers for Disease Control and Prevention, March 24, 2020. https://www.cdc.gov/healthywater/hygiene/index.html.

Coffey A, and P. Atkinson. (1996) *Making Sense of Qualitative Data*. Thousand Oaks: Sage.

Collier, R. "The Studies That Launched a Thousand Snips." *Canadian Medical Association Journal* 184, no. 1 (2011). https://doi.org/10.1503/cmaj.109-4029.

Darby, Robert. 2003. "The Masturbation Taboo and the Rise of Routine Male Circumcision: A Review of the Historiography." *Journal of Social History* 36(3):737-757.

Darby, Robert and J. Steven Svoboda. 2008. "A Rose by Any Other Name? Rethinking the Similarities and Differences between Male and Female Genital Cutting." *Medical Anthropology Quarterly* 21(3):301-323.

Davidson, F. "Yeasts and Circumcision in the Male." *Sexually Transmitted Infections* 53, no. 2 (1977): 121–22. https://doi.org/10.1136/sti.53.2.121.

Eisenberg, Michael L., Deron Galusha, William A. Kennedy, and Mark R. Cullen. "The Relationship between Neonatal Circumcision, Urinary Tract Infection, and Health." *The World Journal of Men's Health* 36, no. 3 (2018): 176. https://doi.org/10.5534/wjmh.180006.

Fish, Max, Arianne Shahvasi, Tatenda Gwaambuka, Godfrey B. Tangwa, Daniel Ncayiyana, and Brian D. Earp. "A New Tuskegee? Unethical Human Experimentation and Western

Neocolonialism in the Mass Circumcision of African Men." *Developing World Bioethics* 00 (2020): 1–16. https://doi.org/10.1111/dewb.12285.

Fleiss, P M, F M Hodges, and R S Van Howe. "Immunological Functions of the Human Prepuce." *Sexually Transmitted Infections* 74, no. 5 (1998): 364–67. https://doi.org/10.1136/sti.74.5.364.

Frisch, Morten, Yves Aigrain, Vidmantas Barauskas, Ragnar Bjarnason, Su-Anna Boddy, Piotr Czaudern, Robert P.E. de Gier, *et al.* 2013. "Cultural Bias in the Aap's 2012 Technical Report and Policy Statement on Male Circumcision." *Pediatrics* 131(4): 796-800.

Gluckman, Max. 1949. "The Role of the Sexes in Wiko Circumcision Ceremonies." In *Social Structure: Studies Presented to A.R.Radcliffe-Brown*, ed. M Fortes, pp. 145–67. Oxford: Clarendon.

Goldberg, Harvey E. 1996. Cambridge in the Land of Canaan: Descent, Alliance, Circumcision, and Instruction in the Bible. *Journal of the Ancient Near Eastern Society* 24:9-34.

Gollaher, David L. 1994. "From Ritual to Science: The Medical Transformation of Circumcision in America." *Journal of Social History* 28(1): 5-36.

Gordon, Daniel. 1991. "Female Circumcision and Genital Operations in Egypt and the Sudan: A Dilemma for Medical Anthropology." *Medical Anthropology Quarterly* 5:3-14.

Greenberg, Zoe. 2017. "When Jewish Parents Decide Not to Circumcise." *The New York Times.* https://www.nytimes.com/2017/07/25/well/family/cutting-out-the-bris.html

Hodgson, Dominic. "USA and UK : Differences on Neonatal Circumcision." *Trends in Urology & Men's Health* 11, no. 2 (2020): 27–29. https://doi.org/10.1002/tre.742.

Hodžić Saida. *The Twilight of Cutting: African Activism and Life after NGOs*. Oakland, CA: University of California Press, 2017.

Howson, Amanda. 2019. "Medicalization." *Salem Press Encyclopedia*.

Kleinman, Arthur, and Don Seeman. "Personal Experience of Illness." *Handbook of Social Studies in Health and Medicine*, n.d., 230–42. https://doi.org/10.4135/9781848608412.n15.

Krill, Aaron J., Lane S. Palmer, and Jeffrey S. Palmer. "Complications of Circumcision." *The Scientific World JOURNAL* 11 (2011): 2458–68. https://doi.org/10.1100/2011/373829.

Larsen, Ulla. 2002. "The Effects of Type of Female Circumcision on Infertility and Fertility in Sudan." *Journal of Biosocial Science* 34:363-377.

Maeda, Jared Lane, Ramya Chari, and Anne Elixhauser. 2012. *Circumcisions Performed in U.S. Community Hospitals, 2009: Statistical Brief #126.* (Rockville, MD: Agency for Healthcare Research and Quality (US), 2012).

Merrill, Chaya T., Mika Nagamine, and Claudia Steiner. 2008. *Circumcisions Performed in U.S. Community Hospitals, 2005. HCUP Statistical Brief #45*. Agency for Healthcare

Research and Quality, Rockville, MD.
http://www.hcupus.ahrq.gov/reports/statbriefs/sb45.pdf

Morris, Brian J, Richard G Wamai, Esther B Henebeng, Aaron AR Tobian, Jeffrey D Klausner, Joya Banerjee, and Catherine A Hankins. “Estimation of Country-Specific and Global Prevalence of Male Circumcision.” *Population Health Metrics* 14, no. 1 (2016). https://doi.org/10.1186/s12963-016-0073-5.

Paige, Karen E., and Jeffery M. Paige. 1981. *The Politics of Reproductive Ritual*. Berkeley, CA: University of California Press.

Sardi, Lauren, and Kathy Livingston. 2015. "Parental Decision Making in Male Circumcision." *The American Journal of Maternal/Child Nursing* 40(2):110-15.

Saunders, B., J. Sim, T. Kingstone, S. Baker, J. Waterfield, B. Bartlam, H. Burroughs, and C. Jinks. (2018) Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality and Quantity* 52:1893-1907.

Schoen, Edgar J. 1997. "Benefits of Newborn Circumcision: Is European Ignoring Medical Evidence?" *Archives of Disease in Childhood* 77:258-260.

Semega, Jessica, Melissa Kollar, Emily A. Shrider, and John Creamer. “Income and Poverty in the United States: 2019.” The United States Census Bureau, September 15, 2020. https://www.census.gov/library/publications/2020/demo/p60-270.html.

Shell-Duncan, Bettina, and Ylva Hernlund, eds. 2000. *Female "Circumcision" in Africa: Culture, Controversy, and Change*, Directions in Applied Anthropology: Adaptations and Innovations. Boulder, CO: Lynne Rienner Publishers, Inc.

Silverman, Eric K. 2004. "Anthropology and Circumcision." *Annual Review of Anthropology* 33(1): 419-45.

Silverman, Eric K. 2006. *From Abraham to America: A History of Jewish Circumcision.* Lanham, MD: Rowman & Littlefield Publishers, Inc.

Singer, Philip and Daniel E. DeSole. 1967. "The Australian Subincision Ceremony Reconsidered: Vaginal Envy or Kangaroo Bifid Penis Envy." *American Anthropologist* 69:355–58.

Soori, Nnko, Boerma J. Ties, Robert Washija, and Mark Urassa. 1997. "The Popularization of Male Circumcision in Africa: Changing Practices Among the Sukuma of Tanzania. *African Anthropologist* 4:68-79.

Strauss, A. and J. Corbin. (1998) *Basics in qualitative research: techniques and procedures for developing Grounded Theory*. 2nd ed. London: Sage Publications.

Svoboda, J. Steven, James G. Dwyer, and Robert S. Van Howe. “Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum.” *Journal of Contemporary Health Law & Policy* 17, no. 1 (2000).

Szazbo, Robert and Roger V. Short. 2000. "How Does Male Circumcision Protect Against HIV Infection?" *BMJ* 320(7249):1592-1594.

Thompson, H.C., L.R. King, E. Knox et al. 1975. "Report of the ad hoc task force on circumcision." *Pediatrics* 56(4):610-611.

Turner, Victor. 1962. Three Symbols of Passage in Ndembu Circumcision Ritual. In *Essays on the Ritual of Social Relations*, ed. M Gluckman. pp. 124–73. Manchester, UK: Manchester University Press.

Wang, Marvin L., Eric A. Macklin, Erin Tracy, Hiyam Nadel, and Elizabeth A. Catlin. 2010. "Updated Parental Viewpoints on Male Neonatal Circumcision in the United States." *Clinical Pediatrics* 49(2): 130–36.

Wilford, Greg. "Young Japanese People Are Not Having Sex." *The Independent*. Independent Digital News and Media, November 14, 2017. https://www.independent.co.uk/news/world/asia/japan-sex-problem-demographic-timebomb-birth-rates-sex-robots-fertility-crisis-virgins-romance-porn-tokyo-a7831041.html.

World Health Organization. "HIV/AIDS: Key Facts." *World Health Organization,* 2019. https://www.who.int/en/news-room/fact-sheets/detail/hiv-aids

World Health Organization. *Male Circumcision: Global Trends and Determinants of Prevalence, Safety and Acceptability*. Geneva: World Health Organization, 2007.

World Health Organization. "Water, Sanitation and Hygiene Links to Health." World Health Organization. World Health Organization, February 21, 2009. https://www.who.int/water_sanitation_health/publications/facts2004/en/.

CHAPTER 3: SOCIAL FACTORS IN PARENTS' CIRCUMCISION DECISION-MAKING

The second section of the thesis, an article entitled "Social Factors in Parents' Circumcision Decision-Making" and prepared for submission for publication in the *Culture, Health, and Sexuality* journal, is dedicated to exploring the so-called "social" factors with potential influence on parental decision-making about neonatal male circumcision. This article is intended to be taken together with the preceding article, "Situating Parents' Circumcision Decision-Making within Health Research, Knowledge, and Experience," which captures the "medical" factors that might impact parents' choices to circumcise their children or leave them intact. The second article serves the entire thesis through an analysis of qualitative interview data, which demystifies the continued prevalence of circumcision in the US.

Article #2:

Prepared for submission to journal: *Culture, Health, and Sexuality*

https://www.tandfonline.com/toc/tchs20/current

Social Factors in Parents' Circumcision Decision-Making

Abstract

This research analyses the narratives of 33 US parents concerning their decisions to circumcise or not circumcise their children. The United States differs from other nations in the Global North due to its comparatively high rates of male neonatal circumcision performed as preventative surgery, rather than for cultural or religious indications. However, in recent years, rates of circumcision have begun to decline. This study sought to gain a nuanced understanding of these trends by examining the factors that influenced parents' decision-making in my sample. The results show that parents' circumcision decisions were affected by their concerns and expectations regarding their child's future sexual functioning and pleasure, as well as cultural assumptions about bodily autonomy and integrity. The results of this study also shed light on the ways that parents are sometimes 'selective' with the information they use to make decisions. Overall, the findings in this research offer valuable insights into parents' decision-making processes and contribute to scholarship on the social dimensions of circumcision, including existing research on the predictiveness of the father's circumcision status on the child's circumcision status.

Keywords: male circumcision, neonatal circumcision, sexual pleasure, sexual function, bodily autonomy, United States

Introduction

Despite a considerable decline in the prevalence of this procedure since 1999, neonatal circumcision is the most common surgery performed on male newborns in the United States

(Maeda et al. 2012). A practice with a historical basis within certain religious traditions—such as Judaism and Islam—neonatal male circumcision is has been performed in large numbers since the first half of the 19th century (Gollaher 1994). In recent years, the medical practice of circumcision has become increasingly contested in the United States (US), especially by activist groups ("intactivists"), and even by medical professionals such as members of Doctors Opposing Circumcision— an international network of physicians against genital cutting.[11]

Despite the controversy surrounding the practice, circumcision is still prevalent and is supported—but not recommended as a routine procedure—by the American Academy of Pediatrics, an authoritative body on the health of US children (AAP 2012). Still, these debates illustrate that circumcision represents conflicted terrain, and raise questions regarding their impact on parents who must sign an informed consent document for the procedure to be conducted on their child. Thus, it is important to examine and understand how parents make their decisions. In particular, what are parents' social justifications for circumcising or not circumcising their children?

This article presents findings from research examining the motivations of parents who consented for their child to be circumcised at birth (or recently after birth) for non-religious reasons, as well as parents who did not consent to neonatal circumcision. I argue that parents weigh circumcision as a procedure with complex social ramifications that extend into the future, rather than as a medical decision alone.

[11] See: https://www.doctorsopposingcircumcision.org/

Understanding circumcision in social science research

Circumcision is well-studied in the discipline of anthropology (Shell-Duncan & Hernlund 2000; Silverman 2004). Within the field, research regarding male circumcision has been oriented around understanding the practice's role as a rite of passage, especially for indigenous groups in Africa, such as the Wiko and Ndembu peoples (Gluckman 1949; Paige & Paige 1981; Turner 1962). Anthropologists have also documented practices of subincision by indigenous Australians (Ashley-Montagu 1937; Singer & DeSole 1967), as well as biblical or Abrahamic circumcision as it occurs in the Jewish faith during the *brit milah* ceremony; these studies interpret the practice as a rite to distance infant boys from femininity and their mothers, and to masculinize them (Bilu 2000; Boyarin & Boyarin 1995; Goldberg 1996; Silverman 2006).

Anthropological attention also has been dedicated to the topic of female circumcision—a group of practices sometimes referred to by the term female genital cutting (FGC) (Hodžić 2016). Many researchers have explored the symbolic quality of the practice in Muslim communities (Ahmadu 2000; Boddy 1996; Shell-Duncan & Hernlund 2000) while others have addressed its potential implications for health (Gordon 1991; Larsen 2002). Anthropologist Eric Silverman, in a comprehensive review of anthropological scholarship on circumcision, notes that opposition to male circumcision is poorly documented in the discipline of anthropology, in contrast to the attention to female circumcision (2004). This discrepancy has not gone unnoticed, as indicated by a critique from historian Robert Darby and child rights attorney J. Steven Svoboda (2008), who suggested that anthropology's engagement with male and female genital cutting differs due to a tendency to separate the practices into two different categories—circumcision when it affects the male body, and mutilation when it impacts the female one.

According to Darby and Svoboda (2008:312), this 'double standard' is predicated upon Western nations' historical familiarity with Jewish customs through the Old Testament, in contrast to suspicion toward the practices of 'obscure barbarians' who participated in female genital cutting.

The topic of male circumcision has also been investigated in other social sciences. The work of sociologist Genaro Castro-Vázquez on male circumcision in Japan (2015) is of particular relevance. Castro-Vázquez investigated the rise of adult circumcision procedures in Tokyo and drew upon data he collected from interviews with men, women, medical professionals, and mothers of male children to argue that these uncommon circumcisions are sought out by Japanese men to enhance their virility and interest in sexual activity in the context of a nation with decades of declining and below-replacement birthrates (2015). Other research that is of interest are studies that explore parental decision-making using questionnaire and survey data to determine what factors are predictive of whether a child will or will not be circumcised (Binner et al. 2002). Binner et al. (2002) found that the education level of the parent affected their consent to circumcision; parents with a college education were more likely to consent to neonatal circumcision than those with a grade school or high school education. According to Binner et al. (2002), a child's circumcision became even more likely if their father was also circumcised.

My research builds upon the preceding scholarship to augment existing studies regarding parental decision-making about circumcision, particularly from an anthropological standpoint.

Circumcision, the body, and bodily autonomy

Theorization regarding the body is also relevant to this research, particularly as it relates to the idea of individual autonomy. Medical anthropologists have centered the human body in their work, and in doing so, have conceptualized it in different ways, as explored by Nancy Scheper-Hughes and Margaret M. Lock in their discussion of the field's approaches to the topic (1987). In

the context of my research, Marcel Mauss' notion of *la personne morale*—the distinctly Western conceptualization of personhood as it is asserted through an individual's autonomy (1985 [1938])—can be used to understand how some of the parents in my sample view their children as individuals with the ability to make their own medical decisions as adults, and whose autonomy should not be violated through circumcision without consent.

This research seeks to understand the motivations for parents to choose or not choose circumcision beyond medical concerns. Through 33 interviews, I found the most prevalent motivating factors to be father's circumcision status, concerns over future sexual functioning, and concerns over bodily autonomy to be the most prevalent. This leads me to argue that the decisions of circumcising and non-circumcising parents are not merely based on medical science, but also their cultural ideas surrounding the practice.

Methods

This article draws on semi-structured, qualitative interviews with 33 parents conducted from May to July 2020. I developed an interview guide for my sample, with lines of inquiry covering domains of experiences and perspectives on circumcision via open-ended responses. Further probing questions allowed for follow-up and expansion of ideas by research participants.

The inclusion criteria for my sample of parents required participants to be (1) at least 18 years old, and (2) the parent of a child born in or after 2013 and have opted for or against circumcision. Of the first sample, 18 parents reported not circumcising their children, eight parents reported going through with their child's circumcision, and seven parents reported circumcising an initial child or children, but not circumcising in subsequent births. Thirty-one participants in this sample identified as ethnically white, one identified as Black, and one as

Black/Latinx. Overall, the sample of parents was more educated than the national average, with more than half holding an advanced degree (American Council on Education 2021). More than half of my participants had a higher household income than the national median of $68,703 (Semega et al. 2020). All parents in this sample were in the United States at the time of birth, except for one parent who gave birth on a US military base overseas. (See Table 1: Sample characteristics, parents.)

The interviews lasted on average around 30-45 minutes, and up to 60 minutes, and were conducted via telephone and video conferencing services like Zoom and Skype. All interviews were audio-recorded with participants' permission and transcribed verbatim. The samples permitted saturation of themes (Saunders et al 2018). Data analysis included systematic coding using the qualitative analysis software Dedoose. The coding process followed the "dynamic and fluid process" of the grounded theory approach (Strauss and Corbin 1998) which allows for both predetermined, *a priori codes* to be explored (e.g., interactions with providers), and the emergence of inductive, not previously considered factors or explanations (e.g., sexual pleasure and function) (Coffey and Atkinson 1996). Completion of the coding process generated a detailed thematic dataset. The names of the research participants referenced in this article have been changed to pseudonyms to adhere to confidentiality protocols.

A limitation of this research is the composition of the sample, which included predominantly white individuals with higher income and education levels than the national averages. Other limitations include the sample size, and the lack of data collected about respondents' geographic location. Thus, the interview data collected from my parent sample cannot be used to make any nationally representative claims (though this was not the intent of the research regardless).

Like father, like son?

Research by Binner et al. (2002) on the effects of parental education on decision-making regarding neonatal circumcision conducted in the US established that there is a significant link between the father's circumcision status and parents' decisions to circumcise. Specifically, they found that an infant was more likely to be circumcised if its father had also been circumcised, whereas having an uncircumcised father would make it more likely that the infant would remain uncircumcised (Binner et al. 2002:458).

My research supports the previous study and shows that the father's circumcision status was, in fact, a factor considered by parents in their decision-making. For instance, when I asked Elijah—a father in his early thirties who is circumcised—what motivated him to circumcise his son Alex, he responded: 'Really, I just wanted him to look like me'. Later in his interview, Elijah described a conversation with his family pediatrician that reaffirmed his decision: 'We spoke with our pediatrician about it. He said that it really is a preference thing and up to the parents. And, when the doctor asked me if I was circumcised, he said "it'd be good for him to look like daddy"'. Angela, Alex's mother and Elijah's wife, corroborated:

> That was just our pediatrician's recommendation. Our pediatrician is our family doctor, so he sees all of us. He was already aware of everything about us, and he basically just said, "You don't want your son to grow up and see that he's different, so he should look like dad, and that way if he has questions, dad will already know what to tell him". He did say to me he never suggests necessarily that a parent does it [circumcises], but he does recommend that the child match the father.

The recommendation of Alex's pediatrician is worth addressing here, primarily because it can be conceptualized as privileging the physical resemblance between parent and child over a consistent stance on circumcision. This is significant because such advice may serve to reinforce

the notion that children must look like their parents, which adheres to the way that kinship ties in the US are legitimized through physical similarity (Samuels 2009:86). While not inherently harmful, positions such as the pediatrician's are evocative of an ideology that reinforces the stigma experienced by children who do not bear a resemblance to their parents or other family members, such as adoptees, and especially transracial adoptees (Samuels 2009).

Likewise, when I asked Jade—a mother of one in her early thirties—why she didn't circumcise her son Tyler, she explained: 'We [my husband and I] felt like there were a few reasons [not to circumcise]. My husband is not [circumcised]—so that's one—we just decided to keep it that way'. Jade also mentioned that as a Christian she included 'a lot of biblical research' and ultimately felt the procedure was 'unnecessary', which factored into her and her husband's decision.

One father I interviewed, Andrew, chose to not circumcise his son and had experienced continued criticism from army doctors for not having been circumcised himself. He felt he was very well-informed about the benefits and drawbacks of being uncircumcised, but had to resist the pressure: 'Being an intact male in my age group was really uncommon, and I've had a lot of providers try to force circumcision on me, even though it wasn't required. I was in the army, and they were like, "We should do this". And I was like, "No".' Andrew and his ex-wife chose not to circumcise their son Luke, because: 'I'm not circumcised, so I didn't see any purpose of doing it because the functions of the foreskin can benefit both men and women'.

The experiences of these parents demonstrate that a father's circumcision status can be an influential factor in the decision whether to circumcise a child. When providers like Angela and Elijah's pediatrician make recommendations that the child 'match' the father, this seems even more likely.

However, despite it being an important factor for parents' consideration, the circumcision status of the father was not always convincing. Amanda—a mother in her early thirties—opposed circumcision before she even planned to have a baby. However, her husband Steve, a lawyer, had assumed that they would circumcise their child. Because both parents were not in agreement, they decided to research the topic, including watching an instructional video of circumcision for medical students. Steve was 'horrified' by the nature of the procedure but remained 'on the fence' because of concerns that his son's circumcision status differing from his own would create hardship for the son. Amanda described how she addressed her husband's hesitation:

> Where he kind of ended up was, "I do think that it's wrong, but like I don't want him to feel weird because I'm circumcised and he isn't. What if he sees my penis and he's like, 'why doesn't my penis look like your penis?'" And my final argument was—the thing that shifted his opinion about it was—I was like, "Well, if you think it's wrong and understand that the rates are falling, then aren't you essentially putting this burden on him? What if he has a kid someday and he has to make this decision that he has that his penis different than his kid? And that's a burden that he has to have? Wouldn't you rather take that for him?" And he was like, "yeah, that's a really good point, I feel like that's a good first thing to do as a parent" or whatever.

Interestingly, not circumcising a child was conceptualized by Amanda and Steve as a sacrifice on his part rather than inaction. In essence, because of the ubiquitous nature of circumcision, parents may feel burdened with the effort to resist normative pressures when refusing to circumcise, despite the fact that the penis is uncircumcised by default. Thus, leaving a child as they were born, i.e., doing nothing, now necessitates intention, decision-making, and resilience.

Though Amanda argued against circumcision, her discussion of her son's possible future 'burden' also exemplifies a discourse that prioritizes sameness between parent and child—the very same discourse that Steve used to try to convince her to agree with the procedure. Thus, despite initially taking two different sides, both parents' arguments favored conformity between father and son, potentially re-affirming ideas that perpetuate the stigmatization of bodies that are 'different'.

Sometimes the decision is perceived to belong to the father, potentially indicating a gendered dimension to the decision to circumcise. For example, Jordan, a stay-at-home mother in her late twenties, circumcised her first son to match her husband and recounted that 'it was kind of his decision'. However, they both decided against circumcising their second son after learning more about the procedure. When asked how the circumcision status of her husband and first son factored into her decision, she answered:

> I was initially worried [about the difference], however, I actually had a friend who put it to me in a very succinct way. She said, "Whenever you come up against that question, you just need to ask your husband, 'When was the last time you compared penises with your father?' That's not something you're going around doing. You're not going, 'Hey. [laugh] Look at me!'" She said, "you can tell them, 'This is what was done to daddy when he was a baby and we chose not to do it to you'".

Jordan found her friend's advice about addressing the aesthetic differences between circumcised and uncircumcised penises to be more than enough to convince her to disregard her reservations against not circumcising her son.

On the other hand, some parents found the idea of 'matching' to be ridiculous altogether and certainly not worthy of contention or deliberation. When I asked Rebekah—a stay-at-home

mother in her early thirties—if she and her husband Patrick had ever considered his circumcision status when they thought about whether to circumcise their son, she laughed:

> No. That's something we laugh at because we wonder, “who are these people comparing their penises?” My husband said that he absolutely never compared his penis to his father's. That didn't even factor in for us. He felt more strongly that it's something our son should be allowed to choose, and he doesn't care that they don't match.

Rebekah’s opinion was echoed by Barbara, a mother in her late thirties who discussed circumcision with her husband before deciding to not circumcise their son:

> We thought about it a little bit, but generally, the reason I hear on that note is, “Well, the father and the son won't match”. They don't match anyway! One's little and one's big, and they're not super into running around naked anyway. We decided that was not going to be a factor for us.

The narratives offered by participants like Amanda and Jordan illustrate that deciding not to circumcise the child of a circumcised parent can create worry and anxiety about the aesthetic differences between the penises of father and son, but also that a father’s circumcision status is not always the most important factor considered by parents in their decision-making. Meanwhile, Rebekah and Barbara’s accounts indicate that the idea of ‘matching’ is sometimes discarded completely by parents as an illogical concept.

In addition to this part’s exploration of the influence of the father’s circumcision status on parental decision-making, I will detail parents’ discussions of the potential effects of circumcision on child’s future sex life in the next section.

Potential effects of circumcision on child's future sex life

Much of the controversy surrounding circumcision as a practice is fueled by the assumption that removing the foreskin can have a detrimental impact on an individual's sexual function and pleasure (Collier 2011). However, recent research on the topic does not necessarily support this idea. For example, in their review of the determinants, prevalence, safety, and acceptability of male circumcision in sub-Saharan Africa, the World Health Organization found that men's beliefs that the practice would enhance their sexual performance and pleasure served as motivation for them to participate in the surgery (2007:25).

Of course, a belief that something is true does not always make it so—an idea that is reinforced by Earp et al.'s survey on circumcision satisfaction in US men, which demonstrated that a greater endorsement of inaccurate beliefs about circumcision and penile anatomy was predictive of higher satisfaction with the procedure (2018:948). Earp et al.'s research is important to keep in mind when discussing research on circumcision satisfaction, as it may account for the satisfaction and lack-of-harm reported by circumcised men in other studies (2018:948).

This being said, current systematic reviews on the sexual effects of circumcision do not establish a relationship between the surgery and inferior sexual function (Shabanzadeh et al. 2016), nor do they suggest circumcision causes decreased penile sensitivity, reduced pleasure (Krieger et al. 2008), or premature ejaculation (Yang et al. 2018). Furthermore, in a systematic review of publications on the effects of male circumcision on sexual function, penile sensation, or sexual pleasure, medical scientist and circumcision advocate Brian J. Morris and urologist John N. Krieger (2020) argued that the highest quality literature demonstrate that circumcision has little to no effect on sexual pleasure and performance and can even provide some benefits.

Still, evaluations of circumcision's effect—if any—on one's sexual function are complicated by the fact that some aspects of sexuality are not objectively measurable; these questions are made even more complex by an individual's sociocultural and historical background, which influences whether they perceive their circumcision status positively or negatively (Marco and García Heil 2020). Given the contention surrounding circumcision and sexuality, I was not surprised by how often sexual function and pleasure were mentioned by noncircumcising parents as additional benefits to not circumcising their children that had factored into their decision-making. For example, when I asked Julie, a birth doula and mother in her early twenties, about the research she conducted to help her make 'an educated decision' about her child's health, she told me what she discovered:

> I found there's increased chance of erectile dysfunction when he's an adult. He then loses the protection of the foreskin on the glans of his penis, and so it becomes dried out, like keratinized. Then there's also no lubrication as a natural lubricant when you have a foreskin, and so he would lose that. There's also no way to tell for sure how much foreskin the penis needs to when fully erect when he's an adult.

Meanwhile, Caroline, a mother who described herself as being 'well-educated' on circumcision due to coursework in child development and sexual psychology, echoed Julie's concerns regarding potential sexual and erectile dysfunction.

> The people that I know that have had circumcisions, they have more discomfort throughout their adult lives than uncircumcised adults, and generally there's more incidents of sexual dysfunction. Again, sample of convenience of the people that I know. It seems like, why would you ask for trouble? I also knew that there were some medical issues that can occur later in life, like as the penis grows, the foreskin doesn't grow at the same time where it might be needed later.

While Caroline is indeed relying on a 'sample of convenience' to re-affirm her decision not to circumcise, it is worth noting that her and Julie's concerns about tissue loss have been documented in research (Taylor et al. 1996). Circumcision entails a loss in the surface area of the penis, sometimes resulting in an insufficient amount of skin for it to expand when erect; this can make erections painful and tight for a circumcised individual (Hammond and Carmack 2017:200) and has even been suggested to contribute to a loss in the length of the erect penis (Richters et al. 1994:77).

Aside from Julie, other parents remarked upon the lubrication provided by the foreskin, such as Isabel, a stay-at-home mother in her late thirties. When I asked Isabel what benefits she saw to not circumcising her child, she explained: 'Well, mostly [it] was sexual benefits. As he gets older, there's lots of nerve endings that are being taken away [if he was circumcised], and also as far as the natural lubrication that the foreskin provides, and also for the benefit for his future partner [or] spouse.'

Indeed, circumcision has been associated with a requirement for artificial lubrication during masturbation and heterosexual sex, especially due to keratinization of the glans (Boyle and Bensley 2001:12), which can contribute to friction during intercourse that is uncomfortable for both partners (O'Hara and O'Hara 1999:81; Sorrells et al. 2007:868). It is likely that Andrew is referencing the natural lubrication provided by the foreskin in his answer to my question about what he knew about circumcision before his son Luke was born. He explained:

> The foreskin works for both the man and the woman [during sex]; it keeps the penis healthy. All the functions are beneficial, and there's so many methods if there's even a problem with the foreskin, that you don't need to conduct a circumcision. There's so many other methods to prevent that.

Isabel and Andrew's answers not only indicate a consideration of the potential effects of circumcision on their child's future sex life, but also a concern for how it may impact any of their children's future sexual partners. Their scrutiny is not unfounded; in cases of heterosexual intercourse, circumcision has also been linked to increased vaginal dryness (Cortés-González et al. 2009), whereas the uncircumcised penis is associated with increased likelihood of female orgasm (Bensley and Boyle 2003). Still, these findings are disputed by other research suggesting that overall, circumcision does not negatively impact female sexual satisfaction (Kigozi et al. 2009:1698) and that women may actually prefer having intercourse with circumcised men over men who are intact (Morris et al. 2019:159). Neonatal circumcision is recorded to have little effect on male-to-male sexual behaviors and experiences, though gay men circumcised *after* infancy were more likely to experience erection difficulties and to prefer receptive—rather than insertive—anal sex (Mao et al. 2008).

Among the parents in this study who circumcised, only one mentioned the effects of circumcision on sexual pleasure. Grace, a doctoral candidate from Nigeria, circumcised her son James to adhere with her home country's religious and cultural traditions. When I asked her if she knew of any risks to the surgery, she answered: 'I've heard people in Nigeria who are against it, saying it will decrease his sexual pleasure when he grows up. But even if there's a mixed view on circumcision where I come from, a majority of boys still get circumcised.' In Grace's case, her cultural and religious beliefs were the most important factor and made her son's circumcision a given event rather than one subjected to extended deliberation. Ultimately, it was unsurprising that none of the other circumcising parents connected the procedure to a decrease in pleasure, as many of them were circumcised or had only had sexual experiences with circumcised people.

Regardless of the actual impact circumcision may have on one's sex life, it is a perception of negative effects that influenced the decisions of parents in my sample. Much of the time, a considerable amount of effort went into their self-education on circumcision, as many of the claims made my parents could be supported by research. However, just as many studies exist to contradict their findings. This suggests that there may have been a certain amount of selectivity in effect, insofar as parents 'endorsing' the data that confirmed or re-affirmed their position while discarding those that supported circumcision. Because studies exploring the effects of circumcision on sexuality are complicated by a lack of objective standards to measure certain elements of sexual function—for instance, body image—the entire body of research creates uncertainties about how much results are skewed by the cultural conceptions of participants (Earp et al. 2018; Marco and García Heil 2020), which may have also played a part in how different findings were rejected and accepted by parents. In my next section, I will address how parents' concerns regarding ethics and bodily autonomy also affected their choices.

Circumcision, consent, and bodily autonomy

Many of the parents in my sample that opted to not circumcise their child(ren) viewed the decision not to circumcise as related to morality and ethics, and the procedure itself as a violation of bodily integrity and autonomy.

When I interviewed Hayley, a statistician and mother in her late thirties, she informed me that her husband Will was circumcised himself and was initially 'opinionless' on the matter. Meanwhile, Hayley had become aware of the divisive nature of the issue due to previous experiences in informal parenting groups online and sought to educate herself on the controversy by 'doing a lot of reading'. According to Hayley, she had a conversation with Will about not circumcising their child that went as follows:

> It was just like, “what's healthy for our child?” And “what do we think is a moral decision for his ability to consent to things that happen to his body?” Like there are things that, you know, a baby can't consent to that you have to decide for them, but this is something that there's no reason we have to decide that for him.

Hayley had accepted that her role of a parent may necessitate consenting to treatments for her son’s wellbeing—such as intubation, for instance—but to her, circumcision did not constitute a medical necessity. Similarly, Amanda imagined the decision to circumcise as one outside her purview as a parent:

> It immediately felt crazy to me to make that decision for another person. Because as far as cutting off a part of someone's body goes, it just felt like, “how can I make that decision for another person?” Especially without knowing anything about them really, you know? The baby doesn't have opinions about stuff yet.

Julie explained that she and her husband chose not to circumcise their son because they felt that ‘he should be able to decide what happens to his own genitals when he's an adult’. She described her son’s bodily autonomy as ‘a basic human right’ that she didn’t want to infringe upon by going through with the procedure. Julie’s opinion is shared by some legal scholars, who conceptualize the practice of male circumcision as a violation of both medical ethics and human rights under international law (Svoboda et al. 2000:61-62).

Additionally, Julie’s view of circumcision as a decision that could be left until later was not unique among my sample. In fact, Amanda entertained this option, as her husband Steve came from a Jewish family. She explained: ‘But if he grows up and he's like “I want to be Jewish and part of that, for me, is getting circumcised”, of course I would support that, but I just don't want to make that decision for someone else’.

Another participant, Rebekah, felt that the irreversible[12] nature of the procedure precluded both her and her husband from consenting for their son. 'We feel like if he grows up and he decides he wants it done, that's a choice he can make. But, if we make the decision for him as a newborn, he can't go back and undo that. So it was, for us, an issue of bodily autonomy, more than anything else'.

Summer, a doctoral candidate in her early forties, also felt more comfortable allowing her son to consent to the procedure in the future, rather than agreeing to it herself: 'I just felt like in the absence of a reason to circumcise, [it's] better to not. He could always do it as an adult if he wanted to.'

Summer's statement—and those of other parents—can be understood through engagement with the idea of *la personne morale* (Mauss 1985[1938]; Scheper-Hughes and Lock 1987; Willems 2000). In essence, the narratives from parents detailed above imply that from their perspective, circumcision is an act that limits the rights and violates the autonomy of their children. Therefore, foregoing newborn circumcision so their children can decide to circumcise as adults allows the children to assert their personhood through individual consent to the procedure.

Overall, the narratives offered by parents in this section indicate that circumcision is not just a medical decision, but also one subject to moral and ethical attention. Additionally, the procedure is viewed by parents as distinct from other life-saving interventions they are prepared and willing to consent to on their child's behalf. Because it is not thought by these participants to

[12] Though circumcision is indeed an irreversible procedure in that some parts of the modified penis can never be recovered, nonsurgical foreskin restoration procedures such as the approach advised by the National Organization of Restoring Men (NORM) have achieved success (Collier 2011).

be a medical necessity, they are more comfortable waiting until their child is old enough to consent on their own.

Conclusions

This study highlights the way that decision-making surrounding circumcision is not limited to a consideration of its medical ramifications but is also influenced by parents' cultural assumptions about the procedure and their imagination of its future effects.

Three findings from this study may explain why neonatal circumcision is decreasing in the US. First, the narratives of my participants illustrate that while influential, the father's circumcision status is not always predictive of the child's. This may be especially true when ideas about 'matching the father' are increasingly rejected by non-circumcising parents as illogical or not important. The aesthetic difference between the circumcised father and intact child may even be viewed as a 'sacrifice' on the part of the former. Furthermore, advice from medical providers such as pediatricians indicating that the child should match the father can contribute to the stigmatization of physical difference, even among non-circumcising parents.

Second, parents' concerns regarding the potential effects of circumcision on their child's future sex life, including their ability to function and experience pleasure, are relevant to their decision-making. The accounts of my participants indicate a perception that the procedure causes impaired sexual performance and diminished pleasure for the circumcised individual and their partner. Parents' fears existed in congruence with a body of research that can be scoured for supportive information, but that research also offers findings that rebuke such notions. To further complicate the matter, studies regarding the effects of circumcision on sexuality rely on subjective assessment of sexual functioning and pleasure, which therefore may not encompass goals that are meaningful across the population. This calls into question the extent to which their

results are influenced by participants' own assumptions and creating grounds for parental dismissal of the research's validity.

Finally, many of the non-circumcising parents in my sample viewed circumcision as a violation of medico-legal ethics and their child's bodily autonomy, contributing to their rejection of the procedure. According to my participants, their refusal to circumcise their children was rationalized by their conception of the surgery as outside the realm of medical necessity, as well as the knowledge that their child could consent to circumcision later in life as an adult.

This study contributes to medical anthropology scholarship regarding the social factors that influence medical decision-making and male circumcision, particularly in a US context, by illuminating the complex process that underlies parent's decisions for their children. Furthermore, it provides an understanding of why circumcision rates in the US are gradually declining; however, the cultural assumptions of the parents—including those regarding the idea that the child 'match' the father, can still account for its remaining prevalence.

Ethical approval

This research was reviewed and approved by the University of Central Florida's Institutional Review Board in May 2020, study #00001715.

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Appendix

Table 1: Sample characteristics, parents

Parent	Circumcised Child?	Age Range	Ethnicity	Religious Affiliation	Approx. Income (Household/Year)	Level of Education	Employment	Marital/Partnership Status	Health Insurance/ Coverag
1	No	31-35	White	None	70,000 - 100,000	Bachelor's Degree	Part-time	Married	Public (AIM, ACA)
2	No	36-40	White	No affiliation - Spiritual	70,000 - 100,000	Master's Degree	Part-time	Married	Private, full
3	No	36-40	White	Pagan	20,000 - 50,000	Master's Degree	Stay-at-home	Married	Private, full
4	No	41-45	White	Unitarian	100,000 <	Master's Degree, Doctoral Candidate	Full-time	Married	Private, full
5	Yes, then No	36-40	White	None	20,000 - 50,000	Bachelor's Degree	Part-time	Married	Private, full
6	Yes, then No	36-40	White	None	50,000 - 70,000	Master's Degree	Part-time	Married	Public (state job), full
7	Yes	31-35	Black/Latinx	Christian	20,000 - 50,000	Bachelor's Degree	Full-time	Married	Private, full
8	Yes	26-30	White	Christian	20,000 - 50,000	Bachelor's Degree	Part-time	Married	Private, full
9	No	36-40	White	None	20,000 - 50,000	Master's Degree, Doctoral Candidate	Full-time	Married	Private, full
10	No	18-25	White	Christian	50,000 - 70,000	Some College	Full-time	Married	Private+ Public, partial
11	Yes, then No	31-35	White	None	100,000 <	Master's Degree	Full-time	Married	Private
12	No	31-35	White	Christian	50,000 - 70,000	Bachelors	Full-time	Married	Private, full
13	No	31-35	White	Unitarian Universalist	50,000 - 70,000	Some College	Part-time	Married	Tri-Care
14	No	18-25	White	None	20,000 - 50,000	Associate's Degree	Full-time	Married	Public (Medicaid)
15	Yes, then no	41-45	White	Christian	100,000 <	Some College	Part-time	Married	Private, partial
16	No	41-45	White	Unitarian	100,000 <	Doctorate's Degree	Full-time	Married	Private, full
17	No	36-40	White	Christian (Non Denominational)	70,000 - 100,000	Bachelor's Degree	Part-time	Married	Private, Full
18	No	36-40	White	Protestant (not practicing)	100,000 <	Doctorate's Degree	Full-time	Married	Private, full
19	Yes	31-35	Black	Christian (Non Denominational)	>20,000	Master's Degree, Doctoral Candidate	Full-time	Married	Public (state job), full
20	No	26-30	White	Catholic (Non Practicing)	70,000 - 100,000	Bachelor's Degree	Full-time	Married	Private, Full
21	No	36-50	White	Christian	100,000 <	Master's Degree	Stay-at-home	Married	Tri-Care
22	Yes, then No	41-45	White	Christian (Non Denominational)	20,000 - 50,000	Master's Degree	Full-time	Married	Private, full
23	No	31-35	White	None	70,000 - 100,000	Master's Degree	Full-time	Married	Private, full
24	No	31-35	White	Christian	20,000 - 50,000	High School Diploma	Stay-at-home	Married	Private
25	No	31-35	White	Agnostic	70,000 - 100,000	Associate's Degree	Full-time	Divorced	Tri-Care
26	Yes	31-35	White	None	70,000 - 100,000	Master's Degree	Full-time	Married	Public (state job), full
27	No	41-45	White	None	50,000 - 70,000	Associate's Degree	Full-time	Single	Private, full
28	Yes, then No	26-30	White	Christian	70,000 - 100,000	Bachelor's Degree	Stay-at-home	Married	Tri-Care
29	Yes	36-40	White	None	100,000 <	Master's Degree	Full-time	Married	Private, full
30	Yes, then No	46-50	White	Atheist	100,000 <	Doctorate's Degree	Full-time	Married	Private, full
31	Yes	31-35	White	Christian (Non Denominational)	100,000 <	Master's Degree	Full-time	Married	Private, full
32	Yes	36-40	White	None	70,000 - 100,000	Doctorate's Degree	Full-time	Married	Private, full
33	Yes	36-40	White	Lutheran	100,000 <	Associate's Degree	Part-time	Married	Private, full

References

Ahmadu, Fuambai. 2000. "Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision." In *Female "Circumcision" in Africa: Culture, Controversy, and Change*, ed. Bettina Shell-Duncan and Ylva Hernlund, pp. 283-312. Boulder, CO: Lynne Rienner Publishers, Inc.

American Academy of Pediatrics. "Circumcision Policy Statement." *PEDIATRICS* 130, no. 3 (2012): 585–86. https://doi.org/10.1542/peds.2012-1989.

American Council on Education. "Educational Attainment, by Race and Ethnicity." Race and Ethnicity in Higher Education, September 10, 2020.

Ashley-Montagu, Montague F. 1937. The Origin of Subincision in Australia. *Oceania* 8:193–207.

Bañuelos Marco, Beatriz, and Jessica Leigh García Heil. "Circumcision in Childhood and Male Sexual Function: a Blessing or a Curse?" *International Journal of Impotence Research* 33, no. 2 (2020): 139–48. https://doi.org/10.1038/s41443-020-00354-y.

Bensley, Gillian A., and Gregory J. Boyle. "Effects of Male Circumcision on Female Arousal and Orgasm." *New Zealand Medical Journal* 115, no. 1181 (2003): 595–96.

Bilu, Yoram. 2000. "Circumcision, the First Haircut and the Torah: Ritual and Male Identity among the Ultraorthodox Community of Contemporary Israel. In *Imagined Masculinities: Male Identity and Culture in the Modem Middle East*, ed. Mai Ghoussoub and Emma Sinclair-Webb, pp. 33-63. London, UK: Saqi Books.

Binner, Sharon L., Joan M. Mastrobattista, Mary-Clare Day, Laurie S. Swaim, and Manju Monga. 2002. "Effect of Parental Education on Decision Making About Neonatal Circumcision." *Southern Medical Journal* 95(4): 457-61.

Boddy, Janet. 1996. "Violence Embodied?: Circumcision, Gender Politics, and Cultural Aesthetics." In *Rethinking Violence Against Women*, ed. R. Emerson Dobash and Russell P. Dobash, pp. 77-110. Thousand Oaks, CA: Sage Publications.

Boyarin, Jonathan, and Daniel Boyarin. 1995. "Self-Exposure as Theory: The Double-Mark of the Male Jew." In *Rhetorics of Self-Making*, ed. Debbora Battaglia, pp. 16-42. Berkeley, CA: University of California Press.

Boyle, Gregory J., and Gillian A. Bensley. "Adverse Sexual and Psychological Effects of Male Infant Circumcision." *Psychological Reports* 88, no. 3_suppl (2001): 1105–6. https://doi.org/10.2466/pr0.2001.88.3c.1105.

Castro-Vázquez, Genaro. 2015. *Male Circumcision in Japan.* New York, NY: PalgraveMacmillan.

Coffey A, and P. Atkinson. (1996) *Making Sense of Qualitative Data*. Thousand Oaks: Sage.

Collier, R. “The Studies That Launched a Thousand Snips.” *Canadian Medical Association Journal* 184, no. 1 (2011). https://doi.org/10.1503/cmaj.109-4029.

Cortés-González, Jeff R., Jorge A. Arratia-Maqueo, Rafael Martínez-Montelongo, and Lauro S. Gómez-Guerra. “¿Tiene La Circuncisión Algún Efecto En La Percepción De La Satisfacción Sexual Masculina?” *Archivos Españoles de Urología (Ed. impresa)* 62, no. 9 (2009). https://doi.org/10.4321/s0004-06142009000900008.

Darby, Robert and J. Steven Svoboda. 2008. "A Rose by Any Other Name? Rethinking the Similarities and Differences between Male and Female Genital Cutting." *Medical Anthropology Quarterly* 21(3):301-323.

Earp, Brian D., Lauren M. Sardi, and William A. Jellison. “False Beliefs Predict Increased Circumcision Satisfaction in a Sample of US American Men.” *Culture, Health and Sexuality* 20, no. 8 (2017): 945–59. https://doi.org/10.1080/13691058.2017.1400104.

Gluckman, Max. 1949. "The Role of the Sexes in Wiko Circumcision Ceremonies." In *Social Structure: Studies Presented to A.R.Radcliffe-Brown*, ed. M Fortes, pp. 145–67. Oxford: Clarendon.

Goldberg, Harvey E. 1996. Cambridge in the Land of Canaan: Descent, Alliance, Circumcision, and Instruction in the Bible. *Journal of the Ancient Near Eastern Society* 24:9-34.

Gollaher, David L. 1994. "From Ritual to Science: The Medical Transformation of Circumcision in America." *Journal of Social History* 28(1): 5-36.

Gordon, Daniel. 1991. "Female Circumcision and Genital Operations in Egypt and the Sudan: A Dilemma for Medical Anthropology." *Medical Anthropology Quarterly* 5:3-14.

Hammond, Tim, and Adrienne Carmack. “Long-Term Adverse Outcomes from Neonatal Circumcision Reported in a Survey of 1,008 Men: an Overview of Health and Human Rights Implications.” *The International Journal of Human Rights* 21, no. 2 (2017): 189–218. https://doi.org/10.1080/13642987.2016.1260007.

Hodžić Saida. *The Twilight of Cutting: African Activism and Life after NGOs*. Oakland, CA: University of California Press, 2017.

Kigozi, Godfrey, Ivan Lukabwe, Joseph Kagaayi, Maria J. Wawer, Betty Nantume, Grace Kigozi, Fred Nalugoda, et al. “Sexual Satisfaction of Women Partners of Circumcised Men in a Randomized Trial of Male Circumcision in Rakai, Uganda.” *BJU International* 104, no. 11 (2009): 1698–1701. https://doi.org/10.1111/j.1464-410x.2009.08683.x.

Krieger, John N., Supriya D. Mehta, Robert C. Bailey, Kawango Agot, Jeckoniah O. NdinyaAchola, Corette Parker, and Stephen Moses. “Adult Male Circumcision: Effects on Sexual Function and Sexual Satisfaction in Kisumu, Kenya.” *The Journal of Sexual Medicine* 5, no. 11 (2008): 2610–22. https://doi.org/10.1111/j.1743-6109.2008.00979.x.

Larsen, Ulla. 2002. "The Effects of Type of Female Circumcision on Infertility and Fertility in Sudan." *Journal of Biosocial Science* 34:363-377.

Maeda, Jared Lane, Ramya Chari, and Anne Elixhauser. 2012. *Circumcisions Performed in U.S. Community Hospitals, 2009: Statistical Brief #126.* (Rockville, MD: Agency for Healthcare Research and Quality (US), 2012).

Mao, Limin, David J. Templeton, June Crawford, John Imrie, Garrett P. Prestage, Andrew E. Grulich, Basil Donovan, John M. Kaldor, and Susan C. Kippax. "Does Circumcision Make a Difference to the Sexual Experience of Gay Men? Findings from the Health in Men (HIM) Cohort." *The Journal of Sexual Medicine* 5, no. 11 (2008): 2557–61. https://doi.org/10.1111/j.1743-6109.2008.00845.x.

Mauss, Marcel. "A Category of the Human Mind: the Notion of Person; the Notion of Self." Essay. In *The Category of the Person: Anthropology, Philosophy, History*, edited by M. Carrithers, S. Collins, and S. Lukes, 1–25. Cambridge: Cambridge University Press, 1985.

Morris, Brian J., and John N. Krieger. "The Contrasting Evidence Concerning the Effect of Male Circumcision on Sexual Function, Sensation, and Pleasure: A Systematic Review." *Sexual Medicine* 8, no. 4 (2020): 577–98. https://doi.org/10.1016/j.esxm.2020.08.011.

Morris, Brian J., Catherine A. Hankins, Eugenie R. Lumbers, Adrian Mindel, Jeffrey D. Klausner, John N. Krieger, and Guy Cox. "Sex and Male Circumcision: Women's Preferences Across Different Cultures and Countries: A Systematic Review." *Sexual Medicine* 7, no. 2 (2019): 145–61. https://doi.org/10.1016/j.esxm.2019.03.003.

O'Hara, K., and J. O'Hara. "The Effect of Male Circumcision on the Sexual Enjoyment of the Female Partner." *BJU International* 83, no. S1 (2002): 79–84. https://doi.org/10.1046/j.1464-410x.1999.0830s1079.x.

Paige, Karen E., and Jeffery M. Paige. 1981. *The Politics of Reproductive Ritual*. Berkeley, CA: University of California Press.

Richters, Juliet, John Paul Gerofi, and Basil Donovan. "Are Condoms the Right Size(s)? A Method for Self-Measurement of the Erect Penis." *Venereology* 8, no. 2 (1994): 77–81.

Samuels, Gina Miranda. "'Being Raised by White People': Navigating Racial Difference Among Adopted Multiracial Adults." *Journal of Marriage and Family* 71, no. 1 (2009): 80–94. https://doi.org/10.1111/j.1741-3737.2008.00581.x.

Saunders, B., J. Sim, T. Kingstone, S. Baker, J. Waterfield, B. Bartlam, H. Burroughs, and C. Jinks. (2018) Saturation in qualitative research: exploring its conceptualization and operationalization. *Quality and Quantity* 52:1893-1907.

Scheper-Hughes, Nancy, and Margaret M. Lock. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology." *Medical Anthropology Quarterly* 1, no. 1 (1987): 6–41. https://doi.org/10.1525/maq.1987.1.1.02a00020.

Semega, Jessica, Melissa Kollar, Emily A. Shrider, and John Creamer. "Income and Poverty in the United States: 2019." The United States Census Bureau, September 15, 2020. https://www.census.gov/library/publications/2020/demo/p60-270.html.

Shabanzadeh, Daniel M., Signe Düring, and Cai Frimodt-Møller. “Male Circumcision Does Not Result in Inferior Perceived Male Sexual Function - a Systematic Review.” *Danish Medical Journal* 63, no. 7 (2016): 1–9.

Shell-Duncan, Bettina, and Ylva Hernlund, eds. 2000. *Female "Circumcision" in Africa: Culture, Controversy, and Change*, Directions in Applied Anthropology: Adaptations and Innovations. Boulder, CO: Lynne Rienner Publishers, Inc.

Silverman, Eric K. 2004. "Anthropology and Circumcision." *Annual Review of Anthropology* 33(1): 419-45.

Silverman, Eric K. 2006. *From Abraham to America: A History of Jewish Circumcision.* Lanham, MD: Rowman & Littlefield Publishers, Inc.

Singer, Philip and Daniel E. DeSole. 1967. "The Australian Subincision Ceremony Reconsidered: Vaginal Envy or Kangaroo Bifid Penis Envy." *American Anthropologist* 69:355–58.

Sorrells, Morris L., James L. Snyder, Mark D. Reiss, Christopher Eden, Marilyn F. Milos, Norma Wilcox, and Robert S. Van Howe. “Fine-Touch Pressure Thresholds in the Adult Penis.” *BJU International* 99, no. 4 (2007): 864–69. https://doi.org/10.1111/j.1464410x.2006.06685.x.

Strauss, A. and J. Corbin. (1998) *Basics in qualitative research: techniques and procedures for developing Grounded Theory*. 2nd ed. London: Sage Publications.

Svoboda, J. Steven, James G. Dwyer, and Robert S. Van Howe. “Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum.” *Journal of Contemporary Health Law & Policy* 17, no. 1 (2000).

Taylor, J.R., A.P. Lockwood, and A.J. Taylor. “The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision.” *British Journal of Urology* 77, no. 2 (1996): 291–95. https://doi.org/10.1046/j.1464-410x.1996.85023.x.

Turner, Victor. 1962. Three Symbols of Passage in Ndembu Circumcision Ritual. In *Essays on the Ritual of Social Relations,* ed. M Gluckman. pp. 124–73. Manchester, UK: Manchester University Press.

Willems, Dick. “Managing One's Body Using Self-Management Techniques: Practicing Autonomy.” *Theoretical Medicine and Bioethics* 21, no. 1 (2000): 23–38. https://doi.org/10.1023/a:1009995018677.

World Health Organization. *Male Circumcision: Global Trends and Determinants of Prevalence, Safety and Acceptability*. Geneva: World Health Organization, 2007.

Yang, Y., X. Wang, Y. Bai, and P. Han. “Circumcision Does Not Have Effect on Premature Ejaculation: A Systematic Review and Meta-Analysis.” *Andrologia* 50, no. 2 (2017). https://doi.org/10.1111/and.12851.

CHAPTER 4: CONCLUSIONS

This thesis builds upon and contributes to literature in medical anthropology and other disciplines regarding medical decision-making and male circumcision, particularly in the context of the US, by exploring the complexities that underpin parents' decisions for their children. The findings of the first manuscript, "Situating Parents' Circumcision Decision-Making within Health Research, Knowledge, and Experience," account for the influence of factors related to medicine and health, whereas the findings of the second manuscript, "Social Factors in Parents' Circumcision Decision-Making," address the social considerations affecting parents' decisions.

Both articles that emerged from this study contribute to understanding why circumcision as a medical practice persists in the United States. Narratives from the first article about the hygienic benefits of circumcision re-affirm conceptualizations of the procedure by parents in this study as one that has been subjected to the process of medicalization and indicate that its continued prevalence may be fueled by enduring ideas about the foreskin as a source of disease. The first manuscript also presents data from participants that reveal a vulnerability related to parent-provider interactions, particularly about parents' consent to the procedure. In essence, some of the parents interviewed consented to circumcision despite possessing an incomplete understanding of the procedure's ramifications. This finding implies that some parents may consent to circumcision more readily than they might if they were better informed, revealing a need for professional medical associations to revisit the question of what ought to count as fully informed consent for this procedure in the US. Findings from the second manuscript illustrate that circumcision's persistence may be linked to the circumcision status of the child's father, which can have a predictive effect as demonstrated in previous research (Binner et al. 2002). In the US about 75% of men above the age of 15 are circumcised (WHO 2007); thus, it is likely that

many of these men are having children who are then circumcised to "match daddy," a theme that emerged in my interview data. However, this finding also serves to demystify circumcision's decline, as there are uncircumcised fathers who choose not to circumcise their children in pursuit of "matching," which then results in fewer circumcisions overall.

The findings of both articles also shed light on recent circumcision trends such as the waning prevalence of the procedure in the US. Findings from the first article illustrate that while parents value evidence-based healthcare, certain ambiguities within US circumcision guidelines exist. This vagueness may influence parents to seek sources of health information abroad, which may contrast with the AAP's recommendations regarding benefits and risks and present more critical views of the procedure (Hodgson 2020). Thus, it is not surprising that non-circumcising parents in my sample discussed seeking medical advice from sources in the United Kingdom and Australia that aided them in their decisions to not circumcise their children. The second manuscript's findings further illustrate why circumcision may be on the decline. Some parents discussed refusing to circumcise their children due to fears that it may negatively impact their future sexual functioning, while other parents asserted that circumcision represents a violation of their children's bodily integrity and autonomy. Such perspectives may demystify why the procedure's prevalence has fallen since 1999 (Maeda et al. 2012). It is also worth noting that while they are encumbered by ambiguous guidelines and various discourses about circumcision, parents nevertheless show the multifaceted nature of their decisions through thorough research and reliance upon experiential knowledge.

Future Research

This project could be built upon in many ways. For example, future research on this topic might explore the efforts of advocacy groups, such as Your Whole Baby or Doctors Opposing

Circumcision, in providing parents with education about circumcision. Future scholars may conduct discursive analyses of circumcision as a topic in the news and other forms of media, following the example set by Carter, Reyes-Foster, and Rogers' (2015) application of feminist critical discourse analysis to portrayals of breast milk sharing in newspapers in the US. Still others might address decision-making surrounding intersex genital interventions, which have been discussed in tandem with circumcision as both are surgical modifications of infant bodies (Fox and Thomson 2017). Other potential directions include conducting anthropological research within the medical community to understand how health professionals conceptualize the ambiguity of the AAP guidelines, and how they ensure informed consent for circumcision procedures.

Overall, a reproduction of this project with a larger and more diverse sample may capture factors beyond those derived from the parents interviewed in this study, which were predominantly white and of higher socioeconomic statuses. The lack of diversity in my sample is important to keep in mind for further engagement with this topic, as snowball sampling yielded an influx of parents passionate about and committed to intactivism; future research should monitor the sample to ensure a variety of perspectives are captured. Expanding the key informant sample would also be crucial, especially because of the findings regarding power dynamics between parent and provider. Other necessary considerations for an expansion of this study include the addition of participant observation in person at hospitals, parenting education classes, and circumcision advocacy meetings—none of which were feasible during the COVID-19 pandemic—but also virtually in online parenting groups or forums.

My findings also have implications beyond future research directions. Specifically, they can be engaged with by ombudsmen and other public advocates in hospitals to ensure expecting

parents are provided with the necessary information to consent to the procedure. Such engagement might also—but does not necessarily—necessitate a revision of existing informed consent documents (Brown 2013). I hope that this research project will generate new interest in circumcision and all its complexities and provide the springboard to future research in this area.

APPENDIX A: IRB APPROVAL LETTER

UNIVERSITY OF CENTRAL FLORIDA

Institutional Review Board
FWA00000351
IRB00001138, IRB00012110
Office of Research
12201 Research Parkway
Orlando, FL 32826-3246

EXEMPTION DETERMINATION

May 15, 2020

Dear Karli Reeves:

On 5/15/2020, the IRB determined the following submission to be human subjects research that is exempt from regulation:

Type of Review:	Initial Study
Title:	Parental Motivations For and Against Circumcising Newborns in the United States
Investigator:	Karli Reeves
IRB ID:	STUDY00001715
Funding:	None
Grant ID:	None
Documents Reviewed:	• Reeves HRP251, Category: Faculty Research Approval; • Reeves Flyer Key Informants Updated 5-14-2020, Category: Recruitment Materials; • Reeves Flyer Parents Updated 5-14-2020, Category: Recruitment Materials; • Reeves HRP254 Key Informants Updated 5-14-2020, Category: Consent Form; • Reeves HRP254 Parents Updated 5-14-2020, Category: Consent Form; • Reeves HRP255 Updated 5-14-2020, Category: IRB Protocol; • Reeves Interview Guide Key Informants, Category: Test Instruments; • Reeves Interview Guide Parents, Category: Test Instruments;

This determination applies only to the activities described in the IRB submission and does not apply should any changes be made. If changes are made, and there are questions about whether these changes affect the exempt status of the human research, please submit a modification request to the IRB. Guidance on submitting Modifications and Administrative Check-in are detailed in the Investigator Manual (HRP-103), which can be found by navigating to the IRB Library within the IRB system. When you have completed your research, please submit a Study Closure request so that IRB records will be accurate.

If you have any questions, please contact the UCF IRB at 407-823-2901 or irb@ucf.edu. Please include your project title and IRB number in all correspondence with this office.

Due to current COVID-19 restrictions, in-person research is not permitted to begin until you receive further correspondence from the Office of Research stating that the restrictions have been lifted.

Sincerely,

Kamille C. Birkbeck

Kamille Birkbeck
Designated Reviewer

APPENDIX B: INTERVIEW GUIDE (PARENTS)

Project Title: Parental Motivations For and Against Circumcising Newborns in the United States

(After HRP 254 – Explanation of Research)

Thank you for agreeing to talk with me today. My name is Karli Reeves, and I'm an anthropology master's student at the University of Central Florida. In this interview I'm interested in your experiences about your decision to circumcise—or not to circumcise—your child. All the information you give me will be confidential – I will not ask you for your name or any information that could identify you. The interview is voluntary, and it will take 20-60 minutes. Can I audio record our interview or would you prefer I didn't? Would you like to start now?
Research/recruitment Site: _____
Date: _____ Time: _____

Questions about Experiences and Perspectives

1. Was your child circumcised as a newborn?
    a. If you did opt for your child to be circumcised, why?
    b. If you did not opt for your child to be circumcised, why not?
    c. What did you know about circumcision before your child was born?
    d. Did you consider any of the risks (if pro)/benefits (if anti) of circumcision while making your decision?

2. Did you discuss circumcision with the other parent [if applicable]?
    a. If yes: To what extent did you discuss circumcision?
    b. If yes: Did you and the other parent share the same opinion on circumcision?

3. Did you do any research on circumcision before the birth of your child?
    a. If yes: What kinds of sources did you consult?
        i. Did you read any parenting books or blogs?
        ii. Did you look at medical literature such as pamphlets or journals?
        iii. Many people are not aware of it, but have you heard of the recommendation on circumcision released by the American Academy of Pediatrics (AAP) in 2012?
            1. If you were aware, did it influence your decision?
            2. If you were not aware, do you think it would have influenced your decision?

4. Did you make a birth plan before the child was born?
    a. If yes: Do you still have this plan available?

5. Were you involved in any parenting groups or movements before the birth of your child?
    a. If yes: Was circumcision something that was discussed within this group/movement?
        i. If yes: If any, what stance did this group/movement take on circumcision?
        ii. Was this stance different or the same as your own opinion? In what ways was it different or similar?

6. What kind of healthcare professional delivered your child (i.e. a midwife or obstetrician)?
    a. If child is circumcised: Was this the same person who circumcised your child?
    b. Regardless: Did you discuss circumcision with this person before birth?
        i. Did you ask them about the subject, or did they bring it up first?

[Probes: What happened in this conversation? What was said? Did the provider say that circumcision was your decision (as a parent)? Did you feel as if the provider had a preference? Did you ask anyone else during this time for input?]

1. Aside from medical staff, who was present when your child was born?
    a. Did you discuss circumcision with any of these people before birth?
        i. If yes: Did you ask for their input on the subject or did they bring it up first?

    [Probes: What happened in this conversation? What was said?]

2. Did you talk to anyone else about circumcision before the birth of your child?
    [Probes: What happened in this conversation? What was said? Why did you talk to this person?]

3. If you or your partner had medical insurance at the time of birth, including Medicaid or any coverage provided by the state, do you know if it covered circumcision?
    a. Was this something you considered at all if/when you thought about whether to circumcise your child?

    [Probes: Do you recall the cost of the procedure?]

4. If mother: Is the child's father circumcised? If father: Are you circumcised?
    a. Is this something that you considered at all if/when you thought about whether to circumcise your child?

5. Have your feelings towards the procedure changed in any way after the birth of your child?
    a. If yes: Why do you think your feelings changed?
    b. After birth, did your child have any medical issues related to being circumcised or not being circumcised?

    [Probes: How did your feelings change?]

Demographics:
I'd like to close the interview with a few brief demographic questions; you have the option to decline answering any or all of them:

a. Age Range: 18-25 26-30 31-35 36-40 41-45 46-50 51-55 56-60
b. Ethnicity (please state, as self-identified):
c. Religious affiliation, if any (please state, as self-identified):
d. Approximate Income Range Per Year: <20,000 | 20,000-50,000 | 50,000-70,000 | 70,000-100,000 | >100,000
e. Level of education (please state):
f. Employment (please state if full or part time, and type of work):
g. Marital or partnership status (please state):
h. Type of health insurance and coverage:

Thank you very much for your time. Do you have anything else you'd like to add that I didn't ask you? Do you have any questions for me?
Please don't hesitate to contact me if there's anything else that you would like to add that you have not had a chance to say during this interview. Here's my contact information: Karli Reeves, Phone: 850-619-6689 (call or text). Email: kmr98@knights.ucf.edu.

APPENDIX C: INTERVIEW GUIDE (KEY INFORMANTS)

Project Title: Parental Motivations For and Against Circumcising Newborn Babies in the United States

(After HRP 254 – Explanation of Research)

Thank you for agreeing to talk with me today. My name is Karli Reeves, and I'm an anthropology master's student at the University of Central Florida. In this interview I'm interested in your experiences as a healthcare professional or pregnancy/childbirth companion. All the information you give me will be confidential – I will not ask you for your name or any information that could identify you. The interview is voluntary, and it will take 20-60 minutes. Can I audio record our interview? Would you like to start now?

Research/recruitment Site: _____

Date: _____ Time: _____

Questions about Experiences and Perspectives

1. If any, what is your role throughout a parent's pregnancy?

2. In what setting do you care for a pregnant parent? In what setting do you deliver children or assist with the childbirth process?

3. What is your role during childbirth? Tell me about the responsibilities that you have on a standard day.

4. Do you participate in newborn circumcision?
    a. If yes: To what extent?

5. What training do you have regarding circumcision, if any?
    a. If medical professional: Was your training on circumcision consistent throughout medical/nursing school and residency or did it change?
        i. If it did change, how so?

6. What has influenced your opinion about circumcision?

7. When do you discuss circumcision with parents? Before birth? On the day of birth? After birth?
    a. How do you advise them?
    b. How often do parents ask you about circumcision?
    c. Is it more common for you or the parent(s) to initiate the discussion?
    d. What questions do they ask, if any?
        i. Have you noticed any changes in the types of questions asked since you started in this field?

[Probes: Does this advice vary based on patients? Or does it stay the same? If varies, how? When?]

8. Do you or does your institution supply expecting parents with any literature on circumcision, such as pamphlets? Or do you find that this is something parents generally prefer to look up on their own?

Demographics:

I'd like to close the interview with a few brief demographic questions; you have the option to decline answering any or all of them:

a. Employment place/occupation:
b. Country/State where trained:
c. Years in this position:
d. Approximate number of births assisted per month/year:

Thank you very much for your time. Do you have anything else you'd like to add that I didn't ask you? [if not:] Do you have any questions for me about this study?

Please don't hesitate to contact me if there's anything else that you would like to add that you have not had a chance to say during this interview. Here's my contact information: Karli Reeves, Phone: 850-619-6689 (call or text). Email: kmr98@knights.ucf.edu.

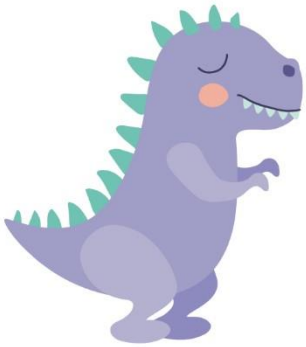
APPENDIX D: RECRUITMENT MATERIALS

VOLUNTEERS NEEDED FOR RESEARCH:

PARENTAL MOTIVATIONS FOR (AND AGAINST) CIRCUMCISING NEWBORNS IN THE UNITED STATES

DETAILS:

This IRB-approved research aims to gain an understanding of how parents make the decision to circumcise or not to circumcise their children.



Eligible participants must be at least 18 years old, and be the parent of a child born in or after 2013, and have opted for circumcision.

Participants will be asked to take part in a CONFIDENTIAL interview lasting no more than one hour. Due to Covid-19, interviews will occur over video-conferencing software such as Skype or Zoom.

CONTACT INFORMATION:

For more information about this study, contact Principal Researcher Karli Reeves via email at kmr98@knights.ucf.edu or by phone at 850-619-6689.

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VOLUNTEERS NEEDED FOR RESEARCH:

PARENTAL MOTIVATIONS FOR (AND AGAINST) CIRCUMCISING NEWBORNS IN THE UNITED STATES

DETAILS:

This IRB-approved research aims to gain an understanding of how parents make the decision to circumcise or not to circumcise their children.

Eligible participants must be at least 18 years old, and be the parent of a child born in or after 2013, and have opted for or against circumcision.

Participants will be asked to take part in a CONFIDENTIAL interview lasting no more than one hour. Due to Covid-19, interviews will occur over video-conferencing software such as Skype or Zoom.

CONTACT INFORMATION:

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RESEARCH ON NEWBORN CIRCUMCISION:

SEEKING HEALTHCARE PROFESSIONALS & TRAINED CHILDBIRTH COMPANIONS

DETAILS:

This IRB-approved research aims to understand perspectives of healthcare professionals and doulas/trained childbirth companions regarding newborn circumcision.

Eligible participants must be at least 18 years of age and be a healthcare professional or a doula/trained childbirth companion who advises and accompanies parents before or after birth.

Participants will be asked to take part in a CONFIDENTIAL interview lasting no more than one hour. Due to Covid-19, interviews will occur over video-conferencing software such as Skype or Zoom.

CONTACT INFORMATION:

For more information about this study, contact Principal Researcher Karli Reeves via email at kmr98@knights.ucf.edu or by phone at 850-619-6689.

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REFERENCES

American Academy of Pediatrics. “Circumcision Policy Statement.” *PEDIATRICS* 130, no. 3 (2012): 585–86. https://doi.org/10.1542/peds.2012-1989.

American Academy of Pediatrics. “About the American Academy of Pediatrics.” HealthyChildren.org. 2021. https://www.healthychildren.org/English/Pages/About-AAP.

Binner, Sharon L., Joan M. Mastrobattista, Mary-Clare Day, Laurie S. Swaim, and Manju Monga. 2002. "Effect of Parental Education on Decision Making About Neonatal Circumcision." *Southern Medical Journal* 95(4): 457-61.

Brown, Jeffrey L. “Medical-Legal Risks Associated with Circumcision of Newborn Males: Need for Revised Consent.” *AAP News* 34, no. 4 (2013).

Carter, Shannon K., Beatriz Reyes-Foster, and Tiffany L. Rogers. “Liquid Gold or Russian Roulette? Risk and Human Milk Sharing in the US News Media.” *Health, Risk & Society* 17, no. 1 (2015): 30–45. https://doi.org/10.1080/13698575.2014.1000269.

CNN Wire Staff. “Benefits of Infant Circumcision Outweigh Risks, Top Pediatrics Group Says.” CNN. Cable News Network, August 27, 2012. https://www.cnn.com/2012/08/27/health/circumcision-policy.

Deacon, Liam. “Men's Rights Group Hold Bizarre Anti-Circumcision Protest On International Men's Day.” Breitbart, November 19, 2015. https://www.breitbart.com/europe/2015/11/19/mens-rights-group-hold-bizarre-anticircumcision-protest-international-mens-day/.

Fox, Marie, and Michael Thomson. “Bodily Integrity, Embodiment, and the Regulation of Parental Choice.” *Journal of Law and Society* 44, no. 4 (2017): 501–31. https://doi.org/10.1111/jols.12056.

Gollaher, David L. 1994. "From Ritual to Science: The Medical Transformation of Circumcision in America." *Journal of Social History* 28(1): 5-36.

Hodgson, Dominic. “USA and UK : Differences on Neonatal Circumcision.” *Trends in Urology & Men's Health* 11, no. 2 (2020): 27–29. https://doi.org/10.1002/tre.742.

Keatley, Susan Reslewic. “Should You Circumcise Your Baby Boy?” The New York Times. The New York Times, April 18, 2020. https://www.nytimes.com/2020/04/17/parenting/guides/circumcision-baby-boy.html.

Maeda, Jared Lane, Ramya Chari, and Anne Elixhauser. 2012. *Circumcisions Performed in U.S. Community Hospitals, 2009: Statistical Brief #126.* (Rockville, MD: Agency for Healthcare Research and Quality (US), 2012).

Revelant, Julie. “Circumcision on the Decline? What Parents Need to Know about the Procedure.” Fox News. FOX News Network, December 19, 2014. https://www.foxnews.com/health/circumcision-on-the-decline-what-parents-need-to-knowabout-the-procedure.

Silverman, Eric K. 2006. *From Abraham to America: A History of Jewish Circumcision.* Lanham, MD: Rowman & Littlefield Publishers, Inc.

World Health Organization. *Male Circumcision: Global Trends and Determinants of Prevalence, Safety and Acceptability*. Geneva: World Health Organization, 2007.

Yiannopoulos, Milo. “No One Wants to Live In A World Of Uncircumcised Penises.” Breitbart, May 28, 2015. https://www.breitbart.com/europe/2015/05/28/no-one-wants-to-live-in-aworld-of-uncircumcised-penises/.