

ABSTRACT

Title of dissertation: Clinical Practice in Prenatal Care: Perspectives of Latina Mothers, Healthcare Providers, and Scientists on Male Circumcision

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This study examines how the interplay between biomedical and ethnomedical perspectives impacts on reproductive health services and consumer decision to circumcise among Latinos in Prince Georges County, Maryland. International research influenced circumcision decision-making during prenatal care: little is known about how neonatal male circumcision (MC) is understood at local clinics; about what patients and providers know regarding circumcision benefits; and the reasoning behind the choices made regarding MC among Latinos. What are the beliefs, practices, and policies regarding MC at community clinics and the international research that influences these policies? Ethnographic research was conducted in three clinics in the state of Maryland including participant observation in the clinics, and interviews with healthcare providers, Latina women who sought services, and scientists and policy makers currently active in MC research. The study explored the interplay between biomedical and ethnomedical

knowledge of prenatal care services. Interviews were also conducted with six scientists and policy makers currently active in MC research. The study found that as a reproductive health procedure MC illustrated a complex interplay between biomedical and consumer knowledge. Specifically, healthcare providers did not talk about MC to patients mainly because: 1) They thought that the majority of the Latina women seeking services did not want the procedure; 2) The clinics are constrained for resources and circumcision is not a priority when compared to other prenatal care topics deemed more important in the short prenatal visits. In addition, the policy makers and scientists made assumptions referring to the discussion of circumcision by reproductive and sexual health services clinics when providing prenatal care to clients. Their knowledge relied exclusively on the results of clinical trial data, and how this data could inform policy and clinical guidelines. This dissertation contributes to understanding how services impact MC decision-making and increase the pool of data in regards to the feasibility of overarching MC policies aimed at infants. In addition, this research recommends to critically examine MC as a biomedical practice that is now being rationalized as an HIV prevention strategy.

CLINICAL PRACTICE IN PRENATAL CARE: PERSPECTIVES OF LATINA
MOTHERS, HEALTHCARE PROVIDERS AND SCIENTISTS ON MALE
CIRCUMCISION.

By

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Dedication

Para las mujeres de mi familia, en especial a mis abuelas, y a la memoria de mi mami.

For the women of my family, especially my abuelas and to the memory of my mami.

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List of Abbreviations

In order of appearance in the text

MC	Male Circumcision
EBM	Evidence-based Medicine
HIV	Human Immunodeficiency Virus
WHO	World Health Organization
US	United States
NMC	Neonatal Male Circumcision
STIs	Sexually Transmitted Infections
WHO	World Health Organization
CDC	Centers for Disease and Control Prevention
NHAS	National HIV/AIDS Strategy for the United States
ACA	Affordable Care Act
AAP	American Academy of Pediatrics
ANT	Actor-Network Theory
STS	Science and Technology Studies
GC	Geneva Care clinic
OCM	Oldpine Clinic at Millkeep
OCW	Oldpine Clinic at Waterley
OB/Gyn	Obstetrician/Gynecologist
UTIs	Urinary Tract Infections
FQHC	Federally Qualified Health Centers
NIH	National Institutes of Health

Chapter One

Introduction

Male circumcision (MC) has attracted much attention recently: in the context of human rights of newborn males (Darby and Svoboda 2007; Silverman 2004), Medicaid coverage issues in light of budget cuts at the state level (Clark, et al. 2011; Johns Hopkins Medical Institutions 2011); and as an HIV/AIDS prevention method (Gust, et al. 2011; Tobian, et al. 2013b). Recent discussions among anthropologists regarding MC and HIV/AIDS have been based on the impact and appropriateness of epidemiological clinical trials, yet have not galvanized current ethnographic research on the practice of MC as a prevention strategy (Bailey 2001; Bell 2005; Darby and Svoboda 2007; Green 2009). While epidemiologists have studied MC as a prevention method through ecological studies and clinical trials, anthropological research has concentrated on female circumcision, and on MC as a rite of passage in tribal societies in Southeast Asia, Africa, and Australia, rather than as clinical practice in the US (Bell 2005; Green 2009; Scheper Hughes 1991; Silverman 2004).

My dissertation research investigated three interrelated sectors of MC practice: (1) how healthcare providers practiced MC as a component of prenatal care in community clinics that deliver reproductive and sexual health services; (2) how Latina patients perceived MC as they received pre- and post-natal care services; and, (3) how scientists' research on MC influenced policy, public discourse and evidence-based practices. Thus, the dissertation linked macro (scientists and policy makers), meso (health care providers), and micro (Latina women who are clients) levels to examine the impact that evidence-

based medicine (EBM)¹ can have on a routine medical procedure—such as MC—from an anthropological perspective. This approach allows for understanding ethnographically how MC policy recommendations are practiced in sexual and reproductive health clinics focusing on three different practices of MC: as the result of clinical trials and its ensuing policy recommendations; as clinical guidelines and practices regarding MC in the clinics; and as decision making process of Latina women seeking services.

Research Problem and Research Questions

Public health policies informed by epidemiological findings, otherwise known as evidence-based policy-making, regularly sideline the broader context of their target populations, especially as these policies are expected to drive service delivery and behavior change at the local level (Timmermans and Berg 2010; Waterston 1997). I conducted ethnographic research that investigated the extent to which epidemiological research on MC influenced information given during pre-natal care in these clinics. The research problem questions the practice of ignoring contextual variables in policy recommendations, which can invariably fracture the EBM relationship between international epidemiological research, practitioners delivering care, and subsequently the patients who consume these services. This practice disconnects the perceived legitimacy

¹ EBM is a biomedical paradigm that provides research evidence based on clinical trials and meta-analysis in order to inform clinical guidelines (Timmermans and Berg 2010). EBM is highly regarded for providing objective measures to the subjective world of clinical practice; it is definite, decisive, unevolving, and authoritative. A clinical trial provides evidence for hypothesized relationships, such as circumcision. Clinical trials are conducted to address epidemiological research problems complementing other qualitative research methods (Timmermans and Kolker 2004; Timmermans and Berg 2010).

of scientific health research in local, national and international settings; the translation of that research to national recommendations as ‘silver bullet’ approaches; and its relationship to the beliefs and practices of target groups.

I explored this research problem through the following research questions:

1. How do Latina women in Prince George’s County, Maryland enact circumcision as they seek pre- and post-natal care services in clinics? How does their knowledge of MC affect their decision-making process and practices?
2. How do the health recommendations regarding male circumcision at the international and national levels affect local service delivery, if at all? And how can service delivery affect a Latina mother’s decision to circumcise her son(s) or not?
3. Finally, how do scientists/policy makers come to enact their research as policy and ensuing clinical delivery guidelines regarding service delivery?

For the rest of the chapter, I will present a literature review that will discuss the practice of MC and its ensuing medicalization in the US; the relationship between MC and HIV prevention; the role of MC in biomedicine and the delivery of reproductive and sexual health services; MC and HIV prevention among Latino populations; and the theoretical frameworks that will contextualize the discussion of the ethnographic data and its conclusions.

History of MC and its Medicalization

MC is believed to have arisen as an early public health measure in the ancient Middle East and North Africa as a way to avoid the infection of the glans known as balinitis

caused by sand accumulation in the penis (Hutson 2004). Modern ideas of non-religious MC in the US are rooted in Victorian-era notions of sexuality and hygiene, in which circumcision was used to cure phimosis, to curb masturbation, as well as to control and manipulate nervous and sexual anomalies in boys. MC provided a medical solution for specific historical anxieties tied to penile hygiene and repudiation of smegma² (Bailis and Halperin 2006; Bell 2005; Darby and Svoboda 2007; Silverman 2004). To scrutinize how MC is understood today is to examine how the foreskin has been historically understood as ‘extra-skin’ and useless in the context of body image and religiosity. The Western world familiarity with Judeo-Christian ideas made the procedure look milder and less foreign. The idea of what constituted a healthy body (and a healthy body image) was transformed during the Victorian period and the Industrial Revolution in the context of germ theory of disease (Bell 2005; Darby and Cozijn 2013).

Subsequent social and cultural events cemented the practice; as the First World War unfolded, soldiers from Australia and the US were circumcised to combat epidemics of balanitis (Hutson 2004). This practice continued during the Second World War and when soldiers eventually returned home, the procedure was subsequently practiced on the soldier’s children with the unwritten assumption that they would fight in the next big war (Hutson 2004).

Nowadays, circumcision is performed based on a variety of lay notions of health and hygiene despite the fact that a circumcised penis is by no means more hygienic than an uncircumcised one (Bell 2005; Hutson 2004). Arguments that rationalize routine NMC

² Residue present in the glans of an uncircumcised penis. Its removal is performed by retracting the foreskin.

are ideologically separated from religious MC—though they can coexist and often do—as the practice seems to instill gender socialization to American newborn males rapidly after birth in a clinical setting, making the procedure look like a modern biomedical ritual. The American Academy of Pediatrics (AAP) does not strictly recommend MC, yet it is perceived by many as another aspect of the birthing process. While the procedure of MC is simple and involves very low risks/complications, it is not to be dismissed as trivial and as a process without risk (Gerharz and Haarmann 2000).

The WHO (2007) estimates that approximately 30% of men in the world are circumcised, most of whom are located in Muslim countries, Israel, the US, and South Korea; and among industrialized countries in the world, the US ranks high in the number of neonatal routine circumcisions that are carried out. In the US, MC tends to be performed on children with high socioeconomic status (who are more likely to be covered by private insurance), males born in the Midwest and the Northeast, and Black/African-Americans (World Health Organization 2007; Zhang, et al. 2011). Currently, MC in the US seems to be stabilized around a prevalence of 60% in the general population (see figure 1).

Data on circumcision in the US is underestimated and imprecise since datasets do not account for NMCs performed outside of hospitals and because self-report has been found to yield to misclassification in regards to self-circumcision status³ (Centers for Disease Prevention and Control 2008; Morbidity and Mortality Weekly Report 2011; Risser, et al. 2004). Aside from the US, prevalence of MC in the Americas (especially the Caribbean, Central and South America) is very low (no higher than 20% rate in any one country) and

³ Especially among self-report in adolescents.

there is scarce information on why that is and MC decision-making (World Health Organization 2007). This dissertation will explore decision-making and provide data on the decision-making process related to circumcision among Latinas in the US.

Figure 1: Circumcision by the Numbers

Survey	Prevalence of MC	Years	Race / Ethnicity
National Health and Examination Survey (NHANES)	79%	1999-2004	88% Non-Hispanic White
			73% Non-Hispanic Black
			42% Mexican American
			50% Other Races / Ethnicities
National Hospital Discharge Survey (NHDS)	65%	1999	
	59.1%	1999-2010	
National Inpatient Sample (NIS)	61%	1997-2000	
	57.8%	1999-2010	
Change Data Master (CDM)	55.8%	1999-2010	

Source: author's tabulations based on Xu, Markowitz, Sternberg, et al. (2007), Centers for Disease Control and Prevention (2010), Zhang, Shinde, Kilmarx, et al. (2011) and Morbidity and Mortality Weekly Report (2011).

To understand the pervasiveness of MC in the US, it is useful to contextualize its history within what is known as medicalization. Medicalization is a framework used in medical anthropology to refer to how medical technologies encroach on life transitions, extending medical authority to normal occurrences during the life course. Medicalization is an extension of biomedicine's goal of understanding the material world, so that nature could be described in objective ways (Lock and Nguyen 2010). This extension of medical authority into the social world results in regulating normal life, as well as making the body and its manifestations 'disease like' (Lock 2004; Sobo 2009). Reproductive health has been increasingly medicalized through the years, and major criticisms has stemmed

from the social sciences (especially from feminists and authors identifying as People of Color), who have interpreted medicalization as playing an oppressive role through history: such as the clinical trials of the contraceptive pill in Puerto Rico (see Lapp 1995; Tyrer 1999), forced sterilization of indigenous women in Oaxaca, México (see González Montes 2009) , as well as the current ways in which reproduction plays into public policy and affects ethnic minorities (see González Montes 2009; Lonergan 2012).

MC intersects with the past, with modern ideas of hygiene and medicine, as well as with the ethical concerns of using surgery for religious/social/preventative measures in complex ways (Hutson 2004). The surgery is now being advocated for its simplicity and perceived innocuous nature, since it does not hamper men's sexual pleasure and can have a preventative effect for STIs. However, it does sever nerves present in the foreskin and desensitizes the glans. Proponents of MC see this loss of sensitivity as insignificant or unimportant, yet it is highlighted by those who oppose MC (Bell 2005; Darby and Cozijn 2013; Johns Hopkins Medical Institutions 2011; Westercamp and Bailey 2007). Some pro-MC scientists argue that their scientific findings are beyond ethical considerations raised by anti-MC activists, as well as above arguments of how appropriate or not MC is as an HIV prevention strategy (Johns Hopkins Medical Institutions 2011; Short 2004).

The concerns of bodily autonomy and integrity come into light in the contemporary widespread implementation of medicalized health policies related to HIV prevention, and in their reverberation throughout the industrialized, and developing world (Bonner 2001). Medicalization—in this instance—provides a protective effect to circumcised male genitalia based on how the penis and its foreskin have been re-imagined to converge on religious, modern, biomedical and hygienic ideas associated with reproductive and sexual health

(Lakoff and Collier 2004; Silverman 2004). Some have argued that the contemporary medicalization of MC demonstrates the disconnect of healthcare providers from the cultural history of our Western biomedical health system that has maligned the foreskin through MC (Bonner 2001; Gerharz and Haarmann 2000).

Human rights activists have decried the asymmetry of the disparate discourses regarding female and male circumcision and have actively opposed both procedures on the account that they violate body integrity (Bell 2005; Darby and Svoboda 2007). Likewise, physicians and scientists have also spoken against the broad assumptions made in the clinical trials and their applicability to different contexts beyond the settings of the clinical trials in the African continent (Fox and Thomson 2005; Green, et al. 2008; Green, et al. 2010).

As a growing concern in past decades, *intactivist* movements have voiced their opposition to routine NMC. As recently as February of 2011, San Francisco citizens sought to put a ban on MC on their electoral ballot, an effort that was eventually thwarted when Governor Brown signed a law forbidding bans on MC (York 2011). Health care professionals who are proponents of MC contend *intactivists'* activism—trying to defund and ban MC in the US—is highly unethical given the protective effect it can have to prevent HIV and other STIs (Johns Hopkins Medical Institutions 2011).

The *intactivist* movements, in their different manifestations, parallels those that oppose female circumcision. They argue that similarly to female circumcision, MC does not respect the body integrity of males, given that oftentimes the procedure is performed

without the patients' expressed consent⁴. Anti-circumcision discourses confront the status quo with open discussions about sexuality, arguing that medical decisions made early in the lives of children can have unintended effects on the socialized adult male. The risks of routine MC are often minimized and ignored, and there is little discussion on the repercussions that the procedure might have on the emotional wellbeing of that male when he becomes an adult (Darby and Svoboda 2007). A major concern that intactivists capitalize on—also discussed by scientists and physicians against NMC—is that the procedure is ethically unnecessary in the absence of disease, and as such the risks that come with the procedure should not be tolerated (Hutson 2004).

Men who regret having been circumcised as newborns have “*likened the procedure to rape and maternal abandonment*”, and to feeling mutilated as the result a violent and intrusive procedure performed by medicine, morally justified on public health research, religion, and ideas of the male Western body (Hellsten 2004:248; Robbins 2011; Silverman 2004). This shows that a study of circumcision must look beyond the realm of medicalization and integrate the perspectives of experiences related to circumcision.

Critics that have raised ethical concerns have highlighted how an infant's lack of consent connotes a degree of mutilation (Robbins 2011). As recently as June 2012, a court in Cologne, Germany ruled that “*involuntary religious circumcision should be made illegal because it could inflict serious bodily harm on people who had not consented to it*” (MSNBC.Com ; Robbins 2011). Pro-circumcision scientists criticize these views by stating that anti-MC activists are creating misinformation by

⁴ Given that most of the time it is performed at childbirth

“misreading” the scientific data (Banerjee, et al. 2011; Johns Hopkins Medical Institutions 2011).

Bell and Bonner highlight that circumcision should not be perceived as a “*natural condom*”, meaning that while MC diminishes risk of HIV contagion, the reasoning behind promoting circumcision is still founded on a male-dominated sexual ideology in which men are driven by testosterone-driven impulses and cannot control their natural urges to be promiscuous (Bell 2005; Bonner 2001: 143,151).⁵ Bell and Bonner have interpreted MC as an HIV/AIDS prevention strategy, to those that cannot be bothered engaging in safe sex practices. In this manner MC can provide a sense of protection to men who are going to engage in unprotected sex anyway, given that their circumcised penis serves as a “*prophylactic*” against infection (Short 2004: 241).

The debate for and against circumcision is not limited to men who were circumcised without their consent and feel wronged by the procedure. Health professionals and researchers alike have questioned the purpose of the procedure, the manner in which the clinical trials were conducted, and the resulting recommendations of MC as an HIV prevention strategy (Bonner 2001; Dekkers 2009; Fox and Thomson 2010; Johns Hopkins Medical Institutions 2011; Titus and Moodley 2009).

The debate about circumcision has centered on the prepuce and the purpose of the foreskin. I argue that these debates are shaped by the way society perceives the penis as a social construction. As Bonner (2001) elucidates, MC proponents see it as simple fold of skin, a redundant piece of tissue serving a vestigial purpose, reducing the foreskin to a

⁵ As cited by Bonner from Fink, AJ. Newborn circumcision: a long-term strategy for AIDS prevention. Journal of the Royal Society of Medicine 1989:82:695.

physiological purpose. This dissertation research ponders the repercussions of the embodiment of HIV/AIDS in the US when adding circumcision as a prevention strategy to reproductive and sexual health services.

MC, HIV Prevention, and Reproductive Health Services

Research in the past decade has shown that MC can have up to a 60% protective effect against HIV infection in men engaging in penile-vaginal intercourse. Researchers Auvert and colleagues (2005), Bailey and colleagues (2007), and Gray and colleagues (2007) have drawn attention to their three paramount clinical trials in Kenya, Uganda and South Africa when recommending MC as a prevention strategy in Sub-Saharan Africa. Given the applicability of the results in these three countries, the World Health Organization (WHO) promptly added MC to their recommended HIV prevention strategies (World Health Organization 2007).

In spite of this, eighteen states of the US have defunded coverage of MC from Medicaid and the number of circumcised males has been dwindling since the 1970's (Banerjee, et al. 2011; Johns Hopkins Medical Institutions 2011; Morbidity and Mortality Weekly Report 2011; Morris 2007). The influx of migrants from Latin American countries and China—where circumcision rates have been historically low—has contributed to the steady and slow decline of NMC rates in the US (see figure 1) (Bell 2005; Bonner 2001; World Health Organization 2007; Zhang, et al. 2011).

In response to this (the decline of the number of circumcisions in the US and the defunding of Medicaid) health professionals have stressed the importance of NMC as a complementary strategy to prevent HIV infection (Morris, et al. 2014a). Through a policy

statement of the AAP, a number of physicians—as well as epidemiologists—in the US have recommended that prospective parents be provided the full breadth of information regarding the benefits and risks of MC, to encourage the performance of the procedure immediately after birth (American Academy of Pediatrics 2012; Hutchinson 2011; Morris 2007). The policy statement reads:

Systematic evaluation of English-language peer-reviewed literature from 1995 through 2010 indicates that preventive health benefits of elective circumcision of male newborns outweigh the risks of the procedure. Benefits include significant reductions in the risk of urinary tract infection in the first year of life and, subsequently, in the risk of heterosexual acquisition of HIV and the transmission of other sexually transmitted infections... Although health benefits are not great enough to recommend routine circumcision for all male newborns, the benefits of circumcision are sufficient to justify access to this procedure for families choosing it and to warrant third-party payment for circumcision of male newborns. It is important that clinicians routinely inform parents of the health benefits and risks of male newborn circumcision in an unbiased and accurate manner. [American Academy of Pediatrics 2012:585]

Scientists that participated in the three clinical trials have strongly emphasized the benefits of MC through the scientific literature and popular media. The aforementioned research has documented the preventive effects of HIV through MC. MC advocates have even compared the MC decision-making process of a newborn son to the decision-making process of vaccinating children (Gerharz and Haarmann 2000; Hutson 2004; Johns Hopkins Medical Institutions 2011). Anti-MC activists have been quick to point out the differences between the two given that MC denotes a surgery and should not be equated to another prevention strategy (vaccination) that does not involve surgery.

The clinical trials in Africa relied on the assumption of unchanging exposure (unprotected sex), which resulted in evidence that suggested a lower relative risk of contracting HIV in circumcised men if exposure stayed the same. The clinical trial data

and its ensuing recommendations presumed that an individual's risky behaviors will remain unchanged, without taking into consideration social, cultural and historical factors (Bonner 2001). Much like the gendered discourse comparing MC to a "*natural condom*", a medicalized procedure as an HIV prevention method can serve those individuals whose risky behaviors and attitudes might resist change. But, it can also underscore or even potentially replace open discussions about safer sexual practices and methods that might be equally effective to those same individuals.

The recommendation of the AAP—the first HIV prevention strategy that targets male newborns—fails to account for the different sociocultural factors that influence sexual relationships in Sub-Saharan Africa (when compared to the US) and their respective prevention strategies. It also fails to critically engage in analyzing localized epidemics as well as practices and beliefs surrounding circumcision, and the service provision strategies that are already in place in local clinics. This is especially important given that the HIV/AIDS epidemic in the US is predominantly reported to be the result of risky male-to-male sexual contact, whereas in Sub-Saharan Africa it is mostly risky heterosexual contact; thus the exact impact of MC as a potential prevention strategy in the US—versus Sub-Saharan Africa—is currently unknown, aside from mathematical models (Centers for Disease Prevention and Control 2010; 2011; Kacker S 2012). The circumcision trials in these three African countries only addressed heterosexual transmission; there is currently no consistent evidence that supports a positive relationship between male-to-male sexual transmission and being circumcised (Centers for Disease Prevention and Control 2008; Maulsby, et al. 2014; Millett, et al. 2007; Millett, et al. 2008; Sansom, et al. 2010; Smith, et al. 2010; Warner, et al. 2009).

The AAP's recommendation also ignores how local reproductive and sexual health clinics deliver services in light of budget and resource constraints. These clinics aim to link sexual and reproductive health with prevention of sexually transmitted infections (STIs), provide support for sexual violence, and deliver birth control services, in spite of—more than often—politicized (conservative) environments and limited economic resources (Dudgeon and Inhorn 2004; Gavin, et al. 2009; Glasier and Gülmezoglu 2006). Integrating MC as a prevention strategy within reproductive and sexual health services would be in line with the holistic view of sexual health that the WHO (2004:21-22) encourages, but it is currently unknown how this happens, if at all.

My research addresses the paradigmatic problem of perceiving circumcision only through the lens of biomedicine and its sociocultural history within the US. I strived for more than a narrow view of science that does not account for non-quantifiable social and cultural variables that can be proven through clinical trial research—the golden standard of epidemiology (Timmermans and Berg 2010).

As NMC is being promoted as an HIV prevention strategy among a changing and diverse population in the US, my research study sought to clarify the conditions under which NMC was used—or not used—as a prevention strategy. Focusing on Latino populations in Prince George's County in the state of Maryland, I explored the arguments and practices between three study populations: Latina mothers seeking prenatal care, healthcare service providers, and scientists/policy makers. More specifically, this research sought to address questions such as: What do Latino parents know about circumcision? To what extent have they been explained that there is a positive relationship between circumcision and HIV prevention? What do Latino parents know

about HIV and its prevalence in the US where they will raise their child? How do they believe they will protect their child against these diseases? What do they ultimately decide when they give birth? Does their decision-making change throughout pregnancy and delivery? How is circumcision brought up in prenatal care services? What are the beliefs and practices of health professionals regarding circumcision?

I investigated these questions, by studying them within the delivery of sexual and reproductive health care access, and how these beliefs and practices are affected by the acceptability of new prevention technologies. It is vital to consider how service acceptability is affected by access to those services, including HIV/AIDS prevention strategies in settings where they might be discussed—as is the case of discussing MC in pre-natal care services. To address these questions, such as understanding programmatic strategies and policy recommendations, context was crucial. This research seeks to explore the experiences of Latina women of Prince George’s County in regards to their access to reproductive and sexual health services. More specifically, how their decision-making on NMC was related to service providers’ beliefs and practices. This research is an inquiry into the beliefs and practices of mothers throughout pre and post natal care services and how other stakeholders influenced their decisions: biomedical practitioners, social workers, midwives, parents—even if residing abroad—husband/partner, neighbors or other members of their local networks. The analysis of various perspectives on the practices NMC throughout pregnancy, helped to understand the outcome of the decision to circumcise or not, and, in turn to understand issues of access to sexual and reproductive health care services and compliance with educational messages about HIV prevention.

HIV, its Impact on the Latino Population, and Access to Services

The Centers for Disease and Control Prevention (CDC) estimate that 1.2 million people in the U.S. are living with HIV and that 1 in 5 of those individuals are unaware that they are infected (Centers for Disease Prevention and Control 2012). In 2012, Latinos accounted for 21% of new HIV infections in the United States although they account for only approximately 16% of the total population (Centers for Disease Prevention and Control 2014). Reasons provided for the disproportionate prevalence include test avoidance due to the stigma ascribed to the disease, fear of disclosing their undocumented immigrant status, and an increase in risky behaviors of highly acculturated immigrants (Centers for Disease Prevention and Control 2011; 2014).

The state of Maryland ranks 4th in the nation in reported AIDS Cases and is among the top ten in both cumulative HIV and AIDS diagnoses. Prince George's County accounts for the second highest reported cases of HIV/AIDS in the state, with higher rates in areas geographically inside the Capital Beltway⁶ (Centers for Disease Prevention and Control 2011; Health Department Prince George's County 2010). When compared to adjacent counties and to the state of Maryland as a whole, Prince George's County African-American/Black⁷ and Latino populations suffer from poorer health status than other populations (Adventist Health Care Center on Health Disparities 2011). However, very few racial disparities can be identified for the County as a whole, due to the presence of

⁶ A major highway of the Washington D.C., Virginia, and Maryland Metropolitan area that geographically bound the inner and outer suburbs of the Washington DC Metropolitan area.

⁷ Although African American is the most common designation, Black is also mentioned given the high number of African immigrants in the County that are lumped together with African Americans in current statistics.

both affluent African-American and White communities living in the area⁸ (Adventist Health Care Center on Health Disparities 2007).

Statistics show that Latinos in Prince George's County have a very low infection rate, in comparison to other ethnic/racial groups as shown in Figure 2. Though Latinos are disproportionately affected by the HIV/AIDS epidemic at the national level, Prince George's County Health Department has reported low rates of infection among Latinos (Centers for Disease Prevention and Control 2014). Thus, the national and county level data do not seem to correspond with one another. The low reported rates of HIV transmission among Latinos in Prince George's County could be explained by what the CDC mentions as a misclassification issue, given that Latinos can identify as different races on health based surveys (Centers for Disease Prevention and Control 2011; 2012). These reasons though, are not exhaustive.

⁸ The three study clinics are not located in affluent neighborhoods.

Figure 2: Prince George's County HIV Statistics at a glance

Sex		
	Females	37.9% HIV Cases
	Males	62.1% HIV Cases
Race/Ethnicity		
	African-American/Blacks	87.4% HIV Cases
	Whites	6.6.% HIV Cases
	Latino/Hispanic	4.7% HIV Cases
Age		
	40-49	35.7% HIV Cases
	30-39	23.4% HIV Cases
	50-59	20.6% HIV Cases
Exposure		
	Heterosexual Transmission	44.4% HIV Cases
	Men Who Have Sex With Men	36.8% HIV Cases
	Intravenous Drug Use	14.6% HIV Cases

Based on Health Department Prince George's County (2010).

While HIV/AIDS prevention and treatment are inextricably related, worldwide efforts have historically focused on treatment in lieu of prevention. Subsequently, this has resulted in negative effects on those suffering from marginalization, poverty, homelessness, drug use, incarceration and risky sexual behaviors that are linked to higher risk, since they limit access to services (Laurecin, et al. 2008). The Affordable Care Act (ACA) passed in 2010, as well as the National HIV/AIDS Strategy for the United States (NHAS) published in 2012, aims to address the unfavorable relationship between insurance coverage and HIV treatment/prevention. One of the goals of the presidential plan is to improve access to HIV/AIDS care and its related health outcomes. As of 2011, 45% of patients diagnosed with AIDS had been diagnosed with HIV three years prior, showing that people living with HIV face difficulty in accessing quality health care services, medication and treatment (Yehia and Frank 2011). The NHAS aims to reduce the gap between diagnosis and treatment by coordinating efforts between agencies and

organizations, expanding Medicaid to people under 65, and increasing the poverty level threshold to 133% for petitioning these services. The plan will also:

Establish a seamless system to immediately link people to continuous and coordinated quality care when they are diagnosed with HIV; Take deliberate steps to increase the number and diversity of available providers of clinical care and related services for people living with HIV; and support people living with HIV with co-occurring health conditions and those who have challenges meeting their basic needs, such as housing. [White House Office of National AIDS Policy 2010]

Integrating HIV prevention strategies into family planning services has shown to improve the quality of care and increase the likelihood of client utilization (Glasier and Gülmezoglu 2006; Hall, et al. 2012; World Health Organization 2004). Young Latina women are known to have a lower rate of utilization of family planning services⁹ than young Non-Hispanic African-Americans or Non-Hispanic White women; though 72.7% percent of US women 15-44 years of age have received some sort of family planning service, non-Hispanic African-Americans and Hispanic women are more likely to have received their first family planning services from a non-private doctor; utilize Title X clinics^{10 11}; be 25 years or younger; and pay family planning services with Medicaid (Chandra, et al. 2005; Gavin, et al. 2009). As of 2012, 151,000 Prince George's County residents lacked health insurance and 102,000 received Medicaid assistance (Health Department Prince George's County 2010; Wiggins 2009).

⁹ This is in regards to HIV and other STD prevention services, as well as reproductive sexual health services.

¹⁰ Designed for low-income individuals.

¹¹ Though, one half of Title X clients are non-Hispanic White women. In addition, Women using Title X clinics, were more likely to have never been married or cohabited, and were in the lowest income group.

Given this, Prince George's County proved to be an ideal setting to study how a potential HIV prevention strategy—MC—is or is not integrated into the provision of pre-natal care, as it allows for the potential to maintain the low rates of HIV infection within the Latino population.

Theoretical Frameworks

Patients, healthcare providers, scientists, and policy makers have been using the terms risk reduction and prevention interchangeably, equating MC with a lower risk of HIV infection (Castro, et al. 2010e; Johns Hopkins Medical Institutions 2011; Morris 2007; Morris, et al. 2014a; Morris, et al. 2012). This type of discourse obscures the critical analysis of NMC as a 'ritualized' birthing procedure—which is performed in a hospital— in contrast to an HIV/AIDS preventative medical intervention. Interventions and policy recommendations regarding public health initiatives seldom take into account the cultural and social repercussions of new therapies and interventions and fail to inquire into how they will be adopted. Given the multicultural scenario of the United States and the different social and cultural contexts involved in translating research, there is a need to interpret the findings of the aforementioned clinical trials in light of the United States HIV epidemic.

MC has been discussed in academic and public contexts when referring to sexual health, HIV/AIDS, development discourses, ethics, human rights, and medicalization (Bell 2005; Bonner 2001; Boyle, et al. 2002; British Medical 2004). Much of this discourse has suffered from a selective reading of anthropological data that has

essentialized the MC behavior of the non-White/indigenous '*Other*'¹² tying it with rites of passage and symbolic meanings of manhood (Silverman 2004). Non-religious views of circumcision in the US range from accepting the procedure as a normal body modification done during the birthing process, to repudiating the procedure as a mutilation of the body based on gendered notions of health (Bell 2005; Darby and Svoboda 2007).

Anthropology seeks to understand disease in the context of health care, and attempting to understand the medical sciences as embedded in social systems and therefore as part of the forces of the state that shape these systems (Foucault 1976). As research moves away from studying diseases at the discrete level, communities and groups are better understood within their local context. This is especially important when studying underserved populations such as Latinos and immigrants, and the politics involved in immigration and health disparities (Butler 2011). As Chavez (2003: 197) states “all medicine is politics”, and reproductive and sexual health implies a myriad of historical, social and political factors that permeate disease prevention and treatment (Martínez Silva 2006).

Reflexivity has been integral in recent anthropology, especially as we evaluate the role of applied work and how we can engage with communities and inform public policies (Pollock 2009). Experiential data has recently served as a critical interpretative tool in examining how biomedical discourses are communicated to consumers/patients (Briggs 2011; Cohen 2008; Susan Reynolds 2009). This reflexive stance qualifies global health and how we engage with multiple stakeholders, particularly when dealing with race and

¹² The non-Western, indigenous, non-white subjects of modernist anthropology.

ethnicity in health settings (Adams, et al. 2008; Gravlee and Sweet 2008; Pfeiffer and Nichter 2008).

Enactment in Science and Technology Studies

The Science and Technology Studies (STS) paradigm centers on the ontology of the practice of science¹³; instead of focusing on people as subjects, it studies practices (see Latour 1993; 2014; Law and Singleton 2014). STS has developed techniques by which to study empirical work itself, and the relations in which this work is affixed by “treating knowledge as expression of these practices” (Law 2012; Lin and Law 2014: 802).

Studying the relationship between actors and the networks in which they engage—and the practices they perform within these networks—has framed the study of the range of performative agents that relate to one another (Oppenheim 2007). To study these relationships is to be in contact with the people involved in them and how they relate to one another: which is to study actor-networks (Latour 1993; 2014). MC was not the focus of the investigations, but its enactment in a variety of practices by different actors (Mol 2002). The study of actor-networks is referred to as Actor-Network Theory (ANT), which provides a researcher, such as myself, semiotic tools to study the social world as an all-encompassing web of relations and the practices that support them (Law 2009).

Medical anthropology has examined how social discourses can be reflected in the body; biomedicine has normalized the body as a locus of pathological variation with reference to ‘normal curves’ stipulated for larger populations (Lock and Nguyen 2010). While critical medical anthropology has conceived the body as a repository—and reflector—of

¹³ STS is the study of scientific practices, as opposed to scientific knowledge.

society and culture (Lock and Nguyen 2010; Scheper-Hughes and Lock 1987), the interdisciplinary framework of STS has examined biomedical practices as they converge on the body to direct anthropological research to the networks that sustain said practices (Latour 2014; Law 2009; 2012).

Annemarie Mol's work has effectively utilized ANT to study the body as it refers to the multiple actor-networks involved in disease diagnosis and treatment and performed in clinical settings (Oppenheim 2007). In her book *The Body Multiple* (2002), Mol presents her research by describing a picture of how arteriosclerosis is performed—or enacted as she proposes in this book—as the result of the interactions between a multitude of actors (patient, doctor, lab technician, surgeon, among others) and how each of them depend on their networks to perform arteriosclerosis; that is, diagnose, treat, explain its pathology and symptoms in a way that multiplies reality, but not the practice itself. Arteriosclerosis in this case is an example of a fractional object that depends on multiple realities in order to be performed in a specific setting to form a full picture that is coherent (Law 2002; Mol 2002): arteriosclerosis is performed by the patient when he or she describes the symptoms to the doctors; arteriosclerosis is performed by the physician by conducting physical tests on the patients; arteriosclerosis is performed by the lab technician by testing for a specific numeric level of lipid content in the blood; and arteriosclerosis is performed by the surgeon by surgically examining how hardened the arteries in the patient's legs are (example taken from Mol 2002). The different actor-networks come to construct arteriosclerosis through multiple practices, yet the disease itself remains singular. Each practice by each actor generates a material reality that is distinctive—and diverse—from one another (Law 2009; Mol 2002).

Mol has used the term *enacting*, as an alternative to *performing*, to describe practices that manifest a multiplicity of realities:

Talking about the enactment of objects builds on and is a shift away from another way of talking about objects, one in which the term construction has a prominent place...The term construction was used to get across the view that objects have no fixed and given identities, but gradually come into being...To look for another term. A word that is still relatively innocent, one that resonates with fewer agendas. I have found one. And, even if I have been using the term performance elsewhere in the past, I have carefully banned it from the present text. I use another verb instead, enact, for which I give no references, precisely because I would like you to read it in as fresh a way as possible. In practice, objects are enacted...The (serious) game played here makes a move that is the other way around: like (human) subjects, (natural) objects are framed as parts of events that occur and plays that are staged. If an object is real this is because it is part of a practice. It is a reality enacted. [Mol 2002: 41,44]

If practices are foregrounded, there is no longer a single passive object in the background, waiting to be seen from an endless series of perspectives. This approach presents a reality that is multiplied and provides access to the study of practices that enact reality in multiplicity; “the reality we live with is one performed in a variety of practices” (Mol 1999: 74; Mol 2002). In a multiple reality, it becomes possible to understand how knowledge is manipulated through practices—as opposed to opinions of these practices—and how they recreate a coherent clinical body (Law and Mol 2002). The realities are seen through the lens of the clinic, and the practices that happen within it by having access to the logic behind these practices (Law 2012; Mol 2008). The dissertation research project focused on MC was studied as the performative result of clinical trial research, pre-natal care guidelines, and the ethnomedical knowledge of patients seeking services in reproductive and sexual health clinics in Prince George’s County. Latina women seeking services, health care providers, and scientists/policy makers are “all generated in the relations that develop between them” (Law 2012: 2).

This research was framed by Mol's paradigm by focusing on how MC was enacted by different actor-networks and as practice. Rather than just eliciting the opinions of particular subjects, I studied multiple forms of MC as they were practiced (Mol 1999). I located knowledge in performative practices revealing how different actors constructed—or enacted—their own version of MC and the clinical body (Law and Mol 2002; Mol 2002).

Thus, the research presented here is not solely on the body, but on its social enactment as embodiment. I investigated the relationship between MC, as it was translated from research, to evidence-based policy to clinical practice. I looked at these practices as multiplied realities to be studied in the clinic setting; where they clash, depend on, and create tension with one another when enacted by the three study populations (Mol 1999). The practices that I studied relied on the evidence-based medicine assumption that clinical practice is informed by scientific research and its ensuing policy recommendations. Once again, this understanding is referred to as the paradigm of evidence-based medicine which as Sackett and Rosenberg describe, entails “the conscientious, explicit, and judicious use of current best evidence in making decisions about the care of individual patients” (Timmermans and Berg 2010:3).

Grounded in practice, my research examined MC through actor-networks that regulate the body politic with reference to sexuality and reproduction (Scheper-Hughes and Lock 1987). I follow on the anthropological interest on the semiotic practices of networks and its enactments by looking at the multiplicity of MC through different actor-networks (Haraway 1993; Haraway 1988; Oppenheim 2007). I continue an anthropological tradition on reliance on STS, and its school of ANT, by studying practices and networks.

Therefore, I will be using the concepts presented here for analyzing and presenting the data results and conclusions.

Reproductive Justice

Another paradigm that informs my research is reproductive justice. Reproductive justice allows researchers, educators, and health care providers to engage in holistic analysis of STIs, by suggesting that structural and societal circumstances place women in some population groups in more vulnerable life situations than others (Stephens, et al. 2012). This framework “emphasizes reproductive health, as well as the social, economic, and political power to make healthy decisions about one’s body, sexuality, and reproduction” (Davis 2009: 107). Reproductive justice promotes an understanding of the different identities of women, their gender roles, sexual behaviors, and cultural and social values, to contextualize quality reproductive care as a social justice movement (Stephens, et al. 2012). Using this approach, I was able to work with institutions—clinics—and existing health related structures to address the degrees of “economic insecurity, oppression, discrimination, and lack of resources” that put women of color at greater vulnerability for lack of reproductive and sexual healthcare (Stephens, et al. 2012: 122). Informed by this paradigm, I used an intersectional perspective to analyze reproductive health services and assess their quality. (Luna 2009).

The intersectional perspective on reproductive justice enriched my anthropological project on Latina women in Prince George’s County by prompting me to explore the impact of disparities among clinic users on both outcomes and identity formation (Luna 2009; Stephens, et al. 2012). In addition, the intersectional perspective on reproductive

justice allowed to better understand the diverse composition of women's identities, and the conduct of research on the health disparities—and its underlying factors— among these women (Stephens, et al. 2012: 136-137).

Significance of this Study

In 2008, the CDC questioned the feasibility of circumcision among men and infants belonging to racial and ethnic groups that have lower rates of HIV infection (2008). If the procedure is to be envisioned as a prevention strategy, the beliefs and practices of individuals engaged in the decision making process need to be added to the diverse reasons given (aesthetic, social acceptability, lay notions of health, etc) for accepting the procedure.

Despite the fact that US researchers have been promoting the potential benefits of the procedure among minorities, the disadvantaged, and the poor¹⁴ (Bonner 2001; Johns Hopkins Medical Institutions 2011), there is a dearth of studies that have investigated the feasibility of implementing and promoting circumcision as a preventative tool. The multifaceted nature of HIV transmission and the complexity of prevention strategies call for investigating the ways circumcision is construed, to provide proper context to the debate on HIV prevention in the US. Medical anthropology has demonstrated that therapies and ways to manage illnesses dramatically change the social symptoms¹⁵ with

¹⁴ Though these researchers from Johns Hopkins University failed to detail exactly how circumcision could help minorities and the disadvantaged.

¹⁵ A term used by Abadía-Barerro and Castro (2006) to elucidate how a community, group, society, etc (e.g. a country, nation or state) comes to describe an illness and its symptoms. In the context of the author's article, Brazil's response to the epidemic has shifted the perception of HIV/AIDS as something to be feared for its characteristic

regards to a disease and with how the threat of the illness is perceived by society (Barrero, et al. 2006). How will circumcision as a prevention strategy reconfigure and change the social symptoms of HIV/AIDS? Will circumcision provide a false sense of protection for those who will engage in risky sexual behaviors? This research is an inquiry into the critical examination of circumcision as a prevention strategy for HIV since ethical concerns—along with claims of body integrity and human rights have been raised regarding subjecting newborns through selective surgery, without proper knowledge of the sociocultural context of the procedure and its history (Bonner 2001; Centers for Disease Prevention and Control 2008; Darby and Svoboda 2007; Dekkers 2009; Gerharz and Haarmann 2000; Zoske 1998). This study provides an analytical approach to understand the dynamic sources of subjectivity and ethical reasoning underlying bodily modifications that might serve as a prophylactic against HIV/AIDS (Fox and Thomson 2005; Lakoff and Collier 2004).

morbidity, to a manageable disease that can even bring some economic benefits to young kids who are HIV positive and are taken care of by the state.

Chapter Two

Methods

This research articulates the interactions between policy, service delivery and service seeking in a Maryland County by looking at the practices of actors and their networks using an ethnographic approach. Ethnography allowed me to explore and uncover the semiotic nature of the research problem, as well as the “conceptual world” behind the discourses of MC (Smart 2012). As the ethnographer, I attempted to understand the research problem by investigating the social and the cultural aspects of MC in local service delivery from micro, meso, and macro perspectives (Fetterman 2009). I examined MC as a procedure that is performed—or hereinafter referred to as enacted; a procedure that is active, that does not reside or exist within itself, and that is practiced and enacted by actor-networks (Mol 2002). Ethnographic research elicits knowledge about bodies and their practices, and transcends the fleshy and messy everyday realities (Law 2009). Ethnography allowed me to engage in the translation of medical knowledge to policy and service provision, to act as interpreter between professional and lay knowledge, attempting to understand what these actors did and why they did it. Thus my study revealed how they knew what they knew, and how they performed this knowledge (Latour 2014; Mol 2002: 31). Following Law (2012), my fieldwork investigated practices in a site.

Guiding Questions

How do Latina women in Prince George's County enact circumcision as they seek pre- and post-natal care services in clinics? How does their knowledge of MC affect their decision-making process and practices?

How do the health recommendations regarding male circumcision at the international and national levels affect local service delivery, if at all? And how can service delivery affect a Latina mother's decision to circumcise her son(s) or not?

Finally, how do the group of scientists/policy makers come to enact their research as policy and ensuing clinical delivery guidelines regarding service delivery?

Research Sites

Through preliminary research, I learned about the clinics in Prince George's County that served primarily as reproductive and sexual health clinics. I visited the clinics that health care providers recommended to me during this preliminary research stage of my dissertation. I visited and made initial contact with seven clinics in Prince George's County first during the Summer of 2012, and subsequently in between the months of November of 2012 and March 2013. After contacting the appropriate individuals in each clinic and seeking permission, three clinics granted me permission to conduct fieldwork activities: Geneva Care (GC), and two Oldpine clinics: one located in Millkeep (OCM) and the other one in Waterley (OCW).¹⁶

¹⁶ Pseudonyms are being used in place of the names of the clinics to protect confidentiality of participants

GC and OCM are located in Prince George's County, whereas OCM is in Montgomery County, Maryland—and neighbors the county line that separates them both. These clinics were identified because a large number of their clientele (over 50%)¹⁷ are Latina patients that reside in Prince George's County. An unintended shared characteristic of the three clinics selected for the study, is that they are non-profit community clinics that also provide services to uninsured patients. By focusing on these particular clinics, I wanted to bring light to the practical implications of circumcision in the service delivery setting among Latinas—who have low rates of circumcising their sons (Bell 2005; Bonner 2001; World Health Organization 2007; Zhang, et al. 2011). The clinics were useful in demonstrating integration of the various levels of analysis that this project wanted to attempt: the clinic's Latina clientele represents a micro level; the health care providers a meso level; and the scientists constitute the macro level.

Other research sites included the offices of the scientists where the interviews were conducted in various universities and organizations located in Maryland and Washington DC. Finally, I also conducted fieldwork in Prince George's County itself, participating in health related community events such as town hall meetings and health fairs.

Research Procedures

I conducted this dissertation research over a period of 15 months: first during the months of July to August of 2012, and subsequently during January to December of 2013. My activities during this time were designed to meet the project's objectives:

¹⁷ Knowledge from pre-dissertation research data

1. Investigate the relationship of evidence-based medicine and policy making, in regards to circumcision, and how it relates to local specific contexts; and
2. Understand the way MC is enacted by health policy makers/scientists, health providers, and Latina mothers; and
3. Study the practices and beliefs of health care providers and Latina mothers in regards to MC, as well as how the decision-making process happens.

The research activities of this project were divided into three phases:

1. Phase 1 - Archival Research and Contact with Clinics (Summer 2012; January-February 2013)
2. Phase 2 - Sampling, Interviewing, and Ethnographic Activities (Summer 2012; March-December 2014)
3. Phase 3 - Data Analysis (January 2014-June 2014)
4. Phase 4 - Writing (July 2014- Present)

Phase 1 - Archival Research and Contact with Clinics

The objective of phase 1 was to conduct archival research related to research and national policies of circumcision; to initiate contact with centers/clinics in the Prince George's County area to access the study populations, and to begin the process of selecting a sample.

I conducted a literature search on circumcision at international and national levels. This also included research on policies/directives that addressed circumcision at the national level. I gathered grey literature, press releases, and organizations' mission statements, among other materials, for subsequent analysis with the qualitative data resulting from fieldwork and interviews. I also surveyed research articles in different research databases and set email alerts to web and media content on the topic of MC.

I had already had access to the GC clinic, as I had previously conducted fieldwork in the summer of 2012. I subsequently visited and contacted the rest of the clinics. After obtaining approval and endorsement to conduct research at the particular clinic, I started

visiting them on a regular basis during the months of March 2013 until December 2013. I visited each clinic for at least three months in each location thorough the year.

Phase 2 - Sampling, Interviewing, and Ethnographic Activities

The objective of Phase 2 was to select a sample from the study populations, conduct interviews with the individuals in the sample, and conduct participant observation in the clinics.

The samples to be studied were defined from the study population as follows:

1. Latina mothers were defined as women who either thought they were pregnant, who were pregnant, or were mothers at the time of the interview. They were patients at the clinic/center, or a client seeking services in the clinic, and were 18 years or older. I operationalized the label Latina as an ethnic category that encapsulates Latina, Hispanic, and other categories that denote populations born or descended from Latin America and the Caribbean. The women will be identified hereafter by their status as either pregnant women or mothers, at the moment of the interview, instead of a pseudonym. This naming technique reflects their status—seeking prenatal or postnatal care services—at the moment of the interview, to protect anonymity since no names were collected.
2. Healthcare providers were defined as clinic staff who worked in prenatal services, delivery services, and other roles related to health services in prenatal and pediatric care. This category includes staff, doctors, and other healthcare professionals. I used pseudonyms for the health care providers to protect their anonymity.
3. Scientists were defined as investigators that conducted research on the topic of circumcision and HIV. This also included an individual who used research in her work in analysis and design implementation of policies and interventions. I used pseudonyms for the scientists to protect their anonymity.
 - Within this sample, I also interviewed an anti-MC activist. The anti-MC activist is an active member of an organization that speaks out against MC in newborn males. I used a pseudonym to protect his anonymity.

I conducted participant observation in the clinics' waiting rooms and other areas where I was allowed access, taking care that my presence did not violate privacy concerns of the Health Insurance Portability and Accountability Act (HIPAA) and did not interrupt delivery of services. Participant observation, as systematic observation of the clinic

environment, entailed my immersion in the clinic environment so that I could try and “speak the language of and participate as fully as possible in the life of the members of a group...with specific goals in mind” (Foster 2009). This provided me with a context for the interviews, which took place as part of that immersion process in each clinic. This type of technique allowed me to “get in” the clinic environment and be able to “talk to people about sensitive topics...” while trying my best to blend in and participate as much as I could in the clinic’s activities, so that when I was present, they were not solely focused on me (Bernard 2006: 344).

As a continuous process, participant-observation helped me integrate myself in the everyday life of the clinic, which allowed me to better understand the practices and enactment of circumcision in the clinic, as well as creating an intellectual distance (between my previous and current knowledge) for consequent analysis when these practices are transformed into data (Bernard 2006). Participant-observation allowed me to tell a story about MC as sustained by its practices and its actor-networks through ethnography.

At GC, this meant sitting and observing near the receptionist area. Being seated near the reception area allowed me to talk to any of the staff members who were on the reception desk, or coming in and out of the private examination rooms. This also meant that I would sit and sometimes talk with the patients in the waiting room area, adjacent to the receptionists’ desk. Being seated there encouraged the Ob/Gyn to refer any patients that he had just seen to me, since I was there when he opened the door. Further, being in that area also allowed me to talk with different providers as they came and went.

At OCM, participant observation entailed observing in the waiting room area, the medical assistant's room, and an empty examination room that I was allowed to use each time I went to the clinic. I waited in the examination room until called by one of the medical assistants, who encouraged me to interview patients that were waiting for a nurse, midwife, or pediatrician in another examination room. The medical assistants knew about my sampling criteria, and after asking patients if they wanted to talk to me, they would usher me in so that I could conduct the interview. I also spent time in the medical assistant's room and conducted informal interviews with Latina mothers there.

At OCW, I conducted observation in the waiting room areas, and in some other parts of the clinic as I shadowed and talked to other providers. Because of the lack of space, every time I went to OCW, I was given an empty desk in the midwives'/nurses' office. While there, the medical assistants who knew about my sampling criteria asked patients if they would like to talk to me, in a manner similar to the medical assistants at OCM. I would approach and interview Latina mothers as they waited to be seen by a provider in the examination room. I also conducted informal interviews with the midwives and nurses in their offices.

While I conducted observations in the waiting room of all the clinics, I distributed flyers for recruitment purposes, sat and observed while taking notes. Other settings in the clinics where I conducted participant observation and was able to engage in discussions with the staff included the staff kitchen, the nurses' station, the patients' records room, the doctors' offices, and the medical assistants' room.

When creating the schedule for visiting the clinics, I took into account the fact that the clinic is a dynamic environment, and I sought to limit the ways in which my presence

would disrupt health service delivery. Because of the nature of my fieldwork, I avoided a long term, everyday presence:

...in many applied settings, long-term continuous fieldwork is neither possible nor desirable. Although Malinowski's position that long-term continuous work in the field is essential applies to foreign cultures, it may be an overstatement for work conducted in one's own culture...This approach allowed me to pull back and make sense of what I had observed and recorded, and then return to the field to test my hypotheses. (Fetterman 2009: 19).

I set a schedule to visit each of the clinics on a regular weekly schedule during the months of March 2013 and December 2013.

1. During the months of March to July 2013, I conducted fieldwork at GC on a weekly basis; twice a week in the beginning, and one day a week later on.
2. From June to November 2013, I conducted fieldwork at OCM on a weekly basis; twice a week.
3. From August to December 2013 I conducted fieldwork at OCW on a weekly basis; twice a week.

This schedule allowed me to visit the clinics regularly, while still conducting fieldwork in other places and events in the County. I attended town hall meetings, health fairs, and other public/community activities organized by the County's health department and the clinics that were part of the study. I gave priority to events that had a health focus, and that included the Latino population of the county. The purpose of attending these events was to provide ample context for the data I was collecting, but also to understand the networks in which these actors were embedded. By engaging with multiple stakeholders during the research, I was able to engage in triangulation techniques that elucidated different aspects of the delivery of health services, as well as the deep phenomenology of MC (Sobo 2009).

Health care providers were recruited by conducting fieldwork in the clinics where they were working/providing services at the time of my visit; while conducting participant

observation I interviewed thirteen health care providers. The providers interviewed were nurse practitioners, midwives, medical assistants, pediatricians, an obstetrician/gynecologist (Ob/Gyn), a perinatologist, and administrative employees of the clinic. I approached them with an introductory script that briefly described the research project. Following a positive response and informed consent, I scheduled an interview in a private space of the clinic. In order to understand the multiple realities of MC in the clinic I conducted unstructured and semi-structured interviews with providers. The purpose of these interviews was to elicit their experiences in: providing prenatal care, providing reproductive and sexual health services to the Prince George's community, as well as experiences outside of these objectives, but related to NMC.¹⁸ The questions explored the nature of the services provided in the center/clinic. These types of interviews were ideal for eliciting lived experiences, building rapport, and allowing communication to freely flow from key informants (Bernard 2006). After the initial interview, I followed-up with informal interviews while conducting participant observation activities in the clinics.

I engaged in snowball sampling by asking the healthcare professionals I interviewed to refer me to other healthcare professionals providing sexual and reproductive health care in the clinic. Snowball sampling was ideal for this project because it allowed people to refer me to 'experts in the field'. In this manner, they referred me to: obstetricians and other personnel who perform circumcisions; midwives and nurses who had experience discussing circumcision and prenatal care with expectant families; and other providers with experience in the delivery of sexual and reproductive health care services. By being

¹⁸ See Appendix 1 for the semi-structured interview guide for health care providers.

introduced and referred to other participants, I was able to reduce my own biases as an investigator, since it was the participants who were approaching other people to be interviewed (Bernard 2006). I conducted seventeen semi-structured interviews with thirteen healthcare providers, and had informal interviews with approximately twenty-six providers.

I recruited nineteen Latina women for interviews. The women were recruited through respondent-driven and snowball sampling through the health care providers who worked at the clinic. As outlined above, the providers went by my sampling criteria and directed me to patients to be interviewed in private rooms of the clinic. Respondent-driven sampling and snowball sampling were ideal when dealing with this type of hard-to-reach populations (Bernard 2006). This sampling approach worked because participants were recruited as they came to the clinic, and were interviewed for their knowledge on MC as it related to the services offered.

The women seeking services were approached to share their knowledge and practices while they sought services. At GC, the ob/gyn who was working on the particular day that I was at the clinic referred me to patients to interview in a private examination room after his consultation with them. At OCM and OCW it was the medical assistants doing patient intake who mostly referred me to patients. Since medical assistants were tasked with completing the intake of patients, they knew if the patient met my sampling criteria so that I could come in and try to recruit the patient in the examination room while they waited for the next provider.

In the clinics, I approached the referred women in the examination rooms with an introductory script that briefly described the research project. After a positive response

from the patient and completion of informed consent, I conducted an unstructured interview.¹⁹ The interviews were done either in English or Spanish²⁰ and were unstructured to allow the interviewee to be able to participate in the discussion, encouraged by my prompts and guiding questions. Nineteen self-identified Latina women were interviewed. The majority of them knew they were expecting male children. Eleven participants were pregnant at the moment of the interview, whereas the remaining eight had already given birth to male children. Among them, one of the women was initially interviewed when pregnant, and then interviewed again after giving birth, when came back to the clinic for a postnatal care visit.

Unstructured interviewing allowed for flexibility in the conversation between me and the participants in the study, as well as allowing a phenomenological exchange between interviewee and interviewer, though framed with a clear goal in mind (Bernard 2006). The interviews served to explore the mothers' experiences when receiving pre-natal care services, especially in relation to the decision-making process of circumcision. The research schedule allowed me to interview women at different stages of pregnancy and motherhood, and explored their beliefs about circumcision as a medical procedure. In this manner, the decision-making process was related to the health services provided, the services they had access to, the experiences of the mother/expectant mother and their families; all practices tied to specific actor-networks.

To sample scientists I communicated with approximately fifteen scientists that I identified through the literature review. I initially emailed each potential participant and

¹⁹ See Appendix 2 for the semi-structured interview guide for Latina mothers.

²⁰ Depending on what the interviewee was most comfortable with.

conducted interviews with the ones who agreed. I conducted in-depth unstructured interviews with five scientists and one anti-MC activist. Four of these interviews were conducted in person at the interviewees' offices in Baltimore, Maryland or Washington DC. The other two interviews were conducted over the phone.

Phase 3. Data Analysis

The purpose of the analysis was to contextualize the role of MC in prenatal care in these clinics, as well as to examine how MC is presented within the current network of reproductive and sexual health services, and HIV/AIDS prevention services, and how these services are offered to Latina women in Prince George's County. Ethnography entails a continuous process that extends beyond fieldwork, into data analysis (Fetterman 2009).

The resulting recordings of the interviews went through a process of systematic listening to derive initial schemas that guided the analysis (Sobo 2009). The qualitative data was transcribed, imported to TAMS Analyzer²¹, coded, and analyzed thematically through a grounded theory approach. Grounded theory allows for concepts and categories to emerge from the qualitative texts as themes that are continuously linked with the data (Backman and Kyngäs 1999; Chiovitti and Piran 2003; Suddaby 2006). The process of coding themes is repetitive and reflexive, since ethnographic research analysis demands that data collection occur simultaneously with data analysis (Fetterman 2009). The first level of analysis encompassed text that was converted into nominal variables, to aid in developing new hypothesis and to further existing ones. These nominal variables, or

²¹ An open source qualitative analysis program for the Mac OS X operating system.

codes, were developed according to their respective themes as they related to scientific knowledge, praxis, and other ways of enacting MC within and across these three populations.

The codes were organized into a codebook that was used in the data analysis through TAMS Analyzer. The analysis produced clusters of information on the way patients, providers, and scientists came to enact MC. The chapters that follow describe and analyze the actor-networks of each research sample.

Chapter Three

Study Population 1: Latina Women

The first of the actor-networks that will be discussed is the nineteen Latina women who participated in this study. This chapter presents the results of the semi-structured interviews I conducted with this study population, as well as other fieldwork observation activities.

This chapter will address part of the research question: **How do Latina women in Prince George's County enact circumcision as they seek pre- and post-natal services in clinics?** And specifically **How does their knowledge of MC practices affect their decision making process?** I discuss both beliefs and practices of Latina women seeking pre- and post-natal care services and how they enact MC through their networks of information. This chapter will elucidate how these women construe their beliefs surrounding MC, and how these beliefs affect their practices and/or their decision-making process.

In subsection one, *Beliefs About Male Circumcision*, I present the networks of information that inform the participants' beliefs. These beliefs are based on their ethnomedical, social, and biomedical understanding of the neonate male body.

In subsection two, *Practices of Male Circumcision*, I present how the beliefs of the participants regarding MC are enacted into practice through decision-making processes.

Through these chapter subsections, I will demonstrate that MC beliefs and practices are inextricably related in their discourse: the beliefs that these women hold directly influence the practices they engage in. The findings on beliefs are not unrelated to each

other; networks, such as the family, the community, the father of the baby, as well as prenatal care service providers interact in the way MC is enacted by these women.

Figure 3: Basic Statistics of Women Participants at a Glance

	Pregnant Women (N=11)	Mothers (N=8)
Age	22-35 years old (Average = 28.10 years)	24-34 years old (Average = 29.25 years)
Length of pregnancy	24-40 Weeks Pregnant (Average= 34 weeks)	-
Age of Children	-	Male children aged 2 weeks to 15 months old (Average = 4.55 months)

The Latina women who participated in this research project were interviewed in the clinics where I conducted fieldwork. Eleven of the participants were pregnant at the moment of the interview, and the remaining eight had already given birth to male children (see Figure 3). The pregnant women interviewed ranged from 24 to 40 weeks of pregnancy, with the average being 34 weeks pregnant. 34 weeks is a significant date to note, since it is close to the date where the participants would be able to identify the genitalia of the fetus.

The participants who were already mothers had a male child that ranged from 2 weeks to 15 months in age, with the average being 4.55 months. The young age of their children made it possible for them to recall their experiences with prenatal care services in the clinics. Furthermore, all of them were returning to the clinic where they received prenatal care. The majority of women had either immigrated from Central American countries or

had family ties to those countries (see Figure 4); sixteen women were immigrants, whereas three women were born in the US.

Figure 4: Countries of Origin of Latina Women Participants

Country or origin (or family's country of origin)	Pregnant	Mothers	Total
El Salvador	4	5	9
Guatemala	4	1	5
Mexico	1	1	2
Puerto Rico	-	1	1
Unknown	2	-	2
			19

This chapter will present two main findings: First, that MC is something Latinos generally do not practice. MC is closely tied to beliefs of identity, and ultimately acculturation. Inquiring about MC elicits knowledge about health care systems and personal experiences tied to the cultural beliefs of Latino communities. Second, the decision-making process of these participants is directly tied to the degree of information received from health care providers about MC. Knowledge about the benefits of MC, and of the practice of performing it, are low among the women that I interviewed.

Enacting Male Circumcision

In this section I present several thematic categories that inform how the participants coming for pre and post-natal services enacted male circumcision²². It will be useful to understand these enactments as a set of beliefs that the participants held in regards to MC. These beliefs are summarized in Figure 5.

Figure 5: Factors Influencing Knowledge of MC

Item	Number of women mentioning this factor as influencing her knowledge of MC
Did not know about circumcision	5
Ambivalent about circumcision	4
Country of origin/ethnicity	13
Heard it from family/ family experiences	13
Directly talked to family members	3
Talked about MC with friends	7
Heard about it from a tv show/program	2
Community	1
Pregnancy Books	1
Health Care provider	1
Job experience	1
Religion/Bible	1

²² In this project I will continue to refer to these services as post natal services, but these may include routine and ambulatory pediatric services, as well as other scheduled visits after birth.

In my interviews I always asked the participants about their sources of information regarding MC. Five participants gave scattered answers that were not related to the question asked.

During the beginning stages of my fieldwork I thought that this type of response was due to the fact that the topic was rarely addressed, and that perhaps they were less open to discussing it with me, as opposed to a clinic staff member. In the interviews, however, when I received this kind of answer, I took a step back and explained what circumcision. Following that, I received more nuanced responses that showed their genuine lack of familiarity with the subject, and their limited sources of information. For example, Pregnant Woman 8's response: *"No, I don't have a lot of information about circumcision"*.

Though they recollected what MC was, their information was not necessarily accurate, in comparison to the biomedical definition of MC that a health care provider would give. While four of the participants knew something about circumcision, they were ambivalent and unsure as to what it implied. When Mother 15 mentioned that she didn't know about MC: *"...almost nothing, I just know that it's to cut off something off his penis, but I'm not sure ..."* I realized that they were not entirely ignorant about MC, but that they were uncertain of their own knowledge about it.

To find out more, I changed the focus of the questions, to explore the sources of information that informed their knowledge of MC. I still found that five of the participants did not have any information about MC. For Pregnant Woman 3, the occasion had not presented itself before: *"...I've never looked it up, since I only have three daughters. This is my first boy, [and] it was never brought up"*.

The participants who admitted to having some knowledge of the procedure, based it on a variety of sources. Further probing allowed me to uncover their sources of information with respect to circumcision. Their main networks of information were heavily informed by beliefs acquired in their countries of origin, through family knowledge. To a lesser extent they also relied on friends, media, religion and health professionals. I argue that these women are enacting MC in a way that sheds light on the multiple intersectional identities they are engaged in, rather than purely from the standpoint of biomedical knowledge. Immigration and ethnic identity has shaped these women's experiences in particular ways, and this is reflected in the way MC comes to be enacted and thought about. Their knowledge of MC is limited and could not be enacted solely by responding to my questions about their thoughts on the topic.

Countries of Origin Network

Pregnant Woman 5: Back in my country is very different... my mother had never been to a checkup, there was only one midwife, no doctor or anything ... I know it's not customary to do things like that there... they don't go to check ups...

This introductory quote serves to illustrate one of the most frequent findings from the interviews regarding networks of information: the beliefs of the participants were mostly informed by their ethnicities/countries of origin and family members. Relating MC to knowledge that was connected to their country of origin provided the participants with basic understanding when forming their own opinions. Thirteen of the women perceived MC in a way that was tied to ideas that were part of their nationality and identity, and their experiences as immigrants.

The participants' beliefs were shaped by experiences that relied heavily on common practices in their country of origin. Even the participants who said they had not heard of MC before, said it was because it was not a prevalent topic of discussion in their country of origin. For example Mother 15 related that: *"I had not heard of it, nor my family there (Mexico)... I asked my sister because she has two children, and she told me she had never heard of (it) either..."* Conversations about MC made the participants reflect on how they believed members of their own community thought about it, as well as how sparse and few the conversations around the procedure were in their countries of origin. Mother 14 mentioned: *"... there in our country, it's not known (MC). Interviewer: You said, it's not known? Mother 14: No, in our country that's not common. Here it is."* This response indicates a belief that MC is a procedure that is practiced in the US, and not in Latin America.

When I asked Pregnant Woman 1 if anyone had brought up the topic of MC, and what would she do if encountered with the decision to undergo it she mentioned: *"Only my husband, but he already said no.... because he's from El Salvador so he said no. Interviewer: Did he give any reason? Pregnant Woman 1: He said they don't do it in my country, I never had it (done) so..."*

The personal knowledge of the women was related to their experiences with the health care systems in their countries of origin, or those of their family members. Three mothers expressed doubt and suspicion that hospitals in their respective countries of origin would not discuss the procedure with the parents first, and would go ahead and circumcise their sons without the parent's consent. This unfortunate situation had in fact had happened to a participant's nephew who was circumcised without her sister's permission.

These concerns served to contrast the health systems the women are engaging with in the US, and the ones they left behind in their countries of origin. Immigration status is an important intersectional variable, as these women come into a “crash-collision course” with the US health system, while contrasting and making sense of the services they are receiving (Chavez 2003).

Family Network

Closely tied to the notions learned in their countries of origin, was the dependence on the family—and their experiences—as a source of information on MC. Family played an important role in what these women thought about MC, as well as their decision-making process (which will be discussed later in this chapter). Thirteen of the participants mentioned how discussing—or not discussing—MC with their families had influenced their opinion, whether the family members directly discussed the topic and offered their opinion, or whether they omitted to talk about it at all.

For example, Pregnant Woman 8 relied on the experience of her nephew to form her views on the matter.

Yes, for example my sister, she had a boy here and she did not seem to want it done. It seems like the after care is too much after you do the circumcision... that is something very delicate. Like I said, I'm not very aware (of MC), but she did not circumcise her child.

While she admitted that she did not possess enough information of the procedure itself, the experience of her sister influenced her ideas that ultimately affected her decision-making process. Her nephew was not circumcised and this justified her views about the perceived difficulty of the aftercare of the procedure; he was also born “here” in the US. Her sister’s actions reinforced Pregnant Woman 8’s enactment, as she chose not perform

the procedure on her son. Mother 3 also mentioned her experience with her own nephews:

***Interviewer:** Is this something that has been discussed in your family at all?*

***Mother 3:** No...my mother, she's really closed-minded. She never... I don't think my brothers even had that done. But I do know that my sister in law, she did that (MC) to my nephew... I think she is the first one who has done it, 'cause my sister hasn't done that to my nephews.*

As Mother 3 mentioned, MC was not a topic of discussion in her family. Among the participants, MC was not a common practice. Pregnant Woman 1 decided to go online and look for information about the procedure since she did not discuss it with her provider during prenatal care, and had no prior experiences with MC in her family:

***Interviewer:** What prompted you to go online in the first place, if no one here (clinic) talked about it (MC)?*

***Pregnant Woman 1:** I went because I know my family doesn't do it, so I went online to see why I shouldn't...why do they do it, and what are the pros and cons...*

Of the thirteen participants, three mentioned that they had explicitly talked about it with their families. Mother 12's family had talked to her about the importance of the timing of the procedure, and the benefits of having it done as soon as her son was born:

Well, they (her family) said that it is good to circumcise the baby, so that when he grew up it did not hurt... They told me that it was good to do it as soon as he was born, because that's when it has always been done before...

Whereas Mother 9's family told her the opposite: *"My family tells me that no, that (MC) is not good"*.

The most noteworthy responses were those that showed how inexplicable and foreign the procedure seemed to them. For example, Pregnant Woman 10 recalled encountering a

circumcised boy for the first time when she was still living in El Salvador, and received a visit from family members.

...when I was in El Salvador, a young cousin came to visit (from Florida, USA) and when we bathed him, we looked at his penis and did not like it. They (family) all asked why do they do that, and since we did not know about it there (in El Salvador), they said that they do not agree.

Pregnant Woman 10's family were perplexed at encountering a circumcised penis, since it was unusual for them, and reaffirmed their disapproval of the procedure. Once again, the procedure is perceived as a US practice, because of the family member who was visiting. I argue that acculturation might play a part in the role of MC, among Latinos who do decide to get circumcised.

MC is enacted as something unfamiliar to the Latina mothers who participated in this research, and is not seen as associated with their countries of origin. Their past experiences inform their practices and decision-making, which I will discuss later in the chapter. Knowledge of MC is acquired through family experiences, and knowledge is passed down through enculturation. Immigration, acculturation, ethnic and national identity, and family relationships interrelate to enact MC in this way.

Other Networks of Information

In addition to relying upon social and cultural knowledge based on their countries of origin and family experiences, the participants mentioned other ways by which they were informed about MC. The sources or networks of information varied greatly but also informed the way they came to enact MC. The referential nature of the language used to describe MC referred me to other aspects of the participants' lives, as well as the social context they live in (Wilce Jr 2009: 202).

Seven of the participants mentioned either discussing or having heard about MC from their friends. It seemed that talking about MC with friends was more casual than with their families. Pregnant Woman 10's friends told her about the benefits of MC, but ultimately she did not think those benefits warranted the procedure: *"I disagree with that ... They (her friends) say it is good for them (boys), for their growth, but I think he is very little to suffer like that."*

Two participants mentioned that they had heard about MC via television programs. Mother 15 learned about MC from a television program she watched; she learned that the aftercare was somewhat difficult, and did not want to deal with any risks associated with infections after the procedure: *"Well, he (father of baby) wanted to do it, but I did not because of infections and I watched on television that it stings them afterwards...on a reality show, where they have babies and stuff."*

Two other participants learned of the procedure because it was mentioned in the Bible; their deep religious beliefs were associated with sexuality and MC. Mother 13 mentioned how *"Circumcision is in the Bible. Jesus was presented in the temple and then circumcised."* Her responses were confusing to me; Mother 13 seemed to know about the concept of MC, yet it was not accurate if one were to compare it to the biomedical definition. Here biblical knowledge seems to supplant biomedical knowledge. Yet, she associated MC with female puberty, and mentioned how both men and women must: *"...remain intact until marriage. As God wanted it."*

Pregnant Woman 3 mentioned how she learned about the procedure while she worked as a housekeeper in a hospital. Working in the hospital, she was exposed to MC, though that did not mean that she understood what MC was, and why it was done:

I used to work as a housekeeper in a hospital and I would see they would do it to babies...and I wouldn't understand why, I just saw that they would do the little surgery on them...I just wouldn't understand what they were doing, so I knew it was a little surgery procedure going through...but I never, asked anybody.

To a lesser extent, participants mentioned other less frequently mentioned networks of information. One participant had heard about MC in the community; another learned about MC through her pregnancy books; and only Mother 12 had heard about MC from her prenatal care service provider. These less common networks provided information that could be considered prenatal care knowledge to these women.

In conclusion, knowledge related to pregnancy, and more specifically to MC was obtained from friends, media, religion, workplace environments, and their ethnic community. Only one participant had learned about MC from her healthcare provider.

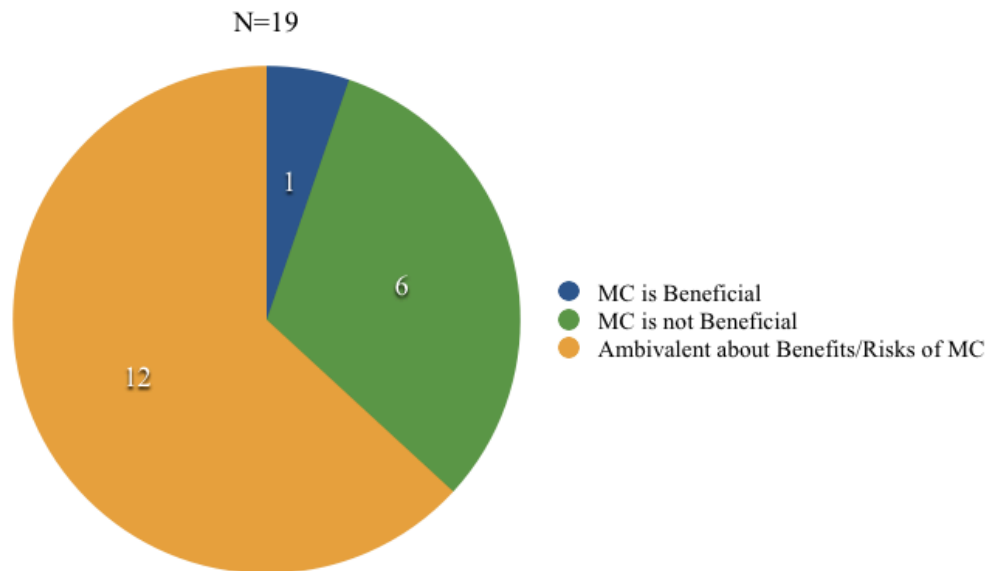
Understanding Male Circumcision

Pregnant Woman 16: *The truth is, I haven't heard much about that. It's very little, what I have heard of circumcision. For example the doctors haven't talked to me about it. Yes I have heard about it from friends, we have talked about it but I'm not too informed of what is it exactly, what are the advantages, and the disadvantages of circumcision.*

Most of the participants demonstrated a low level of understanding of MC; as the aforementioned Figure 5 shows, nine of the nineteen participants had no knowledge of, or were ambivalent towards MC. I argue that this might be due to the few and non-existent interactions they have on the topic with healthcare providers, who are rarely part of the networks of information for these participants. As such, the participants rely on other sources of information outside of their prenatal care services providers. The above introductory quote by Pregnant Woman 16 is typical of her fellow participants in regards to their knowledge of MC, and how they arrived at it. This is an important finding, since

their low level of interaction with health care providers on the topic of MC might explain their limited understanding of the procedure; including its significance, and any informed consideration of its benefits and risks.

Figure 6: Participant's Beliefs About MC Benefits



In turn, this distribution of beliefs can explain why only one participant thought that circumcision was beneficial, whereas six thought that it was not beneficial or necessary (see Figure 6). Mother 2 remarked how her negative opinion of MC was related to her ethnic identity: *“But most of us Latinos hardly anyone...well I do not know anyone who does that with their child...most people do not...”* As well as emphasizing her enacting of MC as something not associated with Latinos, Mother 2 also articulated the invisibility of MC in her community. The participants who felt strongly against MC, were also the ones who believed MC was incongruent with what Latinos do. They perceived the procedure to be foreign to Latino identity, and attributed few benefits to MC.

Twelve participants expressed ambivalence about any benefit or harm that MC could provide. I found that the ambivalence was due to their low level of familiarity with MC, as well as not knowing how MC could affect the future lives of their sons. Mother 3 mentioned: *“Since I don't know anything, I don't know what's good, I don't know what the side effects are, I don't know what he gets out of it. I don't know really.”*

As mentioned previously, only one participant thought that MC was a beneficial and necessary procedure. While pregnant with previous children, Mother 12 had had conversations about MC with a health care provider:

The health provider asked me if I was in agreement to do circumcision if I ever had a son, because they told me this when I had my girls and I told them, that yes I will do it when I have a boy...Mostly they told me it was about hygiene, because there were boys that did not had it done, and it caused them to have infections. So I always wanted to do it.

It is important to note that the only participant who thought that MC was beneficial, was the only one who had previously heard or discussed it with a health care provider. Yet, it is also relevant to note that this happened in another clinic, not in the one where she was receiving prenatal care services at the time of the interview.

Benefits versus Risks

Enacting MC is thus related to networks of information, which, as I have shown, affect knowledge about the procedure. Despite their thoughts, and their decision-making processes, the women had various views in regards to the benefits and risks of MC.

Though only one woman thought that MC was beneficial, ten women identified perceived benefits to MC even though they were ambivalent about the procedure. The most salient benefits of being circumcised were better hygiene, and as a prevention of

urinary tract infections (UTIs). Pregnant Woman 3 mentioned that: *“They said it’s good ‘cause of something about infection, or something like that. I really don’t know...it protects them from infections, as they get older as men...”*

Three participants mentioned a relationship between sexual debut and circumcision. Mother 15 perceived that a circumcised penis would result in a less painful sexual debut for her son: *“He (the father) told me to do it (to circumcise our son) because otherwise it hurts too much during sex.”*²³ MC can be sexualized, and as such the sexual debut of someone with a circumcised penis can be believed to be different than one who is not circumcised.

Only one participant—Pregnant Woman 16—mentioned that MC has been linked with HIV prevention, and identified this as a potential reason to circumcise her son. She had learned about the link between HIV and MC through a news application on her phone.

In contrast, ten women mentioned a variety of reasons as to why MC should not be done and why they thought it was a detrimental or risky procedure to perform on their sons. Mother 9 alluded to the ‘natural’ characteristic that the body has when one is born: *“That is something natural that we all have, then why do they have to take it off if it’s something natural? Why do it when he is a baby? He could develop...and in my family we never have done that”*. Referring to the natural state of the body, Mother 9 alluded to protecting body integrity at the time of birth. Four participants in total argued that their son’s bodily integrity was reason enough to not circumcise. Mother 9 further explained that she did not circumcise her son because: *“For one, we don’t believe in that, we’ve*

²³ This might be due to phimosis, a condition where the foreskin is too tight to allow for a full retraction of the foreskin over the glans. This was not discussed during the interview.

never have done it, and we don't believe it's necessary. And second, it's his own body, do you understand me? That is something that he is going to experience, and we prefer that he does it himself (if he wants to)''. This is an interesting finding in itself, since body integrity is not a relevant biomedical characteristic, especially when talking about MC. This presents a reality where medical discourse provides itself as a space where authority can be challenged, and negotiation has to ensue between provider and patient (Wilce Jr 2009).

Mother 19 voiced a similar concern to Mother 13's religious influence on her knowledge of MC. Mother 19 added that MC should not to be done on a child, unless there was a medical need for it:

...because our religion, I am a Christian, and we have been taught that it (MC) is not to be mandatory unless there is a need and the child has an infection, and the only cure was to circumcise him...

This last finding was especially relevant because it highlighted that the participants' beliefs are complex and are dependent on a lot of circumstances, as well as a confluence of multiple identities and realities that can intersect at the moment one thinks of MC as a medical procedure. But it can be so much more.

Birth is a critical time for the baby and his mother, and the participants expressed hesitation in interrupting this critical time with something extra like the aftercare of MC. As mentioned earlier in this chapter, Pregnant Woman 8 referred to the aftercare process as something delicate, given that the surgery is on the child's penis. I also found the use of the word "delicate" to be interesting, since several participants mentioned it at different times. They constantly referred back to the sensitive nature of the procedure with regards to the pain inflicted on the child. Pregnant Woman 16 voiced such concerns:

“I guess a lot of people think it's (MC) bad, because when it happens the baby is just a few days old, so they don't want the baby to go through pain. So that's why a lot of women don't do it to their child, they don't go through with it.” Among other undesirable reasons, the participants mentioned the additional care that a surgery would require and the risk of infections after the procedure. In contrast to these reasons, three participants did not mention any negative—or not beneficial—aspects of MC.

The results presented in this chapter so far explore the beliefs held by the Latina mothers in the study. I found that the MC decision-making process was dependent for the most part on these beliefs. The following section will illustrate how these beliefs are observed as they are enacted in decision-making practices.

Practices of Male Circumcision

When looking at the practices of MC, it was useful to analyze the practices of these participants as not just demonstrating their particular perspectives, but as actors that are manipulated by practices, as well as actor-networks that interacted with one another (Mol 2002). This analysis focuses on uncovering the realities of MC-related practices among these women.

The Latina women opened the door to multiplies realities as patients: the body, the diseases being prevented, the services rendered by providers, the medical research influencing these services, and the scientists/policy makers influencing medical discourse. Many of the practices—in terms of how they are enacted by the participants—rely on their decision making process of undergoing neonatal circumcision, and the intent to circumcise or not.

Figure 7: Intention of Performing MC Among the Pregnant Women

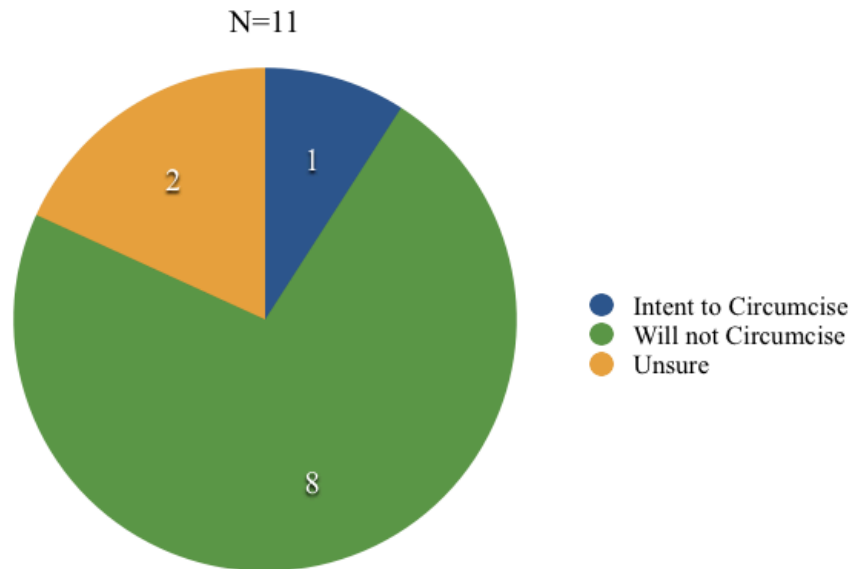
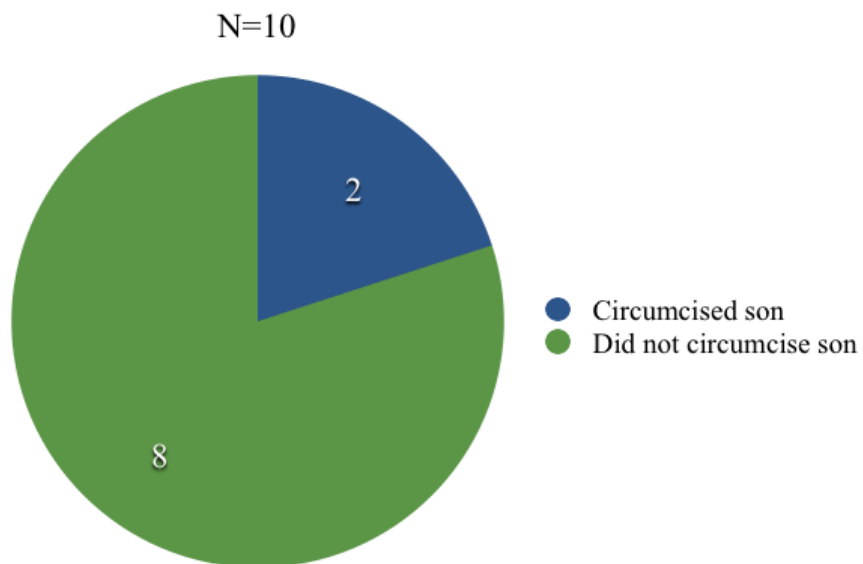


Figure 8: Practice of MC among the Mothers²⁴



²⁴ These two women had not circumcised their youngest sons, but had circumcised older ones after birth due to pathological reasons.

The decision-making process and the intent to circumcise the male child were intrinsically separated with the beliefs held by the women in the study. Figures 7 and 8 summarize these practices.

Do not Want to Circumcise

Figure 9: Participant's Reasons for Circumcising and Reasons for not Circumcising

Reasons for Circumcising	Reasons for not Circumcising
Father wants it	Father does not want it
Prevent UTIs	Lack of information about MC
Prevent pain in sexual initiation	Identification with Latino identity
Medical reasons	Not practiced in country of origin
Hygiene	Bodily integrity
	Religious beliefs

Four of the eleven pregnant women who knew they were not going to circumcise their sons, mentioned that their decision was based in part on their previously described views regarding the beliefs held in their countries of origin. For example, when I asked Pregnant Woman 1 if she had considered circumcising her son she replied: *"I've done research online, I actually decided not to...Interviewer: How so, Why not? Pregnant Woman 1: In our culture... most of the time it is not done"*.

Much like the way it is tied to beliefs, when thinking about the actual practice of MC it is enacted as part of Latino identity, and their cultural community. Community was

explicitly mentioned by two of the participants. While the rest—and the majority—of the women related their decision making process in the context of their country of origin, two women explicitly mentioned their Latina identity as a reason to not circumcise. By relying on the culture they identify with, their decision rested on their perception of customs regarding MC; here in the US, back in their countries of origin, and what is done in Latino culture.

Thirteen of the participants mentioned the relationship between beliefs and practices regarding circumcision, and how their country of origin affected their decision-making. In the case of Pregnant Woman 8, this resulted in not having her son circumcised because he was born in Guatemala and no one talked to her about MC during prenatal care or during delivery.

Pregnant Woman 8: ...over there in our country... (MC) is not done. It's rare that you do that ... perhaps it is because we keep our traditions and have never agreed to that.

Interviewer: So, when you knew that you would have a boy, did the topic come up?

Pregnant Woman 8: Actually, the oldest was not born here, he was born in Guatemala, and they never asked me anything (about circumcision). In Guatemala they hardly do that, even more so. I've never heard them do that in Guatemala at all.

From beliefs to actual practices, I can draw upon the results of some of the participants' decision-making process. For Pregnant Woman 8, as mentioned above, it is not only that MC is enacted as part of a cultural identity and tradition, but also as part of an institutional practice at the hospital; they rarely perform circumcisions there. Her son was born in such an institution, and thus was not circumcised.

Past experiences permeated current rationale for deciding whether to circumcise their child or not. Much like their beliefs, the practices of family members made them think

about their own decision making process. Pregnant Woman 8 added that she decided against MC because of her sister's experience: "...*My sister, she has a son here and neither did not do it either*".

While seven participants did not include their families in their decision-making process, seven did. Families provided different opinions as well as experiences about MC that enriched their decision making process. They often served as starting points in their discussions whether to circumcise or not. Mother 15 asked her sister about the procedure itself: "*I asked my sister because she has two boys, and she told me that she has never heard about it (MC) either...*" As mentioned earlier in this chapter, enacting MC as something that Latinos do not do, accentuates its invisibility in the community.

All eight of the mothers in the study had not circumcised their children. Similarly to some of the pregnant women, the mothers felt that the MC is something Latinos do not need or do. Mother 2 exemplified this:

Interviewer: *Why did you decide not to circumcise your son?*

Mother 2: *Because I thought that, since I am Latina, my baby did not need that. In my family there are many of us, and no one has...like it's not that I'm afraid, but (he) does not need it.*

Another reason to not circumcise her child was unfamiliarity with the procedure. Pregnant Woman 8 put it thus: "*But as I say, I hardly know much ... but we (her spouse and her) are clear that we respect the decision of anyone else, but with our children no, we have never liked circumcision...*"

An important aspect of the findings is how the father/spouse/partner was involved in the decision making process. Thirteen women mentioned that the father of their child was influential. The partners of all of the nineteen participants also identified as

Latino/Hispanic, giving even more strength to the way they enacted MC as it related to their countries of origin and the communities they belong to. Pregnant Woman 10 had discussed MC with her spouse and they were not going to go ahead with it.

Interviewer: *You (her and spouse) agreed that the two of you do not want to circumcise your son?*

Pregnant Woman 10: *Yes.*

Interviewer: *Was there some discussion, or did you have different opinions?*

Pregnant Woman 10: *No, we thought similarly...we were thinking the same thing.*

Conversations with their spouses/partners happened before birth, and in a few cases during the process of delivery. The participants had discussions with their partners, and the fathers gave their opinions as to why their sons should or should not be circumcised. Pregnant Woman 8 mentioned how she and her partner agreed to not circumcise their son: *"I have not talked much. I talked with my husband and we have never agreed with circumcision. I have two other boys and I didn't circumcise them..."* Pregnant Woman 3 reported that her partner did not want to go ahead with the procedure: *"Interviewer: is this something that you have talked your partner/spouse/father? Pregnant Woman 3: We mentioned it, but he does not want it done. Interviewer: Has he said why? Pregnant Woman 3: No he hasn't."* The conversations or discussion about MC with the partners/spouses/child's father were succinct; they were stated as a fact, and the discussions reported did not include in depth conversations about any pros and cons of the procedure. This was certainly the case with Pregnant Woman 10: *"Interviewer: Have you spoken with the child's father/partner/spouse about it? Pregnant Woman 10: Yes, we talked that my baby is a boy and we are not going to do it (MC)..."*

Two mothers indicated how their decision making process was influenced by the setting of the delivery itself. Mother 17 stated that the reason she did not circumcise her son, was because he was born in the US.

***Mother 17:** Well maybe there (Mexico) I would have done it (MC), because I know several...*

***Interviewer:** They do it in the hospital?*

***Mother 17:** ¡Ajá! But is more common, do you understand me? It's more common...it's talked about more ... But I had no children when I was there, so I did not give it much importance...*

Mother 17 affirms an outlying view within my findings, in that she said she knew of the topic because her friends and neighbors had talked about MC. There are different possible answers as to why this might be, including that she is the only participant that is from Mexico. Another outlying view was provided by Mother 12: she intended to have her son circumcised, but did not ultimately do it because she gave birth while on an extended stay in Puerto Rico while visiting family. She mentioned that although she wanted to go ahead with MC when she gave birth, the healthcare providers involved with her delivery dissuaded her from it: *"No, they didn't do it, because he was born in my country (Puerto Rico) they didn't do it it...they just told me to do it myself by hand (retract the foreskin)..."*

Mother 19 and Mother 13 mentioned that their religion—or religious beliefs—influenced their decision-making process; they associated circumcision with pre-marital sex, and asserted the belief that circumcised men tend to engage more in sexual behaviors before marriage. As such, they believe males should not be circumcised.

***Interviewer:** So you are saying that one of the influences in your decision is a matter of religion?*

***Mother 19:** Yes...basically male children must get (to marriage) like females until they decide ... well but men usually decide if they have or not sexual relationships*

before marriage, but it's curiosity more than anything ... females take care of themselves a little better...

Mother 13 mentioned how: *“The bible talks about circumcision...Female and male must be left alone how they came into the world...The child must develop how he is born”*

In sum, for these participants the reasons for not circumcising their sons relied on what was acceptable behavior among the populations they identified with, evidencing the connection between a process that involved many actors: the father of the child, the community, the family, and the health-care providers, among others.

Intent to Circumcise

While only one of the pregnant women had decided that she was going to go ahead with the procedure, six were unsure about their decision at the time of the interview.

Pregnant Woman 3 was due to deliver in the next month and was taken with my questions, since she had not deeply discussed the topic before or thought about MC before.

Interviewer: *So you talked briefly about it, but you haven't actually...*

Pregnant Woman 3: *Like really looked into it, or done any research.... No I have not. I have to (do it) soon, because I'm almost due (next month).*

Interviewer: *That's really soon.*

Pregnant Woman 3: *(laughs) And you just, kinda came at me with that...Um, I'm kinda in between... Since I don't know anything, I don't know what's good, I don't know what the side effects, I don't know what he gets out of it. I don't know really.*

Two of the mothers had already circumcised their sons. They mentioned that their sons were circumcised long after birth as a result of an UTIs, following the recommendations of healthcare providers. In addition, Pregnant Woman 17 already had a son that was circumcised when he was two years old for the same reason: UTIs. In all three cases,

after the treatment, the doctors had explicitly recommended MC as a way to prevent further UTIs. So there are cases where MC was done due to the recommendation and insistence of the health care professionals.

Similar to those who did not intend to circumcise, the participants who did circumcise their sons did not engage in in-depth discussions about MC's benefits and risks, since they had not initially intended to do so.

In some cases there was a difference of opinion between the father of the child and the mother. Mother 15 noted that her former partner wanted to circumcise their son because he wanted him to avoid pain at the time of sexual initiation. Despite this, Mother 15 decided against it because she did not think MC was necessary.

Much like those who had no intention of circumcising their sons, the father/spouse/partner was influential in the decision to circumcise their sons when it was necessary, as in the case of Mother 19: *"Well my husband and I didn't usually talk about these things...we did it because it was necessary, but he didn't agree either...He's from Honduras..."* In conjunction with the spouse/partner/father of their son, experiences with their families were strongly related to their intent to circumcise their child.

Mother 19 mentioned how she would not have circumcised her son, if she were back in her country of origin:

I think that I wouldn't have done it (if still in El Salvador), because remember that science is more advanced here than in our countries... the beliefs there are different than here... Here there is, how do you say it, more liberalism... In contrast, over there (El Salvador) we are more conservative and those type of conversations do not happen, not even in clinics.

Other Instances Regarding Practices of Male Circumcision

All but one of the participants reported that they did not receive information during prenatal care regarding MC. I argue that their ambivalence and their default decision to not go ahead with the procedure was due to the receiving poor or little information during prenatal care. Mother 2 expressed being unaware of the procedure because of the invisibility of MC in her own community, and the people she knew within it. Under different circumstances, she would have preferred to have been provided information by their health care providers:

...and an explanation of what benefits does it have, and maybe if they told me, and explained it to me, maybe I would do it... But the majority of us Latinos, almost nobody....I don't know anyone who did that to their son... The majority of people don't do it...that's an important decision because it's for the rest of the baby's life, and sometimes it may be because they don't give us information...lack of information.

When receiving prenatal care services, they were given little if any information on MC. From their end, the participants did not express any interest in bringing the topic up for discussion during their visits. It has been documented by Chavez (2003) how in addition to the lack of time given to each patient during their visits, other factors like English proficiency, as well as personal views about how they should interact with health professionals, can be part of more holistic explanations as to why the participants are not bringing up the topic of circumcision during their prenatal care visits.

Pregnant Woman 8 could not recall whether she had been informed about MC options during prenatal care, but she does remember that they did not provide her with any information:

With my previous child, they did not ask me anything, neither to my husband, but we didn't circumcise him... Maybe they asked my husband when I was giving birth... That was thirteen years ago, and he said no anyway. But they never gave me information about what it was...

Many participants reported that their decision-making process was influenced by their interactions with several health services professionals, but this rarely happened during prenatal care services; rather, it inevitably presented itself at the moment of delivery or when urological problems arose. These moments played out when the women were directly being addressed or pressed by health care providers to make a decision about MC in the clinical setting outside of prenatal care. Mother 19 recalled her experience when her son had a UTI: “...and he (the father) disagreed, but the doctor said that if we wanted to cure the urinary tract infection, we had to circumcise him.” The health care provider framed MC as the option to cure the infection of her son. A very similar incident happened to Pregnant Woman 17 with a previous child. The situation made her distraught given the limited options she was given to ‘cure’ her son’s infection:

I mean, I was told that the safest thing, the best thing for my child was to do that to him... That made me very upset, it threw me off...because he couldn't urinate... Then the pediatrician and the others told me that it (MC) was the best thing, because he could be older and the same thing could happen again...

Conclusion

The beliefs of these women are inextricably phenomenologically related to their practices, with regards to MC decision-making. The beliefs that these women hold directly influence the practices they engage in. None of the findings regarding beliefs are disassociated from one another: the family, the community, the father, and the role of prenatal care, all of them intersect during the care-seeking process, including enacting MC. This subsequently affects decision-making regarding circumcision.

Salient factors that influenced the practice of circumcision were the country of origin, the opinion of the baby's father, the relationship of the women to the community where they live and the culture they identify with, the information sought and who provided it, and the health services provided during prenatal care. Looking at the choices the patients made, and their limited contact with current reproductive health services, I wanted to account for an intersectional analysis that acknowledges the participants' experiences (Luna 2010).

Networks of information were related and tied to the decision-making process, and to how they were being informed about the procedure. The subsequent decision to circumcise, or not, followed their beliefs. MC did not happen in a vacuum, something I became increasingly aware of as I prompted the women about their ideas and experiences with MC, and they referred to the networks they relied upon for their ideas and their practices. This research about MC made available multiple realities of the practice—or the non practice—of MC, and made me rethink and retool my original framework of analysis, for the current one: ANT and enactment best suited me to explain the practice of circumcision, and the actor-networks undergoing these practices (Latour 2014).

In regards to networks of information, a particular moment during my fieldwork gave me pause, and made me reflect on the issue of how networks influence decision-making. One of the participants, Mother 15, mentioned how she came to know about MC because of a reality show that she had watched. In her interview, Mother 15 stated that she learned that MC left little boys with stinging sensations following the procedure, and that led her to not circumcise her son. I was reminded of this while doing laundry at a laundromat near OCM—I am a resident of Prince George's County, and live close to the clinics—

located in a neighborhood known for its high presence of Salvadorian residents. One of the television screens in the laundromat was showing a rerun of a case from a popular Spanish language court show called *Caso Cerrado*. The case presented was about a man suing his pregnant wife, because she did not want to get vaccinated against Influenza H1N1. The man brought his wife's brother in law to back up his lawsuit against his wife. I thought that this particular episode was very interesting given that it involved a pregnant Latina woman, her husband, and her family; all vying to influence the decision-making in what could be argued is the prenatal care and wellbeing of this pregnant woman. On its own, the show did not elucidate much since the case was not about MC, but coupled with the comment of Mother 15 it made me reflect on how media, like TV, can influence individuals on important topics such as prenatal care.

I say this because it is a show on a major Spanish-speaking network, and watched by many—including my own grandmothers back home. I tended to disagree with how the show approached the topic, but the judge (and host of the show) brought in different doctors, as well as experiences from different people on which to draw an opinion for her ruling. Moments like this made me reflect on my own position as a researcher, as well as how I was using my own gender, class, race, color, and nationality as another research tool, since I was identified as Latino in these settings; I knew as much because I was always spoken to in Spanish in these places. This double consciousness (Harrison 1997), allowed me to interpret this instance in a meaningful manner. It is outside the scope of this research as to how much influence Spanish-speaking media can have on prenatal care and topics like MC. But it is an important topic that deserves further investigation, given the public nature of MC debates, supported primarily by anti-MC activists.

In regards to the knowledge and practices of the participants in regards to MC, I found it confusing that the participants shifted from claiming to not know about the procedure, to later demonstrate that they did have a basic understanding of it. I perceived this disconnect as a result of the women not enacting MC as part of the services that are provided in the clinic. So, during my interviews, they shifted from not knowing what MC was, to then discovering that MC was indeed the procedure they had heard about from family and friends. This phenomenon is not all encompassing, but it was definitively pervasive in this group.

MC is enacted as a procedure that is tied to ethnic identity; something that Latinos do not do. Why? First, it is not a procedure that is performed at higher rates in any particular country in Latin America (World Health Organization 2007), nor is it prevalent in the US among the Latino population (Bisono, et al. 2012; Castro, et al. 2010a). But it is also an intersectional issue that has to deal with access to resources and the clinics themselves—which I will explore in the next chapter. The majority of these women are immigrants, and hold close ties to their particular ethnic and national communities in the area; it follows that these networks of information hold much weight in how they come to enact MC. Country of birth and ethnic identity among Latinos has been found to be closely related to intent to circumcise (Castro, et al. 2010a).

Second, I argue that the lack of overt discussion of MC during the provision of prenatal care to low-income Latinas, is directly related to their inadequate knowledge about the medical procedure offered at time of delivery. They have had various degrees of access to information about the procedure, and rely on family experiences to fill the gaps that are not met by the providers in the clinic. Information about MC is not provided to

these women in these clinics in a consistent manner, which prevents them linking prenatal care and MC. MC is enacted as a non-medical procedure, that they know little about. The women lack a basic biomedical understanding of MC and this is not challenged or clarified by the prenatal care services use. This particular instance has been documented in a very recent sociological study with women of various ethnicities, but composed mostly of Latina women; Sardi and Livingston (2014) found that personal and cultural beliefs played a significant role in MC decision-making—even more so than the medical information received—and that there was a systematic lack of access to accurate information about the risks and benefits of MC. The women relied on social networks of information but lacked a biomedical understanding. Given the pervasiveness of MC rates in the US, this is a sobering finding given the AAP's recommendation that parents engage in informed decision-making.

Finally, I argue that the participants are enacting MC as an element of their own citizenship and degree of acculturation. The complexity of circumcision can only be understood through practice (Mol 2002). MC is enacted as a surgical procedure in the US, and not something that is practiced in their countries of origin. If MC is indeed associated with and enacted in the US by the participants, then it follows that those Latinos who are circumcised are more acculturated to US society. The scarce literature on attitudes towards MC supports this argument (Bisono, et al. 2012; Castro, et al. 2010a). MC is better understood as the intersection of several actor-networks in US hospitals, where the procedure is common. The procedure is invisible to the Latino community because prenatal care providers fail to offer adequate information.

Chapter Four

Study Population 2: Healthcare Providers

This chapter is based on the results of interactions with 34 staff members while conducting fieldwork at the three clinics selected for the study, which included fieldwork notes, informal interviews, and 17 formal semi-structured interviews.

This chapter addresses the following research question: **How do the health recommendations regarding male circumcision at the international and national levels affect local service delivery, if at all? And how does service delivery affect a Latina mother's decision to circumcise her son(s) or not?** I sought to understand the beliefs and practices of MC from a biomedical perspective, while learning how the healthcare providers came to enact MC. The findings are presented in six subsections:

In subsection one, *Seeking Prenatal Care Services*, I present contextual information about how a pregnant woman seeks and receives prenatal care services in the study's clinics.

In subsection two, *Reasons Why Staff Don't Talk About Circumcision*, I present the rationale given by the participants as to why MC is not a topic of public discussion in the clinics.

In subsection three, *Beliefs/Opinions about Circumcision*, I present the diverse ways in which healthcare providers articulate their beliefs on MC.

In subsection four, *Decision Making*, I present the personal and professional experiences of the healthcare providers regarding MC decision-making.

In subsection five, *Experiences with Circumcision*, I present the diverse experiences of the providers as they articulate beliefs, opinions, and practices regarding MC.

Finally, in subsection six, *Power Dynamics Between Patients and Providers*, I present my interpretations of these data as biomedical–ethnomedical relationships in the clinic, as they relate to MC.

Two major findings underlie these subsections: First, that the clinics do not routinely provide information about MC to the patients, nor do the health professionals think they should, as it is not part of their standard of care. Second, that the health professionals and staff members at the clinic already believe that their clientele—which is almost exclusively Latina women—does not want to circumcise their male children at birth.

Seeking Prenatal Care at the Clinics

The initial process of prenatal care was very similar in all three clinics. A woman coming to the clinic underwent a pregnancy test to verify her own home test. If the test results were negative she was then scheduled for family planning services in the clinic. If the tests results were positive, the clinic scheduled the patient a series of visits and would connect the patient with several other pregnancy-related social services, some of which I will explain below.

A family support worker guided the pregnant woman through prenatal enrollment. Prenatal enrollment consists of an initial intake that serves as a way to screen for depression, substance abuse, and domestic violence. If any of these situations were present, the family support worker scheduled other assessments to better decide how to connect the patient with relevant resources in the clinic and her neighborhood. Susan, a

nurse from GC, noted the importance of this screening process before and after the pregnancy, providing me with an example of a recent case she had dealt with:

If they have a history of depression, of not having a place to live, then we refer them to the social workers who work here. They help us out a lot, they connect them to the community. For example I had a lady [with] post partum [depression] who had delivered twins and she was from New York. Her boyfriend had her move here with him but then left her before she delivered these twins by C-section. She was by herself and then she had nobody. She said he came once and threw money at [her] and said, "This is for the twins," but she had no resources in the community. So the social workers were so wonderful. They got a nurse to come in and visit her twice a week and get her all the resources she needed.

If the pregnant woman came to the clinic without health insurance, she was then mentored through the process of applying for emergency Medicaid. Emergency Medicaid insurance in the state of Maryland is a temporary service for uninsured pregnant women that allows them to receive birth delivery services for free. However this temporary insurance service does not include prenatal care services. As such, if the patient wanted to receive prenatal care services, she had to pay for them directly to the clinic even if uninsured.

The price the clients paid for prenatal care services varied, and depended on a sliding scale based on income. The prenatal package included all visits to the clinic before giving birth, as well as all the routine tests the clinic would administer. At the OC clinics, this package assumed that the woman would give birth at Washington Adventist Hospital, since the prenatal care package included services and doctors that worked there. At GC, there was no package, and the women paid per visit on a similar sliding scale.

Within two weeks of the initial intake, the woman had her first visit with a midwife or nurse, which involved additional medical intake such as: documenting her obstetric history; establishing the dates of the pregnancy; discussing options for prenatal care; or

discussing other resources if she did not wish to continue the pregnancy. At this first visit, the pregnant woman was also screened for other health conditions. If tests determined a high-risk pregnancy, she was referred to an ob/gyn to continue her prenatal care. High-risk patients presented conditions that could threaten the viability of the pregnancy. Examples are a previous pre-term birth, thyroid disease, diabetes, or high blood pressure. A woman with any of these conditions might also be required to visit another health professional while receiving prenatal care. At OCW and OCM there are no ob/gyns, and women with high-risk pregnancies were referred to another OC branch. If a woman was deemed high-risk at GC, then she was referred to Dr. Thomson, an ob/gyn, or Dr. Wheeler, a perinatologist, both of whom attended patients on Fridays.

Pregnant women considered high-risk patients were referred to a specialist within the clinic, to aid in treatment of the condition. For example a woman with gestational diabetes at OCW would be scheduled to meet in conjunction with the nutritionist in the clinic. Every pregnant woman was monitored throughout their pregnancy, so that if her situation changed she could be transferred to the appropriate health professional to take care of the issues that arose with the pregnancy. Women not considered to have a high-risk pregnancy were seen throughout their pregnancy by a midwife or a nurse practitioner.

After the initial prenatal visit, the woman was scheduled for appointments every four weeks until the seventh month of her pregnancy; she was then scheduled to come to the clinic every two weeks. After 40 weeks of pregnancy, when she was due to deliver at any moment, she visited every week.

Women who underwent a C-section were encouraged to visit the clinic again within a week of delivery, and once again a month after that. For a vaginal birth the mother was asked to return to the clinic a month after giving birth for a post-natal visit. During these post-natal care visits the health professionals discussed future family planning options, as well as any other topic not addressed during prenatal care.

Reasons Why Staff Do Not Talk about MC

An important research finding was that MC was not a common topic of conversation during prenatal care; it was rarely discussed. This was a consistent finding among the healthcare providers I interviewed in all three clinics, and was corroborated through participant-observation. I focus next on the reasons given by the healthcare providers to explain the lack of MC-related discussions. The three main reasons given were:

1. The time that each staff member has/is allowed/provides for each patient is not enough to talk about MC. Other topics were deemed more pertinent, and were given priority over MC.
2. The way the clinics' services are structured, does not allow for MC to be openly discussed.
3. Circumcision is a cultural topic, outside of the purview of biomedicine.

Staff members from all clinics consistently mentioned the limited time available to dedicate to each patient. In one of my visits to OCW, Julie—the only midwife in the clinic—told me she had too many patients that day; twenty-seven in total. For a regular eight-hour workday, twenty-seven patients meant that Julie was double-booked for each appointment. While she would ideally have liked to dedicate twenty minutes to each patient, the reality was that she would only be able to spend ten minutes with each one:

“Normally if budget problems weren't so bad, I would spend 20 minutes with each

patient. But right now they are double booking me every slot, so each patient gets approximately 10 minutes.” This is without accounting for the paper work that she has to complete before and after each patient.

During a visit to OCM, Dr. Bailey, a pediatrician, said that she had thirty-four patients for the day and had already told nurse Marta—who normally works at OCW, but was helping out at the OCM branch for the day—to stop sending in additional patients: *“I told Marta to stop sending patients. Unless it's an emergency... But if it's an emergency, they should be going to the emergency room anyway.”*

The providers’ concern with limited time was related to resources available to run the clinic. Julie alluded to budget problems, which was also mentioned by other providers during my time conducting fieldwork. The budget problems impacted on the schedule of my visits as well as the staff members I could have access to at particular points in time. A noteworthy experience outside of fieldwork activities made me think more carefully about the issue of resources. While at an informal event outside of the clinics, I noticed that Ede (an administrator for GC) was also in attendance. While we were talking, she asked me which other clinics I was visiting for my fieldwork. When I told her that I was also visiting the OCW and OCM clinics, she commented that OCM was unofficially sending their high-risk pregnancy cases to GC as opposed to their other OC clinic in Washington, DC. She shared how this upset her because without proper referrals, this type of action overburdens the services they are already providing to the surrounding neighborhoods. This was a telling experience because it made me realize how the location of the clinic, as well as how they priced the prenatal services, affected the resources allocated to each patient and the time of visits.

The issue of resources obviously affects the topics discussed and the time allotted to topics. Circumcision was not a priority for the healthcare providers when compared with other topics that were deemed more important to cover during their short prenatal care visits. Lily, a midwife from OCM told me:

The other part of why we don't address it that much, and maybe why it doesn't get addressed in clinics in general, is because we're really busy, and MC is not a priority... When we do have time, our priorities are the basic physical assessments and making sure everything is ok. We talk about breastfeeding and we talk birth control, and we talk about labor and birth, so those are the three main things that we want to make sure we address during pregnancy, and of course if they have any complications. Often we don't even have enough time to do those things so we just try to fit them in, and anything else would be great to talk about.

Lily added that even routine tests are often not fully explained during patient visits because there is not enough time. Patty, a midwife from OCM, added her own concerns regarding the short amount of time providers have during patient's postpartum visit which prevents them from even asking about circumcision:

Some of it is time related, because we have a lot of other things to discuss and I have a lot of patients, so it's kind of something that hasn't been given a priority... There is a lot going on in that visit (postpartum) that asking and finding out about circumcision is pretty low priority.

All but one provider interviewed assumed that when it is time to deliver, the woman will be given information about MC at the hospital, which is why it is given low priority during prenatal care. Patty mentioned that: *"It's standard practice at the hospital to have it (MC) offered, so it's one of those things that is low in the priorities for me because I have to see so many patients a day, and there are more important topics that come first."*

However, when I discussed this topic informally with Sandra, a nurse who doesn't work in these clinics, but has worked in several different hospitals in the state of Maryland, I learned that the process might not be as standard and predictable at the

hospital as Patty suggested. The assumed standard practice of offering MC at the moment of delivery does not mean that the patient is given appropriate information to make an informed decision. Susan explained:

In Maryland, I think there is unintentional peer pressure by the physician to the clients, that this is an expected procedure, that boys get circumcised, and because of that it is not posed as a question. Instead, they come in with the form and they say this is the circumcision; we're going to do it tomorrow, sign here. Unless the client is the one who says, we don't want to do that, then it's a different scenario.

The second reason as to why staff and health professionals did not talk about MC during prenatal care is mainly due to how the clinics are structured to deliver their services. The responses of the staff suggest that talking about MC does not fit within the current practices of the clinic. Ede said: *"I'm not sure if that (not discussing MC) is because of the nature of our clinic, because they're here for prenatal care and they figure you know, that's what we deal with, the pregnant mom, rather than the baby after they're born."*

My fieldwork in the clinics indicates that this might be due to various factors such as: the clinics' focus as community clinics and Federally Qualified Health Centers (FQHC); the low socioeconomic status of the clients seeking and receiving services; the fact that the AAP recommendation on MC does not properly articulate that it should be a mandate; and that there are no ob/gyns in the clinics to discuss MC with the patients, who are regularly the ones who perform circumcisions in hospitals at the moment of delivery.

Patty touched upon how in her previous practice she talked about MC during prenatal care, but that her clients there had very different socioeconomic and racial characteristics from those at OCM, where she currently works:

In my previous practice I was working with educated mostly white women with insurance. MC was discussed in prenatal care, mostly because I would see somewhere between 8-10 patients a day, as opposed to 20 patients (presently). And they would often bring it up.

On the other hand, Dr. Miller, a pediatrician at OCM, suggested an important relationship between MC as a cultural tradition, and how medical authority can (or could) change culture. She was referring to the recommendation of the AAP as well the interplay between behaviors deemed cultural and clinical practice:

Well you have to remember that circumcision is not recommended. It's neither recommended nor not-recommended. So if it were the case, in this point, most people in general are choosing to do what has traditionally been done in their family. If the dad is circumcised they plan to circumcise their son, if the dad is not circumcised, in general they plan to not circumcise, and that's what generally you will find, not in all cases. Now, were the [AAP] recommendation different, were the recommendation to say there is very clear evidence that pediatricians and people taking care of women prenatally, should be recommending circumcision, it would be interesting to see how our population who largely does not circumcise, would respond, if that were a clear recommendation. But since it's not... then we really can't asses that.

Dr. Miller reflected on the relationship between clinical recommendations and patient autonomy. The practice of patient autonomy puts the practice of MC at odds with what happens in the clinic. The guidelines are ambiguous, but they mean to empower the patient in making an informed decision. Providers operate within the dominant biomedical discourse, and as such only provide information that falls within this discourse. The authority providers have within the clinic is only validated with the information that is actually offered (Mol 2002).

Given the current position of the AAP about MC (which is written as a soft recommendation to undergo MC, as opposed to a mandate), not all healthcare providers believe MC is warranted here in the US. For example, Cathy a midwife from GC mentioned her own qualms about the procedure: *Because we don't understand the*

purpose of something, it doesn't necessarily mean (that it has) to be obliterated from your body, and because in that other country it's helpful, doesn't mean it should be the cure for HIV, that's for sure...

Lily also added that even though she is familiar with the research regarding circumcision, she is not inclined to support the rationale for MC:

Personally If I had a baby I would probably not circumcise...I think there is a lot of research to the effect of reduction of HIV transmission... There was some doubt whether that effect could be as strong in a different population, and I'm just inclined to leave things the way they are in those cases. So I mean yeah... as with most things when I talk to patients, these are reasons why you might want to do it, some people think this, these are reasons why you might not want to do it, some people think it's a really great idea for health reasons. There are these studies that may indicate that it reduces HIV. Some people do it because of cultural or family reasons, some people don't want to do it because they think it's harmful, so it's something you need to think about and talk about it with your partner...

Dr. Thomson, an ob/gyn at GC, mentioned that even if he performs routine circumcisions, he is not completely convinced that the scientific literature provides compelling evidence about the topic:

Well in the beginning, I was neither for, nor I was against...but I'm still not for it, nor against it nowadays. It's what people want... I don't agree with the total explanation given by the literature that this should be done...whether it's good, and whether it should be done in a humane way.

A significant finding is that of the three clinics, only one had either (and both) an ob/gyn or a perinatologist. Even in that case, Dr. Thomson, the ob/gyn, and Dr. Wheeler, the perinatologist, only provided services on Fridays. This might be due in part to the small size of the clinics, and how they secured resources. At GC, Drs. Thomson and Wheeler, took care of high-risk pregnant women.

When I asked Dr. Thomson if he talked about MC with his patients, he told me that it is standard procedure to ask the patient about MC, since it is a part of a standardized form²⁵ that is offered to anyone who receives prenatal services from a ob/gyn. I wasn't able to corroborate this with anyone else in the study since he was the only ob/gyn that worked in the clinics, and the only one I interviewed. At OCM, Dr. Bailey once told me in a passing comment that she didn't know what the current practice of talking about MC in the clinic was, especially since there was no ob/gyn at the clinic: "Here I don't know what the practice is, because we don't have OBs here, and I'm not sure if the midwives discuss it with the patients."

This provided another possible explanation as to why MC is not consistently discussed; the rest of the health care providers perceived that MC falls within the realm of obstetrics, and given that the clinics do not have an ob/gyn—with GC the only exception—MC is not discussed. In addition, as Dr. Bailey alluded to in her previous quote, the current clinic environment did not provide for clear communication, or any flow of information, between healthcare providers on the topic of MC.

The study clinics (until the moment of writing) are funded by grant programs that sometimes result in significant transfers of employees' duties as well as attrition of health professionals; employees either move to a different clinic, to other locations within the clinic, or to new jobs. Aside from Cathy, who has been working with GC for the last 5 years, the other providers had not been employed at any particular clinic for more than a year. The clinics' operational structures and professional cultures do not foster an

²⁵ This form is provided by the American Congress of Obstetrician Gynecologists.

environment to freely discuss MC as part of prenatal care. The way the clinics operate do not allow the flexibility—or the ability to modify the current resources—to insert a topic of discussion that is not even mandated by the AAP. All of these factors are at play in addition to the fact that clinics are located in areas that serve a majority of Latino populations, who do not tend to circumcise their males.

The third and final explanation as to why the staff in the clinics do not talk about MC during prenatal care, is their belief that MC is a ‘cultural’ procedure. When conducting fieldwork and interviewing people, I realized that everyone mentioned circumcision as something ‘cultural’.²⁶ For example, both Patty and Lily, midwives working at OCM, reported that they didn’t talk about circumcision unless the patient asked about it.

When Cathy talked about her practice in the clinic she mentioned how the process of giving birth has dramatically changed since the 1940’s. She reflected on how the roles and responsibilities between midwives and doctors have shifted and been redefined. Because of the transition to greater medicalization in prenatal care and delivery services, MC is not treated as a surgery nowadays and is rarely described as such in the context of prenatal care. Cathy stressed that in her experience most people just see MC as another part of the birth process, nothing more or less. Even though to her, MC is a throwback to a more conservative and traditional biomedical belief system: *“I think from my perspective with my mother and her family, it was more of a cleanliness, kind of*

²⁶ I write cultural with quote marks, since it is the participant’s own perception of culture, and it was articulated by many as such without being truly defined.

puritanical...so that they (boys) don't have to touch anything down there, you know, that kind of thing to be honest...”

As Cathy mentioned, I noticed that both tradition and family influences were relevant in regards to the beliefs associated with circumcision. Melissa, a Latina woman and administrator at GC, asked her cousins and her grandmother about MC when she was pregnant in order to assess what would be the best decision: “...*Because I don't have a reason... like our tradition, we don't circumcise boys... I have two nephews and they're not circumcised, and then my cousin's boys I know are not circumcised and that's because the father is from Guyana, and they don't do circumcision either.*”

Cathy added that there is a big influence in regards to what the parents see as normal in their culture:

Seems to me whatever they are that's what they want for their sons, if they are circumcised then that's what they see as normal, culturally and if not then not... I guess that is more the case with Latinos... Some patients are very clear-cut about it and... other people have more questions about it, and sometimes when I ask why are they so clear on it [MC]—it's from a cultural perspective or it's a personal thing that their partners are circumcised, or their brothers were as well... So, it's more of a cultural norm in a society, maybe feeling the pressure of the cultural norms...So, it's more of a cultural norm in a society, maybe feeling the pressure of the cultural norms.

Circumcision is ‘cultural’; as such it is related to acculturation practices among Latino populations (Castro, et al. 2010a; Sardi and Livingston 2014). According to two participants, MC can either be a marker of strong belonging to a Latino community, or conversely, a marker of adaptation (in this case Americanization). Both Sandra and Dr. Thomson mentioned the relevance of acculturation and time spent in the US in relation to the patients’ decision to circumcise or not. Dr. Thomson told me that according to his experience, the longer a Latina woman has resided in the US, the more likely she was to

go ahead and circumcise her child. Those who did not were more often recent immigrants who were more closely associated with ethnic communities and had closer ties with their country of origin's traditions and behaviors. Sandra also added that: *"The Latinos that came in were almost always circumcised as well, unless they came from another country. If they had been born in another country, that was where we would see the discrepancy"*.

Ede added that her own research suggested that in addition to immigration status and time spent in the US, socioeconomic status was also related to the decision to circumcise or not:

From my research, it kind of correlates with socioeconomic status, those that are higher education and higher SES are more prone to circumcise their sons. That is my experience and from my research or reading what data is out there. Personal experience? My husband is Latino and he is circumcised, he does come from...a family of higher socioeconomic status, and so it kinda substantiates that. But that's my experience."

And yet, while decisions about MC might be made according to family traditions and ideas about what is "normal" according to their own cultural beliefs, MC is still not discussed during pre natal care. Melissa suggested that this is information that Latina women seek from their family members: *"They (her family) wouldn't give you an opinion about that, because it's so personal, or, like, it's your kid, it's what you want to do with it, so they don't even tell you..."* This may be one of the reasons why some health care providers like Marta and Cathy occasionally brought up circumcision with their patients. As a Latina woman herself, Marta, a nurse from OCW, felt a connection with her patients because of their shared identity, which is why she mentions it from time to time: *"I'll bring MC up, especially since in our community it's not something that's talked about, and also not something I think is done very often."*

Marta brings it up because most of the time the Latina women do not ask the health professionals about it. Patty, Susan, and Renee, added that the patients just don't ask or bring up MC during prenatal care. Renee, a nurse from OCW reported that: *"They do what's in their culture...People don't really ask me my opinion on circumcision. My guess is that they are probably asking people who they relate to better than me—relatives, family members, people with similar culture"*. Patty reiterated that she thought the reason why they don't ask about it is because MC is a cultural matter:

Susan: *Nobody (patients) asks about circumcision. They just don't ask...*

Interviewer: *So if the patients don't bring it up?*

Susan: *I don't offer it. No. Because they had children before, so you know what they are going to do. 'Cause I think it's like a real cultural thing whether people decide to have their baby circumcised or not.*

Though MC is not often discussed, the staff was highly knowledgeable about the different ways MC was 'cultural'. From the participants' answers I gathered that, to them, 'cultural' meant that it was outside the scope of science or biomedicine. According to them, decisions regarding MC are cultural in nature, and as such the topic does not necessarily fit within the purview of prenatal care services, unless MC was required for medical reasons. If MC was enacted as a cultural procedure by the clinic's clientele, then the providers considered that it lay outside of the purview of the services the clinic can offer. Melissa mentioned as much when she said that: *"I think that, like, in Spanish countries and stuff, it's not something that is practiced, so it's kind of just passed down that you don't even discuss it, unless there is a medical reason..."* Dr. Miller mentioned that sometimes the decision to circumcise or not, does not necessarily respond to evidence-based medicine or recent research findings:

If they are Jewish, and they customarily circumcise their boys in the ceremony, and that's really important to them for that reason, you know having nothing to do with the lower incidence of UTIs, or decreased risk of contracting HIV in the future from unprotected sex, then I will support them in that decision.

Cathy is a clear outlier within these results because she does probe her patients about their thoughts on MC to understand better their decision making process:

Other times, they're just not sure. They just think everybody is (circumcised) because of their exposure. Their exposure is such or they haven't discussed it... so they don't even bring it up. But then when we talk about it, sometimes they'll go back and talk with their partner or someone and discuss it further, and see what their thoughts are.

The rest of the staff does not discuss MC unless the patients request to talk about it or have questions. Ede mentioned how this all depends on the patient. If the patients asked about MC, the staff provided information about the procedure. However, providing information about MC did not necessarily transition into a conversation on decision-making about it:

Usually it's just answering questions, to my knowledge. It's not like information is offered, unless the patient says, "I want to have my son circumcised, how would I go about that? Or is that something that they do at the hospital, or do I have to contact the pediatrician after they are born? How do I that?" Other than that, I don't know of too much more that goes on... Usually it's, like, how or where...when in fact it is discussed. I've heard it discussed when a person has already made up their mind, whether it's because of their cultural or religious background and they're just... they want to know how to go about it, rather than, "I'm kind of unsure If I want to make this decision.

During one of my visits to OCW, I observed how the staff responded to a situation when a woman asked about circumcision. An African-American woman at the clinic wanted to have her son circumcised when she gave birth. The problem was that she was planning to give birth at Washington Adventist Hospital, and that particular hospital is known among the OC clinics for not performing circumcisions. Julie the midwife and

other staff members were trying to figure out what they could do about this particular case. Though I did not learn how this particular situation concluded, it showed me an instance where the clinic seemed unprepared to deal with a client who had a firm desire to circumcise her male child.

In sum, the staff believes that culture, the structure of the clinic, and the time available to them to provide services for each patient during prenatal care, are the main reasons why MC is not discussed at these clinics. These reasons suggest shortcomings in the clinical context of the three clinics, as well as in the strategies employed to deliver prenatal care services.

Beliefs and Opinions about Circumcision

While carrying out interviews with staff members, I learned about their roles in the clinic and how their practice was related to prenatal care and MC. As I explained my research topic to the staff, they often volunteered their opinions about MC. Though I was offered an examination room at OCM to wait for Latina mothers to be interviewed, I often spent my time in the adjacent medical assistants' room. Though the medical assistants were constantly in and out of the room, I was able to chat with them during their down time. Though I met many medical assistants during my research I mostly talked to Iliana, Yedid, Lola, Mirari, and Rafael—who was the only male medical assistant—all of whom were Latinas/os.

My presence in the clinic was quickly noticed, especially since my research topic was deemed interesting as well as controversial. Dr. Miller even casually suggested that I was bringing about changes in the clinic, since everyone was talking about MC now. She had

heard that the midwives were finding out more information about the topic and talking about circumcision; though I was not able to corroborate this through my observations and interviews. Marta echoed a similar sentiment regarding my presence at the OCW clinic.

My presence in the medical assistant's room at OCM always triggered conversations about circumcision. One time Iliana shared with all of us in the room that her boyfriend was circumcised, yet she was opposed to the procedure. She had had previous Latino partners who were intact, as well as White men who were circumcised. She did not like the "extra skin"²⁷ on her intact ex-partners, and shared that she would be inclined to circumcise her child if she were to become a mother. Mirari added that out of her two sons only one was circumcised, but like Iliana she thought that uncircumcised penises "*looked weird*". This sparked more conversation. Yedid replied to both Iliana and Mirari that the way a penis looks should not be a reason to circumcise a newborn child; she said that the "extra skin" was not an issue of contention for her, since it was not a problem to begin with. The conversation then turned to Rafael, and they asked about his opinion of MC. He revealed to us that he would also circumcise his child if he were to become a father, because he had seen too many boys come to the clinic with UTIs. After some prodding from the other medical assistants he admitted to being circumcised. Shortly after, Lola asked all of us if MC affected the size of the penis when the boy grows up. Though Lola was serious, most of the medical assistants laughed at her question. My reply to her was that there is no scientific study that showed that penis size and circumcision status are in any way related.

²⁷ Foreskin

This last question by Lola made me think of previous conversations with Cathy. In one of our interviews she shared her frustration about the ignorance of US parents regarding the proper care of an uncircumcised penis, and how important it is to protect the sensitivity of the penis:

The care of an uncircumcised baby is not difficult.... you really don't have to do anything. Things develop over time and it's not really a big issue. And even I mention (to my patients), sexuality wise, it preserves the sensitivity of the penis, and so it's... more sensitive, and that is a good thing. You take some of that away when you take away the protection from that (foreskin).

The conversations in the medical assistants' room at OCM prompted discussion of personal experiences that were related to MC, which often led to further questions about the penis and male sexual health. On one occasion, the medical assistants in the room asked Rafael if uncircumcised men bled the first time they had sex; he replied in the affirmative. Knowing that his response was not accurate, I added that similarly to vulvas and vaginal canals, everyone's penis is different: some men have tighter foreskins than others and the small percent of men who suffer from it, could experience discomfort during intercourse.

Lola did not know much about MC and asked me what was actually cut during the procedure itself. While answering her question, and others posed by the medical assistants, I noticed that they knew little of the procedure. At some point in one of our discussions, someone asked why circumcisions were performed at all. Lola replied that she had heard that circumcisions helped boys to avoid infections.

During another visit to the medical assistants' room, I became the focus of the questions: they asked me if I was circumcised and what would I do if I had a son. I replied that my response would depend on whether I answered as a researcher or based

on my personal views. Yedid quickly replied: “*No. What do you think about circumcision as a man?*” I gave them my opinion and explained how it was informed by my family experiences, and what I had researched on the topic. I mentioned the recent birth of my nephew in Puerto Rico and the conversations that I had with my sister—a single mother—about the topic, and that ultimately she decided against circumcision.

The opinions of staff members on the subject of MC were very diverse. Cathy held very strong opinions against the procedure. Dr. Thomson expressed not being either pro or against MC, yet he always abided by the patients’ desires. Ede, Renee, and Dr. Bailey on the other hand, did not have a problem with having their own sons circumcised and sharing that information with me. Renee, Susan, and Patty were more circumspect when I asked them and did not give their opinions on the matter. Renee’s answer was very telling because it framed circumcision within the larger context of childbirth in a biomedical framework, yet taking into account the lived realities and experiences of the newborn and his family:

About the actual procedure? I think it’s a very painful thing for a baby newborn to have to experience. However that said, we do a lot of painful things to newborn babies. We give them shots...birth is painful, they have to squeeze through a very small opening... There are a lot of painful things that happen. However, I think usually the first day or two of life is a very important for the baby to be bonding with his parents and... exploring the world in a relaxed way, and anything that... interferes with that seems to me not very good... So I’m kind of saying pluses or minuses, some babies have surgery right after birth and they bounce back, they are strong they will survive it, but it’s painful. They’re strapped to a thing, I’ve seen them around... I’m part Jewish and I’ve seen it done by rabbis, I’ve seen circumcision in the hospital where the baby is strapped down to this metal thing, and it’s horrible. It’s not like a small piece of skin that is cut off. But they survive it and babies aren’t as delicate as many people think they are, they are quite strong. But it is missed time that could be used for other things like breastfeeding and attachment...

While explaining the background of my project I had mentioned the research that was being done in three African countries, as well as the outreach that both pro- and anti-circumcision groups were undertaking. When I mentioned that some scientists supported the AAP revised position by comparing its immediacy to vaccines, Dr. Miller responded very negatively: “...*I think that is a big stretch, because there is an insurmountable body of evidence for vaccines, that vaccines clearly save lives, and to compare circumcision to that is not on the same level.*”

The healthcare providers knew that MC was related to prevention of certain conditions. With the exception of the medical assistants and all but one of the administrators, the providers knew of the link between STD prevention and MC. Sandra told me that she knew there was a decreased risk of STDs in circumcised males, but said that was not communicated to the patients who were seeking information about it in the hospital at the moment of delivery. Dr. Thomson was very familiar with the recent research since he mentioned he had several scientist friends working at NIH. When we talked about the scientific literature on MC he said to me that:

Dr. Thomson: *The latest literature is that you can reduce the transmission of HIV in African males... the research says that there is a decreased incidence in transmission of HIV. Well, in the Washington Beltway area, there is a higher incidence of syphilis, there's a higher incidence of HIV, in this area....*

Interviewer:...and If I hear right what you are saying, it's that this correlation does not translate to this context?

Dr. Thomson: *Yeah, it doesn't correlate at all to me. Because it is a blood borne thing, it is HIV and there's...ejaculation is ejaculation. Why is it supposedly harder than the Langerhans cells where the frenulum is located in the penis on an uncircumcised man...*

Interviewer: *And that's also accounting for unprotected sex anyway.*

Dr. Thomson: *Right...*

Interviewer: *The premise is... people are not going to have protected sex.*

Dr. Thomson: *Correct.*

Dr. Thomson was not entirely sure that the recommendation from the AAP or even the present research warranted that MC be recommended to the greater population in the US. Lily echoed a similar stance: *"I think there is a lot of the research to the effect of reduction of HIV transmission but... there was some doubt whether that effect could be as strong in a different population, and I'm just inclined to leave things the way they are (intact) in those cases."* Meanwhile, the two pediatricians, Drs. Bailey and Miller, acknowledged the importance of the AAP recommendation on MC. The AAP's revised stance in August of 2012 was responding to a number of clinical trials conducted in several African countries pointing to a relationship between circumcision status and HIV prevention:

The most recent research that they are using is that there is a benefit to it. Decreases risk of UTI, decreases risk of HIV transmission later in life, and the most recent statement that they put out said that the benefits outweigh the risks to the infant so that's their (AAP) stance...In my practice? ...The American Academy of Pediatrics sets forth the clinical guidelines, and over the years they have gone back and forth. Do we want to circ (circumcise), do we not want to circ, what are the risks, what are the benefits, what are the pros and the cons. So I take that into account with my practice, if a parent were to ask me, what do I think? I would go based on the AAP clinical guidelines. It's a personal decision. If they ask, then I would provide them with information from the AAP. –Dr. Bailey, Pediatrician, OCM

So, the AAP is essentially the highest standard of guidelines for pediatric practice. So it's not one person making a personal decision, it's a large body of experts reviewing all the evidence and then publishing evidence-based guidelines. And so, there is no mandate, there is no law, but any pediatrician who is practicing based on scientific evidence, would be following the guidelines published by the AAP. They are the governing body, and whether you're a member or not shouldn't make a difference, because it's all about facts. It's just about scientific research, studies, and they just so happen to be the most vocal voice of the compilation of all this information. But you could go to the literature review yourself and look at the Cochran review, because you should obviously look at a metaanalysis and not just an individual study, and you would come to the same conclusion that the AAP has done for you, because that's what they do. So until there is conclusive evidence to the contrary of one of their guidelines, that's the gold standard. –Dr. Miller, Pediatrician, OCM

The pediatricians are following the paradigm of evidence-based medicine and the golden standard of research as a way to inform their clinical practice. It is important that I note they were the only providers who mentioned specifically the role of research and policy when providing services, as they referred back to the guidelines of the AAP.

On the other hand, Cathy and Patty expressed concern about the organization (the AAP) issuing the recommendations, and about the research leading to them. Patty, like Dr. Thomson had qualms about the transferability of the results to the US: *My understanding is that statement is based on a lot of research that was done in other countries, and not research on babies and social practices in this country...*” Cathy on the other hand had reservations about the organization itself:

It's interesting because it's not pediatricians doing circumcisions; it's a done deal already by the time [they] see the baby. It's done in the hospital by an obstetrician, it's not done by pediatricians most of the time, it's an unusual thing. So, by the time someone has seen the pediatrician that decision has been made already in the hospital, by the obstetrician historically...and that to me is very interesting.

There is an issue of how MC, and clinical practice is performed in such a way that responds to research, even when the social context is different; the golden standard of research sees past that and has authority to disseminate its guidelines and inform practice (Timmermans and Kolker 2004; Timmermans and Berg 2010). Cathy does not necessarily follow that strict line of thinking in her practice.

Beyond agreeing or disagreeing with the procedure, the participants perceived MC in a variety of ways. Yet, my conversations with Cathy provided more insight into her own work as a midwife, and how she delivered her services. Firstly, Cathy disagreed with the discursive division of genital mutilation for females, and circumcision for males:

In this country we refer to it as genital mutilation when a female is circumcised, but we don't ever talk about it as a male genital mutilation... That would be like (laughs) WHAT? But commonly that's how it's referred to, so that's very interesting to me... That's not saying that one cut is worse than the other, that's not the issue, that's not the issue at all! Women are the issue... call it what it is. When you call it genital mutilation, that's what it is, whether you can make a case for either way, it's kind of sad to me that that's how this is handled in Africa, that this is what we come up with, the solution. Really? Really? That's... the solution? You have to cut off a part of your body? That's the solution?

Cathy expanded on how MC had been normalized as another medicalized procedure that fails to consider how it can transform the body of the newborn male, when enacted during the provision of prenatal care services. Her personal and work experiences gave substance to the information she then provided to her patients about MC. She believed that MC was at odds with the bodily autonomy of the child, and that current birth practices had cemented the normalization of circumcision. She thought that many in the US thought of MC as another component of childbirth, rather than as a surgical procedure. We had several conversations about this matter, and I shared what I had been learning on Internet forums and Facebook groups from anti-MC groups with similar views; in particular I had read accounts of men that had expressed their regret and disappointment at being circumcised at birth. In response to that, she shared that her approach to talking about MC is holistic:

What I try to tell people, there are a number of things we haven't understood about our bodies, but there's a purpose to it, and to cut something off just because we don't understand it, it's not right...and that's what I try to say to people. I try to respect the human body, even though we don't understand the purpose of every little thing, there is a purpose to every little thing, and I honor that purpose, whether I understand it or not. I have to learn and figure it out, and I'm sorry I didn't learn that sooner...

The providers' beliefs about MC impacted on their own practice and delivery of services. Their views on circumcision varied according to their role in the clinic, their

ethnicity and identity, their personal experiences, and to a lesser extent the policies that informed clinical practice.

Decision Making

You know the bottom line of the (AAP) statement, was that is a parental choice. I fully support that, I think it's really important for a parent to feel that whatever choice they make, they made the right one for the right reasons, whatever that may be...I think it's very important to stress that it is a parental decision, and whichever decision they make is the right one for them, and that is ok, and they did the right thing for their son, no matter what they have chosen. -Dr. Miller, Pediatrician, OCM

As the above quote illustrates, in light of the AAP's recommendation, Dr. Miller is of the mind that the parents are the ones who should make informed decisions about MC.

Susan, a nurse working at GC also agreed with this:

Whatever the patient wants is fine with me, if they don't want it, you know, I want to keep the patient informed and tell them about why they do it so much now because of the HIV and that kind of stuff... if they tell me, "I'm not going to do it," I think that's great... if they told me they are going to do it, what it will entail, we talk about it more... I don't have my own personal beliefs on it, it's whatever the patients would want. A lot of patients are so well read and they could tell you exactly what they want and everything... I think it should be talked about. As a matter of fact in my previous workplace we always had pamphlets on circumcision, for you to decide, just to give you the information about it, and have the patient decide and that's what we need here too probably...

The patient's decision-making process was an interesting factor to make sense of, since it is not frequently enacted as a service in the clinics. As such, I focused on the provider's own experiences with decision-making, to understand how it could relate to service delivery. The staff and health professionals are not exempt from the idiosyncrasies that patients face when having to make a decision on MC. In one of my visits to the medical assistants' room in OCM, Yedid, who was 7 months pregnant at the time, told all of us that she was glad that she was expecting a girl and did not have to deal with having a

discussion about circumcision with her partner. After asking me If I thought that MC was beneficial or not (and being dissatisfied with my neutral answer) the medical assistants asked Dr. Bailey, who was in the vicinity about what she did/would do:

I deferred to my husband. He said that it would be ok, so I went ahead and did it. It was only a week that the baby was in discomfort, and that anyway I was weirded out by the whole penis business.

Whereas Dr. Bailey deferred to her husband on her decision-making, Cathy did the opposite with her younger sons.

I have 5 children, my first son is circumcised, he's 45, my youngest is not, he's 25. But I had my first one when I was very young, and it wasn't presented as an option... But my next three children were girls, so I didn't really have to think about it in terms of decision making... My husband was circumcised, and he was horrified of the idea of not having a child circumcised. Cause I was married twice... By the time, I had the second set of children, he was like (sighs), "Of course you are going to do that." And I was like, of course, of course I'm not circumcising him... I had very strong feelings.

Cathy attributed her decision to circumcise her first son to the circumstances surrounding her first pregnancy; she did not have access to information necessary to making an informed decision. The medical environment at the time did not present circumcision as optional, and the consent process was not as patient-friendly as it is nowadays. This experience made her reflect and find more information about MC and informed her strong feelings against it. Later in her son's life, she had to respond to his questions about his own circumcision. She felt conflicted and emotional about her son's reaction as she acknowledged his questions about the procedure:

I had to actually answer to my oldest son, he was 20 when his brother was born, because he says, "So why did you do that to me?" And I was like (gasps) welled up you know, right away, because he (had) even asked about some of his friends when they were having children. They wanted to have information about circumcision, so... it was a hard conversation to have with him because I didn't

have a good reason... I was just... I didn't know... I was ignorant, and it was just custom and even now it just makes me feel...oh...

When Melissa was pregnant she relied on her family's advice to make a decision about MC due to the insufficient information received throughout prenatal care. She recalled that she had heard about circumcision in a class at school, and that MC at birth was related to cleanliness and hygiene. She shared that through her work at the clinic, she once saw a three-year old with a urinary tract infection; this gave her pause and said that in cases like that, you have to consider circumcision too. MC is enacted as something related to Latino identity; since her community (she identifies as Dominican) does not see routine MC favorably, if she were to do it to her sons, there would have to be a medical reason for it:

Here they say it's a medical need to do so, or a medical reason to do so. We don't see it that way, we just see it like, it's not a need for it...we don't even question it. I just feel like I'm going to keep him clean, and show him how to keep himself clean, I don't need to put him through that.

Theresa, an administrator from OCM, reported that when she gave birth to her son back in Brazil, she could not make an informed decision because she did not receive proper information about MC:

Well as a mother, I would say that my son needed circumcision and I had no idea, because I had no access to that information... I asked the doctor, I asked him about it, and he said oh no, when the baby grows perhaps it will change so there was no need for circumcision. Perhaps this is culturally speaking, I'm from Brazil and we did not see any need for that to happen. My son became an adult and then he needed circumcision, so then he got the painful surgery as an adult when it was completely unnecessary, if I knew that it could be done by birth... the doctor there told me oh no his skin is going to expand and there is going to be everything fine, but the fact is it didn't happen, and I just put a child through a situation that was unnecessary... I wish I had that information to make a better choice about this inconvenient pain... or any health related issue that could happen to him that fortunately didn't happen.

Resources, education, and socioeconomic status are all part of the decision to circumcise or not, as well as the MC-related interpretations by the mothers. MC is being enacted as a medical procedure, within the realm of the delivery process. Except for Dr. Bailey, the common thread seems to be that MC is not fully discussed before delivery.

Not all patients are alike, and not all patients have access to the same services. When talking about her experience as a mother, Dr. Bailey mentioned: *“They also ask you in the hospital before you go home, would you like a circ (circumcision) or not.”* Yet she also acknowledged not being a typical patient. She had access to both private health insurance and private prenatal care, and her providers did talk about MC.

As a parent, and someone who went to a private OB (ob/gyn) and had a son, the question was posed to me before I delivered. So it's not a discussion I had with the pediatrician, it was discussion that I had with the OB as I neared delivery.

Most of Cathy's patients did not have private insurance, and as such she took time to discuss more than just the medical aspects of MC, along other aspects of prenatal care. She encouraged her patients to think about bodily autonomy as well as any potential discontent their children might experience by having the decision taken from them:

I also tell people when you make that decision for your baby, you're taking the choice away from your child. If you choose to be circumcised, it's much kinder when you're an adult, and that's done... you may think it's brutal but it's much kinder because you are going to be medicated beyond belief, you know, not only for the procedure, but afterwards...but you've taken that choice away, you know, that choice can always be made. It doesn't have to be when you're born. If you feel really strongly about it you can do it when the child's two. Or you can do age six, or you can wait for them to decide. You know, to think... that's important to do.

However, most of the staff based their experiences on the perception that Latina women do not want to circumcise their male children. This perception discouraged them from talking about the procedure in the clinic in the first place. This might result in Latina

women not benefitting from proper information about MC that would inform their decision-making process. Renee, a nurse from OCW told me as much: “*Latinos are not going back and forth about doing it (MC) or not*”. Dr. Miller added that assumptions affected the information Latina patients are receiving:

Well I don't think they...spend time with the families and explain both sides of it, because I think they (hospital) make assumptions, because the majority of our patients do not circumcise... I think they assume they don't want it, and don't give them an equal chance for or against.

This demonstrates the difference in enacting MC as a procedure within the clinic’s services to be discussed in prenatal care, in contrast to MC offered at the moment of delivery. My fieldwork demonstrates that no one particular provider consistently practices MC as a service of the clinic. The providers did not perceive a contradiction between their beliefs in having parents making cost-benefit analysis before decision-making, and their practice of not discussing the procedure in the clinics. Patty stated: “*I think it's a very personal choice. If a mom wants to have their baby circumcised she should have the right to have their baby circumcised... and I think it should be offered to everyone, if that's something that they want to do.*” Which was echoed by Susan “*(if they are interested) I tell them all about the procedure because I feel really bad for babies*”. The interesting aspect of all this is that the opposite, believing that parents should not be part of the decision making process, is unheard of within the current biomedical paradigm of service and care. However, offering information on MC to everyone does not seem feasible at the clinics, based on my observations and interviews.

While the clinics operate effectively as they rely on the efficiency and cooperation of each provider, there is not a great degree of intra-clinic communication. The providers

made assumptions about whose job is it to talk about MC and when to discuss it—if at all. Therefore, there was no conclusive answer in regards to who talks to the patient about MC; there is no definitive way to know if MC is indeed offered to everyone at the moment of delivery, and there is no conclusive answer as to whose responsibility it is to raise the topic of MC, if at all. Renee mentioned that in regards to the patients: *“Maybe they are having that conversation with the midwife regularly, and it seems to me they have their minds made up, but... I don't have a huge amount to back that up...”* Theresa also added that: *“I don't know if the medical assistants ask, or the doctors, the OBs, (or if) the midwives ask that...”* Dr. Bailey was equally perplexed about who is having that discussion with the patients about MC, and if they are happening at the hospitals at all: *“I'm not sure how that discussion is happening with our patients in the hospital”*. Lily also was confused and did not know the context of the hospital at the moment of delivery: *“I think that is one of those things that is a moment of when you are in the hospital, “Oh do you want to circumcise your baby? We can do it right now if you want that,” but I don't know if that's what happens or not...”*

Assumptions were made about who talks about MC in the clinics, as well as in the hospital. To add to this, the providers had very little information about how the patient came to learn about the procedure, if at all. Cathy provides a broad scope of information to her patients on MC, to rectify this situation:

Sometimes I think being informed is being informed of the truth of it (MC). Sometimes it's emotionally easier if you don't know the truth of it... but it's my place to give them information, and let them have the information to make whatever decision they are comfortable with... You know, as long as you think that it's kind of an innocuous thing, then it's just like getting your ears pierced or something, then, it's easy, you know. But once you know how it's done, and what the purpose of the foreskin is, you know...that you have a body and the parts are there for a reason, and I think people often do make other choices if they think

there is a choice, you know. I also understand that sometimes it's just because they thought there was that way and that's how you want it to be, or culturally, or religious wise, there are reasons for it. But many times people just go ahead just because they just haven't thought about it, pretty much how it was for me. Cause... there wasn't anything to discuss, the information wasn't presented.

When the discussions happened, it became a challenging topic to approach. Cathy talks to her patients about the surgical aspects of MC, to impress upon her clients the seriousness it deserves:

What I try to present is that if you don't do that at the birth, it is definitely looked on like a surgery. That it's in the hospital, under anesthesia, it is surgery... Because then it's serious, you know. I mean it puts in a different context, completely.

Susan described the procedure as well, since she has had experience of talking about the procedure at previous jobs but only when a patient asked her about it:

I tell them exactly what it is that they're doing, that they are taking off the foreskin...Because I used to see this, I used to watch this in the hospital, I could tell them exactly what they do. When I was at the hospital we used to then... put vaseline and then wrap it. Now they don't do the wrapping anymore, just the vaseline because the wrapping would come off, and the band-aid will stick somewhere else, they want to make sure it doesn't stick on the doctor. And check for bleeding, and all ... you kinda have to watch them pretty close after they are first circumcised.

The staff also mentioned the challenges of providing enough, or sometimes too much information during prenatal care. With MC this can be even more challenging when a patient comes with deeply held beliefs that are not medically accurate. Dr. Thomson shared his frustration because some of his patients relate MC with preventing “infection” without knowing what type of infection they mean.

Because I think people should get a better education, having Grandma, or Grandpa, or the neighbors telling them this information that they should have their baby circumcised, for the same reason, it's perpetuating that it's preventing some sort of infection. But there is no one can tell you what that infection is... I

believe it's because of their education at school. In my listening to other people, they think that is going to help prevent some sort of infection but again even they do not know what they are trying to prevent... Why do you want this, if there is no infection? And then when you ask them what kind of infection do you want to prevent, they... don't know the infection they are trying to prevent, because there is no infection that can be prevented by doing the circumcision.

In certain cases there have been patients who have felt so strongly either against or for circumcision, that they were not dissuaded when presented with alternative viewpoints.

Dr. Thomson asserted as much in his interview: *"If they really want to know, I tell them, I give them the explanation. If they just say I want it done. I'm not... I haven't yet, in 23 years, ever talked somebody out of doing the circumcision, because of what I said to them."* Cathy has had some success in this regard, as she has invited other members of the patient's family, including the father of the child, to receive all the information they can have about MC:

I have had people, that kind of have changed their minds 'cause [I] will say, well if you... want your boyfriend to come in, or your husband to come in, we can talk about it, and we talk about it...and so sometimes people do, and sometimes people don't. But I think it's helpful to have the information so that, um, you can make an informed choice.

And including the spouse/partner/father of the child is important to Cathy because her clients enact MC as a cultural procedure that can have lasting effects in their lives.

According to Cathy, the partner—or father—should be an important component of the decision making process:

Many times I see the women alone, and I don't always see their husband or partner, and I realize the decisions that they're making, they're making them alone... I encourage their spouse or boyfriend to come in, especially for hot topic items like this. It's more important to have them here, in order to answer any type of medical questions, to understand and appreciate the cultural differences... Sometimes these are things that are not discussed, and people assume that is how it is done, and they don't really discuss it before.

Patty believed that decision-making should not be made solely on social variables though:

So, it's more of a cultural norm in a society, maybe feeling the pressure of the cultural norms, like somebody telling her you should get your son circumcised because he's going to look different in the gym from other boys. That's a poor reason to get a circumcision... if the mom chooses to do that because that is her desire, then that's fine, but that's a poor way to introduce the idea, to persuade someone to get a circumcision.

Since circumcision is cultural and social, it is also related to the child's upbringing, and circumcision status can be a marker of how normal—or abnormal—the child is within his community. Renee suggested that when thinking of circumcision, you have to think of the child's interactions later in life:

However you always have to think of the future of your child's life, and if culturally or socially it's going to be that the kid or the adult will stand out because he is not circumcised, and all his peers are circumcised. Then it's not the end of the world, you know, the baby survives it and it's just fine.

The child's circumcision status can make him blend in, or be easily differentiated within the communities he belongs to. Thus the cultural aspects of MC can have beneficial or harmful effects on a child's life beyond enacting MC as a procedure to prevent illness and disease. Cathy shared an experience that illustrated this issue:

I have a friend who also didn't have her boys circumcised and... One of her boys told his sister that he was made fun of in school because he wasn't circumcised. They used to call him anteater and stuff like that... He was very embarrassed by it ...to the point where he kinda influenced her sister when her son was born, and she had her son circumcised.

Experiences with Circumcision

Cathy's emotional response when she recalled the conversation about her son's circumcision, made her think in detail about the ways her experiences had influenced her ideas about MC:

It's just I realized that... it is emotionally packed, you know, because when you realize how it's done, and how I handled it through the years, (how it is) explained to people, this is how... THIS IS how they do it, and this is, you know, they didn't use any kind of anesthesia, they just... cut, you know... and it is painful, and it does interfere, and it does interfere with nursing afterwards, studies have... shown, that babies do have trouble afterwards, you know their nursing is definitely interrupted at least for those first 24 hours, because there is pain involved, you know there is pain for a while.

The experiences of the medical assistants also resonated with the questions and stories they shared with me about MC. Iliana said how her sister “broke” something when she retracted her son's foreskin when he was a baby. To me, this was reminiscent of what Cathy had shared with me in one of her interviews about retracting foreskins on babies and toddlers:

I remember when I started working many years ago. When a baby will come in for its two-month checkup, they will automatically try to retract the foreskin and make a referral for circumcision, boom... that was it, was difficult to retract. But it should be difficult because it's for protection, yet that was the absolute indicator of the time... If it happens good, if not then that was some medical referral because at the time Medicaid would not pay for it unless it was a medical referral, and of course more times than not there was difficulty in retraction. This was in Prince George's County in a public health clinic.

The current situation, where patients do not receive proper information to make an informed decision, was not ideal to the staff that participated in my study. To some, it evoked a more visceral reaction. Cathy mentioned that this situation was no better than the past practices of health care providers, where patients were not empowered to receive true informed consent. Cathy's experiences about how medicalization and lack of

information affected her personal life, as well as her family, influenced the caution she exercised in her practice:

My brothers were circumcised, that seemed to be the way how things worked culturally, but truly there was no consent. There was no discussion. It was, "This is what they're going to do." It wasn't until afterwards that I was horrified, thinking oh...what have I done...But as I grew and learned, it just seemed to me that... there is no reason to cut a piece of your body.... You know we used to do routine tonsillectomies, taking your tonsils out. If you had a bunch of sore throats people will take your tonsils out. I had mine taken out the same time as my brother 'cause he was having his... It was a routine 'cause we didn't understand the function of that part of the body.

Cathy's experiences had made her come to practice MC in a particular way that benefits her clients, regardless of whether they are Latino or not. Her own experiences permeate her prenatal care practice and enactment of MC, since she is not fully participating in an extreme medicalized model of prenatal care and delivery.

Power Dynamics Between Patients and Providers

When talking about MC, the health providers admitted that, like any other service they provide, they have to be careful how they frame it and present it. MC is not exempt from the power dynamics that permeate service delivery in health care.

Lily shared with me her frustration at trying to balance how much information should be provided to the patient in order to help them make an informed decision—even about the most routine and minute procedures—while also making sure her patients were making the right decisions. Her comments also reflected how she managed and prioritized what to discuss during consultations, given the limited time she had with each patient:

Like for example, GBS bacterial testing...it's a bacteria that is commonly growing in the vagina that like 30% of women have. It's a normal bacteria and in a very small number of cases can cause a serious infection in the baby. It's pretty rare that the baby could be infected, but it can be very serious. And so... the recommendation is to test everybody at 36 weeks and that's what we do. We test everybody for the bacteria, and if they have the bacteria they get antibiotics when they are in labor in the hospital. However...my opinion, in an ideal situation, is that we would say this is what this bacteria is, this is why we do the test, this is what we would do if you were positive, here are reasons to do the test, here are reasons to not do the test, here's the reasons pro the treatment, against the treatment, and let them decide. But of course we don't do that. First of all we don't believe they should decline it, and we don't have time, and they might have a hard time understanding it. So what we do is we say this is what we are going to do... I personally don't feel that every medical thing that they are doing to you should be, "This is what we are going to do," and if you are well educated you know that you can decline anything you want, if you have a reason to. But most people don't know that, they don't know they don't have to do everything the doctor tells them to. So if the doctor tells them we are going to do circumcision now... if there are particular strong beliefs that the doctor knows best, then they are going to do it. If the doctor says they don't really need a circumcision, ok I don't need it, doctor says I don't need it.

Considering the issues of authority and who tells what to the patient, I had to be careful myself. Dr. Miller, who also held clinical director duties at OCM, told me not to talk too much with the patients about MC because they might confuse me with a doctor. Initially, she had some concerns about my presence in the clinic, and the questions I had for the clinic's patients. She read my research questions, and gave me feedback over email on how to rephrase them. The next time I went to OCM I followed up with her about her concerns:

Our patient population is predominately Latino and most of our parents, not all of them, most of them, are immigrants... There is relatively low literacy in a fair number of our patients. Most of the information that our patients have comes from their parents, their grandparents, their siblings, their friends. They... do not often look up health information like on the Internet. Some people do, but not to the extent that you will find in some other practices. So when patients come here, the advice that is given by anyone in this clinic is taken as very important, because it may be their only access to a health professional, and so we know to be especially careful in who is giving advice, and what we are saying, because our patients really do take what we say very seriously and follow the advice—more so than

another clinic, where someone says, “Well I’m going to consider what the provider said but I’m also going to do a bit of research on my own and make my own decision”. Our patients are more along the camp, “The provider says that I should do this and so I will do it”, and sometimes they are not sure. When there are a lot of people in the clinic, they don’t necessarily make the distinction, this person is a provider; this other person is a front desk person who doesn’t have any medical training. So if anyone within these walls gives them any advice, they are likely to follow it, so we need to be really careful about what we said.

Lily and Cathy had mentioned to me that patients take medical authority very seriously.

"Patients will do whatever the doctor tells them to do if they think the doctor is right",

Lily told me.

Ultimately I heeded Dr. Miller’s feedback since I did not want to confuse the patients in the clinic regarding my role. Her feedback regarding my interview questions was aimed at shifting emphasis away from the clinic’s services. Dr. Miller read my original questions and thought they were priming the interviewed women to think they should be receiving information about MC from the clinic. Since they were not getting that information consistently, she was concerned that her patients would worry, putting an extra burden on the mothers who might believe they were not getting the services they should get. She told me that: *"these are people who feel guilty that they gave their kids too much juice"*; I was extra careful from then on. This also points to how, even though reassuring the guilt of her patients is not required of the services she provides, Dr. Miller has interpreted the lives and bodies of the community as part of her responsibilities (Mol 2002). I would argue that in this case, Dr. Miller was preventing me from being part of how MC was enacted in the clinics: she does not want her patients to enact MC—or any other procedure—with a non-member of her provider community.

Given these aspects of position, and how information is given, I thought back to some earlier conversations with Sandra, who initially helped me craft my interview questions when I started conducting fieldwork. Since she has experience working at Maryland hospitals, she provided some context that I was missing from the clinics; such as the information that is given at the hospitals at the moment of delivery. Sandra seemed to think that the conversation about MC in the hospital setting was biased, and put the parents in a difficult position so that they were more likely to indeed circumcise their sons. She told me that the health care providers in the hospital were giving the information to the patient and listing the benefits and risks of MC in a way that coerced the patients. Even more so, she noted how different the conversation would be when a nurse offered the information to the patient, as opposed to the ob/gyn. Past research has addressed this difference, and nurses have been identified as the most involved in providing information about MC during postpartum (Sardi and Livingston 2014). Sandra reported that:

Mostly what they talk about is the pros of having the circumcision. They would talk about keeping the penile tip clean, for example, in small children, is very difficult, which can lead to infection, which can lead to X, Y, and Z. And that was the difference between a physician dealing with a patient, and a nurse dealing with a patient...it's two different levels of conversations that you have.

Because of situations like this, Cathy prepares her patients for that potential scenario by outlining all the options before the delivery:

But what I want them to be is prepared... In the hospital someone will ask them to make a decision. So, now is the time to think about it, because that's the time that you'll have to make a decision, at least that's the perspective in the hospital. The women don't actually have to make the decision then and there... they can put it off if they want, I think that's important information to have too, just because you are in the hospital for two days, doesn't mean that has to be done just then. If you are unsure, then wait...

Cathy's comments provided me with more context to Sandra's experience. She noted that even providing information about MC implies a developing power dynamic. As alluded by Dr. Miller, any information given to a mother during prenatal care is for the benefit and wellbeing of both mother and child, yet it is still embedded in power relationships between provider and patient. Knowing this might predispose how the mother thinks about the procedure itself, especially given the current stance on MC by the AAP. Cathy added that:

...I think that as soon as you say that, that puts a definite bias right away. As soon as you put that question out there, if you say there is a benefit, then as a mother, of course you're going to do what's beneficial to your child. So to hear a group actually saying that even if it is quasi over the line beneficial, I think it's very influential with people. Because you're asking your doctor and they say it's beneficial, that you're going to prevent urinary tract infections, and it's not just AIDS and HIV that they're talking about, it's urinary tract infections. I think it's very hard for a woman to say, "Well no, I'm not going to do something that can be beneficial to my child." It's hard because you want to do something that is beneficial, so I think that kind of statement would push someone over, if you were thinking about doing or not doing it.

Conclusion

One of the things that the staff constantly asked me when I was at the clinics was, *What are you finding here?* My first responses were to talk about the patients, and how most of them had not heard about circumcision from the clinic. This led to some people asking me for suggestions, or challenging me to think about how they could incorporate the results of my research into their practice. Theresa, for example, wondered how the clinic could ask the women coming for their postnatal visit about their children's circumcision status:

We could have a questionnaire, "Did you have a boy? Did you have him circumcised?"...That would...let you know exactly how many people from here...

But they (patients) never ask, so I don't know if they just don't know or anything... Or maybe we could ask about it (MC) during prenatal enrollment.

As I mentioned earlier in the chapter, my presence in the clinics was noted and sparked many conversations. Though I am a cisgender man, I avoided speaking directly about myself, instead relying on my experience with my nephew who celebrated his first birthday while I conducted research, to breach a gap between researcher and participants. In formal and informal interviews, I discussed at length how I related to this topic and how my sister and I often talked about her prenatal care back in Puerto Rico. I found this as a great way to engage better as more than an observer.

My presence as an ethnographer in these places heightened some people's perception of the topic, and therefore they told me they asked their patients about it more now. Marta for example told me: *"Can I be honest? It's if I remember to bring it up, and that's when I bring it up, because it is an option they will be given, even now that I'm a little more aware of it."*

The fact that the providers do not talk about MC, and ascribe it to something that Latinos do not do, might be an unintended consequence of cultural competence, where differences are too readily ascribed to cultural differences, as opposed to other factors such as social class and socioeconomic status, and level of education. This might be especially true given the demographics of the county, and the clients using the clinics. MC is more than pros and cons, and while reflecting on my time doing fieldwork, I realize now that these conversations could have been handled differently, and not just revolved around a pro or con attitude towards circumcision—like the ones I had with the medical assistants. The staff did not question why they do not offer MC information to

their clients, nor do they question their role regarding MC decision-making. I ascribed this to the clashes and coherences that enact MC in multiple ways across actor-networks, especially in the clinic.

My findings suggest that discussing MC during prenatal care seems to be a marker of private, non public health insurance and prenatal care. On the one hand, there is a midwife who does discuss MC with her patients, whereas the rest of the providers do not necessarily see MC as part of the services that they provide. Even within her own clinic, Cathy takes extra time to discuss the topic with her patients in detail, even taking on extra appointments with her patients so that the services she provides meet her own standards. MC is thus a practice enacted not only by the policies that inform the procedure, but by how the clientele comes to think about it. The services of the clinic are then tailored to the needs of the clients who are perceived to not want the procedure.

One constant finding of this research is that there are too many patients and very few providers to take care of them. Julie, the midwife at OCW, mentioned often how she was supposed to spend twenty minutes with each patient, but was often double booked. I interviewed Lily, a midwife from OCM, days before she left to work for a private clinic in Oregon. The main appeal of changing jobs was that she was going to spend an hour with each patient she would be seeing, and that she would not have to see more than a set amount of patients per day, to allow proper time to talk about a variety of topics, such as MC, in the time allowed.

The lack of MC discussion is a symptom of other structural problems that clinics face; it's a cultural phenomenon of the Latina women at these clinics who, for social and cultural reasons, are less likely to circumcise their male children. There are then

intangible differences as to why people circumcise and do not circumcise, which are reflected in the patients' results, as well as in the providers.

Culture marks the scope of medical anthropologists' ability to understand these problems. MC does not exist within the clinic itself as an object. MC—as presented here—continues to be messy and complex, and opens up different realities of evidence-based medicine. Since epidemiology does not take into account individual diseases of populations, it follows that policies that attempt to address disease at the population level, rarely take into account individual enactments of disease and its prevention technologies. As such, the providers do not seem able to follow the guidelines of the AAP in a consistent manner, since its policy is ambiguous and does not properly account for the Latina population these clinics serve.

When I was working on this chapter, I realized that during the interview process, I had trouble understanding the relationship between pediatrics, prenatal care, and MC. Tying health policies and recommendations—such as the one from the AAP—to service delivery is challenging, especially when those challenges are replicated at the clinic level: prenatal and pediatrics are not necessarily communicating with each other.

Through my fieldwork, the staff was really interested in knowing what the patients were saying or thinking, as well as the scientists I was able to interview. I shared my view on what I had done so far, as I conducted fieldwork in the clinics. I shared with them the scientists' rhetoric when talking about policy-making, and how contrasting their discourses were when talking to them directly.

Circumcision's cultural characteristic lies in the fact that it is seen as further normalizing how boys are socialized in their community. Latinos do not tend to circumcise because they are themselves more likely to not be circumcised; if you are a Latino male with strong ties to the community, you probably are not circumcised. The providers see acculturation as a predictor of MC, which has been found in one research project done with Hispanic/Latinos in Florida (Bisono, et al. 2012).

After our interview, Susan asked me if I had found that Latinos circumcised their male children. I found this question to be very important, because it made me reflect about the answers I was trying to find with my research. Susan and I were trying to get some of the same answers through my research. For her, that question would yield information about her patients and practice. For me, the answer would contribute to a body of knowledge and praxis in medical anthropology. For a moment we were colleagues, and not just researcher and object of research.

Chapter Five

Study Population 3: Scientists

This chapter is based on six interviews conducted with four scientists, an anti-circumcision lawyer and activist, and a World Bank employee who specializes in HIV prevention in eight African countries and works as a science evaluator in the World Bank. The four scientists interviewed had worked in one of the clinical trials in Eastern Africa.²⁸ This chapter will address the following research question: **how do the group of scientists/policy makers come to enact their research as policy and ensuing service delivery?** The findings are presented in four subsections:

In subsection one, *Clinical Trials are the Gold Standard*, I present the importance that the scientists of this study place on clinical trial research, and how this type of research is deemed to yield the most reliable data.

In subsection two, *Male Circumcision is Protective*, I present the arguments that the participants draw upon to demonstrate the protective effects of MC.

In subsection three, *Male Circumcision as a Prevention Strategy is a New Paradigm*, the participants discuss the novelty of utilizing this surgical procedure to prevent HIV infection, and other STIs.

In subsection four, *Anti-Circumcision Movements*, the participants discuss how the scientists provide information about MC, and the conflict between the scientific research and those who oppose neonatal male circumcision.

²⁸ Citation of the clinical trial not inserted to protect the confidentiality of the participants of the study. The clinical trial is discussed—along with the other two—in the introduction chapter.

Four major findings underlie these subsections: First, scientists made big assumptions about how their research could be implemented into local settings, without knowing the implications of translating their research to clinical practice in reproductive and sexual health services and prenatal care. Second, the participants—except the anti-MC activist—support policies that would have MC covered by Medicaid and private health insurances, yet they are unaware—and in my opinion, seemingly uninterested—to draw from social science research to translate their broad recommendations into clinical practice. Third, only clinical trial research yields the most reliable data for epidemiological studies. Thus, service provision and practice are expected to be based on research evidence. Finally, scientists use scientific knowledge to counter the opinions of anti-MC activists, which are deemed unscientific. The arguments of anti-MC activists are based on their interpretation of human rights, and those arguments do not hold against the results of clinical trial data.

Clinical Trials are the Gold Standard

One of the first most salient themes that I found with this group of scientists was the importance they placed on the results of clinical trial research. The clinical trials had yielded important results that linked MC with protection against HIV heterosexual transmission.²⁹ The scientists considered clinical trial data the highest standard of research when compared with observational³⁰ and ecological studies and instruments such as demographic and health surveys.

Evidence-based medicine (EBM) is grounded on those clinical practices that are based on scientific research, in the form of metaanalysis of current research, clinical trial data,

²⁹ Female to male transmission through penile-vaginal intercourse.

³⁰ including qualitative research.

or both (Timmermans and Berg 2010). EBM provides another highly regarded standard that is supposed to provide an objective measure in the face of the subjective world of clinical practice; it is definite, decisive, unevolving, and authoritative, and in the case of MC, it is backed by analysis in the result of the AAP statement (American Academy of Pediatrics 2012; Timmermans and Berg 2010).

A clinical trial provides a bigger picture in order to prove a hypothesized effect, especially with circumcision. Clinical trials are able to answer epidemiological research problems beyond what other complimentary qualitative research methods can (Timmermans and Kolker 2004; Timmermans and Berg 2010). Three of the scientists interviewed held very strong positions regarding the capacity of randomized clinical trials to answer questions in a reliable and accurate fashion. Dr. Claire Ripley, one of the scientists I interviewed stressed the importance of the research she has been a part of:

My colleagues and I have been working on HIV research on prevention and programs and treatment in East Africa for 25 years. 15 years ago we noticed what has also been reported in other parts of the world, but we have the strongest data for it...that showed that men who were circumcised appeared to have much lower risk of acquiring HIV...(The research teams conducted their research in East and Southern Africa) what we all found that the men who were randomized and received immediate circumcision had about 50-60% lower risk of HIV acquisition, it was consistent in the three sites and with the previous observational studies. In the world of HIV prevention this was such a rare finding, where you had such a strong protective effect, not a 100% but nonetheless quite strong and consistent among different groups... Until the trials we could not say for sure that there were some other factors that were correlated with circumcision that was leading to the hypothesized effect, which in the trials, three trials done with three populations, using different surgical procedures and for the results to be so incredibly consistent, we just fell off our chairs.

Dr. Ripley alludes to having the strongest evidence for a link between MC and HIV prevention, which was ‘proven’ with the results of the clinical trial she was involved in. As quoted above, she even mentioned her amazement at the extent to which the clinical

trial she participated in, were consistent with concurrent trials in Eastern and Southern Africa. Previous hypotheses could not have been proven without a randomized clinical trial. Dr. Joseph Denault, further elaborated on the value of funding these circumcision trials as they are considered more reliable than observational and ecological studies:

That's why the NIH, and other funding agencies were happy to provide millions of dollars to perform these male circumcision trials. Before the trials there were 30 or 40 different observational studies and ecological studies that showed male circumcision likely decreases...prevents HIV acquisition. Some compared western Africa to sub-Saharan Africa. There is more male circumcision in Western Africa... some had done in-country comparisons, but can you really compare Western Africa versus sub-Saharan Africa? Can you really compare Muslims and Jews to Christians? Do they have different sexual practices? So you can't. That's why there were 3 circumcision trials with over ten thousand men.

As stated by Dr. Denault, The National Institutes of Health (NIH) are quick to provide funding to clinical trials, given that observational studies—both naturalistic and ecological—are assumed to be less effective than clinical trials by epidemiologists. This type of opinion held by the scientists interviewed is shared by scientists in the literature who invoke clinical trials' results for broader implementation of MC, especially among populations with high rates of heterosexual transmission (see Nagelkerke, et al. 2007; Weiss, et al. 2008; Weiss, et al. 2009).

MC is enacted as an HIV prevention method that is provable and attainable through the practice of clinical trials. The results of the clinical trials were so evident, that Viv Weker, Science evaluator for the World Bank mentioned that all three clinical trials were terminated early, and MC was offered to the control group:

We find the same in Country C at the population level if we look at the demographic and health survey, circumcised men do not have lower HIV prevalence than uncircumcised men. It's also a small percentage, like in Country C in the general population, it's something like five or six percent [that] are circumcised, and those men are not representative of the population as a whole.

In Tanzania for example, men only get circumcised around the age of 22 or 23, that's the average age of circumcision. So we know a lot of those men have been sexually active before they actually got circumcised... [Yet] all three male circumcision randomized control trials were stopped halfway through... Not just the public health, but the personal health benefits became so clear that they said that it was unethical to not offer male circumcision to the men in the control [group], so they continue to provide MC but just to everybody

The trials can answer questions that correlational analyses might obscure through their descriptive nature. As scientists—and people who deal within a science based ontology—MC comes to be enacted by the conclusive evidence of clinical trial research.

MC proved to be cost-effective

MC should evidently be added to the array of prevention methods of HIV, yet doing so comes with its own particular challenges (Edouard and Okonofua 2007; Weiss, et al. 2008). Another compelling argument that was made by the scientists interviewed was regarding the cost-effectiveness of the procedure. Dr. Joseph Denault, along with another epidemiologist, who worked on a model based on the continuation of declining rates of circumcision in the US, and its impact on health, reported:

So we did a model on this, a Markov simulation that was published last fall... and we looked at if you continue to have declining rates of MC circumcision, in the US, what is the impact. STI would go up substantially, and overall it will increase over 10 annual birth cohorts, it will increase medical expenses by more than four billion dollars.

With his explanation, Dr. Denault is trying to tie in the relationship between population and disease—and in this case, the preventative methods of various diseases. Given that the HIV profile of transmission is very different in the countries where the trials were conducted, the case has still to be made for the procedure to appear feasible and cost-effective in the US.

The relative absence of MC in the US will cause expenses to increase. Circumcision is not only cost effective, but it is an issue of national health. Lack of MC on newborns will put them at risk for all other diseases. Conversely, the physical presence of circumcision on newborn males will shield them and prevent their risk of UTIs and STIs and maintain the current medical expenses in the US.

The penis ability to curb infection is multiplied by the realities in which it can be enacted. The clinical trials have already established a link between protection of HIV in Eastern and Southern Africa. Dr. Denault's argues for the relevancy of MC in the US. As originally mentioned in the introduction, the rates of MC have been declining in the US for decades (Owings, et al. 2013); given this scenario, Dr. Denault's work argues through mathematical simulations in favor of the cost-effectiveness of MC in the US. MC is enacted by scientists through mathematical probabilities into the public health realities of the US, by making it not only cost effective in African countries, but in the US as well (Kacker S 2012; Morris, et al. 2014a; Tobian, et al. 2013b).

But why do scientists like Dr. Denault, arguing for the cost-effectiveness of MC in the US, even though the main form of transmission in the US-male to male transmission—is very different—heterosexual transmission—in the settings of the clinical trials? I argue that this is done as to present their work in a manner that seems palatable to policy. If the scientists are to enact MC through their practices and show that it can be an effective method of prevention, their argument is stronger since they can assure an ensuing intervention that is effective and efficient (Timmermans and Berg 2010). The argument behind the costs is also not lost on the funding agencies, as well as the ensuing policy

these scientists seek to influence. Dr. Ripley alluded to MC's cost-effectiveness as both a benefit, and a challenge to the implementation and further interventions:

Circumcision, unlike a drug doesn't have large medical companies behind it. It's a procedure that is relative simple to do, relative inexpensive. There are now various small circumcision devices being tested, but it's not the kind of thing where somebody goes on medication for life, so there is not a lot of impetus from the drug industry, so it has its challenges.

While MC as a preventative procedure might not seem enticing to pharmaceutical companies, due to its lack of long-term monetary recoupment, the scientists suggests that the way to go about this is through health policy to influence insurance companies in the US to cover the procedure.

So if you where an insurance company and if you were having to pay for, if you're thinking about your lifelong investment in this patient, but the cost of that one time procedure for that infant on a willing parent, seems cheaper than the risk of having to pay for a Cyclovir or penile cancer, or cervical cancer because the dudes are the vectors for the ladies in most cases and sorry to be using my street lingo... so, you know I think that, those increase risks will be translate into higher medical costs, and procedures and medications later down the road. Again, not mandating the procedure, but funding the procedure I think it should be funded.

The literature, which several pro-circumcision scientists have been engaging in, has supported these claims including that penile and prostate cancer is a lifelong benefit of circumcision. I argue that this is the beginning of how circumcision is enacted as a prophylactic procedure. Conversely, I will also expand later as to how the uncircumcised penis is then enacted by these same practices as a magnet for disease.

Male Circumcision is Protective

The legitimacy of MC as a prophylactic method was understood within the golden standard of clinical trials of epidemiological research. The clinical trials provided clear evidence that MC protects against HIV.

One group was in Country A, one in Country B, and we were in Country C. What we all found that the men who were randomized and received immediate circumcision had about 50-60% lower risk of HIV acquisition. It was consistent in the three sites and with the previous observational studies. In the world of HIV prevention, this was such a rare finding where you had such a strong protective effect, not a 100% but nonetheless quite strong and consistent among different groups. Dr. Claire Ripley, Scientist

The results were consistent, and for field of HIV prevention this opened new doors as to what could be done in contexts like the countries where the clinical trials had been conducted. According to Dr. Denault and Dr. Ripley, one of the trials also studied the female partners of the men in the study, and they found a protective effect for women as well.

There were three randomized trials on male circumcision. All three trials were terminated early in 2005 and 2007, and all three trials conclusively showed that male circumcision reduces HIV acquisition by approximately 60%... What's quite interesting is that the Country C trial, not only did they enroll men, but they also enrolled their female partners... making it very clear that we are not talking about female circumcision, this is only the impact of male circumcision in female partners... What we found is that male circumcision reduces HPV in female partners by about 30%... In addition, we found that male circumcision reduces bacterial vaginosis in female partners, and it also reduces Trichomoniasis. Dr. Joseph Denault, Scientist

MC is thus presented as having a protective effect as well for those female partners that are engaging in unprotected penile-vaginal intercourse with circumcised men (Tobian, et al. 2013a). Viv Weker mentioned: “We know that a circumcised man is much less likely to contract not just HIV, but a series of other STI as well”. This is building on previous

research that already has linked circumcised males with lower risk of particular STIs – though there is also research that correlates the inverse relationship (see Rodriguez-Diaz, et al. 2012)—and focuses on the potential benefits that the female partners might obtain (Hankins 2007; Wawer, et al. 2011).

I mean if you look at the data it does seem to me, it does appear it is protective...I mean it's clearly protective in heterosexual transmission. It's clearly protective against HPV and it certainly looks like it's protective against HSV as well.
Dr. John Shirey, Scientist

Dr. Shirey's quote above encapsulates what I am trying to argue in regards to enacting MC. Enacting MC as a scientist in this case, entails relying on the golden standard of the clinical trials; it also has been validated by two other clinical trials in the same continent. But even more so, the results of those practices show a result: the data suggests that MC is protective, and that protection might even go even further than just HIV.

These interviews attempted to understand how this group enacted MC, and so far I have presented how the concept of MC comes about from clinical trials as a protective procedure. But so far they have come to explain how MC comes to be, specifically from their practices based on their participation in said clinical trials. The data is apparently clear to them, and allows them to enact MC through it: scientists assert that MC is a protective procedure based on clinical trial evidence. In order to make their argument even more compelling, Dr. Ripley suggests that research should be funded for more clinical trial performed on males and their female sexual partners. He also mentions the lack of momentum outside of research grants, to fund MC as a one-time procedure with a lifetime of protections—in contrast to the business models of pharmaceutical companies.

One way to do so, is to further enact MC as a protective procedure for female partners, or broadly composed of the female population as mentioned by the participants.

Women also benefit from MC

In order to make the case that this procedure is beneficial to women as well, Dr.

Denault elaborated:

If you think about your overall risk of benefit ratio, and then you start saying ok you got a fairly easy medical intervention, you decrease UTI as a neonate by tenfold, you decrease HIV acquisition, you decrease genital herpes, you decrease genital ulcers, you decrease HPV, you know...so there are all those benefits for the men, and then you have benefits for the female partner. I think it's a very easy decision to make on a medical basis... So not only are there substantial impact for both men, there are clear benefits for their female partners.

So far, I have been referring to MC from a research perspective. What the research obscures is the actual mechanism by which MC prevents HIV infection as well. I will take a moment to generally explain the methodology of the three clinical trials, in order to understand what they are trying to convey.

The clinical trials measured the risk ratio of circumcised self-defined heterosexual men engaging in unprotected intercourse. Previous research based on observational and ecological studies, had concluded that circumcised men had less risk of contracting HIV (Bailey 2001; see Gray, et al. 2007). Clinical trials were the first to randomly sample male populations in Eastern and Southern Africa, circumcise them, and follow them up after circumcision. Compared to the control groups, all three clinical trials found that circumcised men had up to 60% less risk of contracting HIV from their female partners when engaging in penile-vaginal sex.

Now, to argue that MC is a protective procedure, after discussing percentages and risk of infection, they had to argue about the efficacy of the results of the clinical trials. The scientists do this, but they admit that even though the procedure is cost-effective, it is not enough to attract ‘big money’ since it is a one time and relatively cheap procedure. As such, in order to argue its effectiveness in light of Medicaid cuts, and limited funding opportunities for interventions, the scientists build upon the clinical trial results by arguing that: if more men are circumcised, the US would save money in the long term regarding treatment and care of STIs and UTIs (Kacker S 2012; Morris, et al. 2014a; Tobian, et al. 2013b); and that it will potentially prevent infection of women, by having lower rates of infected men (Wawer, et al. 2011).

But to understand all that, you have to go back to the trials and see that they constructed and enacted a circumcised penis that contracts disease by embodying women as the vector of disease in unprotected penile-vaginal sex. The trials were measuring how less risk could be ascertained when circumcised men engaged in unprotected sex; the risk was being assessed through the men, not the women. In this scenario, the women are the ones who are transmitting the disease. Now, even though they only measured how less risk the circumcised men in the study had, the scientists are now arguing for the potential benefit to women. The epistemological hurdles that were established to enact the circumcised penis as protected from disease were in my assessment problematic, as they first relied on not offering protection to the women in the study—since the focus was on men—and later arguing for its benefit to women.

Though this problematic dimension of the research might be brushed aside, given that the goal of this group of scientists is to inform policy and delivery, and get MC covered

by health insurance. Viv Weker for example, informed me how difficult this proved to be in her job.

The Southern Africa Development Community (SADC) had these regional meetings with the health ministers and these issues were debated at length for a number of years before governments became to accept the notion of circumcision as a valid kind of public health benefit...in addition to all the other benefits MC has, it also has an HIV prevention benefit.

The trials provided evidence that the men who participated in the trial had lower rates of other STIs, as well as their female partners. The scientists in the study argue for public health benefits of MC stemming from the clinical trials in Africa. The Country C trial also followed women, in order to ascertain how MC had an effect on women. Dr. Ripley mentioned:

The other thing we found through our trials, we also collected samples for other STI and we found the men who were randomized and received immediate circumcision also had lower rates of genital herpes, HPV which causes penile and cervical cancer, and the women partner of the men who were circumcised had lower HPV and other vaginal infections were reduced, so there were definitive health benefits both to the negative men who had been circumcised and their partners, also the men reported fewer genital ulcers after circumcision, so from the public health viewpoint this was very positive...

The scientists who participated in the trial echoed Dr. Ripley's findings. The prevention benefit that MC provides in infecting their female partners is not seen short term, since it does not seem to directly reduce the risk for the female partner; the potential benefits are long term (Baeten, et al. 2009). But this speaks to a greater argument about the long-term benefits of MC.

The clinical trials ascertained the preventative effect of MC under present conditions, and a few others have confirmed the short term results of circumcising men in the clinical trial countries, but that circumcision status does not necessarily change the risky

behaviors of men, and that its protective benefit does indeed increase over time. Dr.

Denault clarifies this in the following quote:

Although it has been speculated and postulated that there might be changes in behavior, there was no change during the trials... The opponents say there will be a change in behavior...that circumcised men will become, have more high-risk sexual intercourse... But all the data coming out of the trials, coming out of post trial, have not shown any change in behavior after circumcision. If the argument is being driven by evidence-based medicine, all physicians want to practice evidence-based medicine, then we should look where are the data, where is it, what is the evidence, and there is no evidence of this... If you are a low risk guy, you remain a low risk guy. If you are a high-risk guy, you remain a high risk guy... There have been several studies at Country A and Country C, that the protection of male circumcision increases over time, that 55-60% protection of those trials that were terminated by year 2 is probably on the lower end of protection.

As far as risky behaviors go, the aforementioned research that I mentioned earlier from Rodríguez-Díaz et al (2012) found that circumcision status was related to higher risk of STIs, as well as another study among Navy personnel where circumcision status was seen as not relevant among this population (Thomas, et al. 2004). I mention this not to put into doubt the statements of the participants, but to mention that while limited, there is also published material that presents contrary arguments; but these studies are also highly contested (Klausner 2013). When I brought up these studies in my interviews, the response I received from the scientists ranged from wanting to read the study themselves to pointing out that the clinical trials are the gold standard; any other type of study is not equivalent. Viv Weker mentioned to me: *“But you need to be careful interpreting those results because it's not causal analysis...it's correlation right?”*

The research has influenced policy and has been used to advise health organizations such as the WHO, as well as to inform further interventions in Sub-Saharan Africa (see World Health Organization 2007; 2010). Dr. Ripley told me that: *“Obviously we*

presented this data as the other groups did to the WHO, and other agencies with the hope we could start circumcision program, because if there as a vaccine this effective people would be dancing in the street...with circumcision...that protective effect... persists for years after the procedure.” But to bring this data to these organizations, does not only serve to advise, it also helps to legitimize the findings in so far as they are ‘backed’ by international organizations. Dr. Denault added that even with that legitimate distribution of knowledge, there still might be doubts as to the benefits of the research: “The WHO, UNAIDS has clearly made clear that MC has benefits, but I don’t think in the US and Europe the message has been very clear.”

In the US, the AAP based their statement on circumcision on clinical trial research. In my interview with Viv Weker, we talked about how the statement came on the heels of anti-MC outspoken movements who attempted trying to ban circumcision based on their own interpretation of the research. Interestingly, she was quick to clarify that the AAP statement was not a mandate, but a recommendation. She was cautious to claim a direct applicability of the research results from Eastern and Southern Africa to the US, particularly when I inquired about the statements of professional organizations such as the AAP.

Interviewer: *the AAP released a statement...*

Viv Weker: *oh yes I saw, but they are not making it compulsory. They are recommending it.*

Interviewer: *But then that's why, they're basing their recommendation on the research that has been done in international settings, but also in response to anti-circumcision groups in the US, Drs. Chaw and Denault, released a press release statement citing their research in Uganda, as a reason to why people should circumcise their newborn sons. They also used the opportunity to counter the arguments of the anti-circumcision movement. So even though there is not necessarily the same push that it's being done in those international settings, it is being brought up as a reason to circumcise...*

Viv Weker: *Yeah...There is a very specific strategy that the US government is a*

co-publisher of that strategy... I'm sure it's available on the who website, but the Gates foundation, ourselves (World Bank), the US government, UNAIDS, were all co-developers of that strategy, and that strategy is very specific in identifying specific countries where MC should be scaled up...

Given that the settings of the clinical trials have a different HIV transmission profile than the US, what then is the role of scientific research on MC in the US? Dr. Denault argues that evidence-based medicine should be informed by this type of research; it should be done in a scientific manner: *“If the argument is being driven by evidence-based medicine, all physicians want to practice evidence-based medicine, then we should look where are the data, where is, what is the evidence.”*

The evidence in this case led the AAP to recommend the procedure in the light of informed decision-making, given the push of anti-MC groups, and the defunding of the procedure by Medicaid. Dr. Guss Chaw emphasized that the research is there so that parents can make an informed decision regarding MC during their pregnancy. Their scientific research benefits not only the ensuing policies that are crafted from their research, but are enacted as well into the decision-making process of potential parents. The evidence points to MC having a myriad of positive benefits, and as such there shouldn't be any reason as to why it shouldn't be covered by health insurance. Dr. Chaw added:

Well, The American Academy recommended that parents be informed prior to, or during pregnancy of the risks and benefits of circumcision so that they can make their minds about it, rather than the post partum period, and that it is an attainable recommendation...If the question is should be infant circumcision be made readily available and fully covered by insurance in this country and should all parents be informed of the risks and benefit and offered a free choice to their infant, then I would say absolutely.

The ways of HIV transmission in the US are still not the same as the ones where the clinical trials were carried out, yet there are arguments for its benefits in the US. The procedure is then more cost effective to be done to US males, than it is to pay for a variety of other treatments and procedures that are the result of being at greater risk because one is uncircumcised. Dr. John Shirey argues as such, taking the point of view of an insurance company:

If you were an insurance company and if you were having to pay for, if you're thinking about your lifelong investment in this patient, but the cost of that one time procedure for that infant on a willing parent, seems cheaper than the risk of having to pay for a cyclovir or penile cancer, or cervical cancer because the dudes are the vectors for the ladies in most cases and...sorry to be using my street lingo... so, you know I think that, those increase risks will be translate into higher medical costs, and procedures and medications later down the road. Again, not mandating the procedure, but funding the procedure I think it should be funded.

Based on these interviews, I suggest that MC is enacted as a prophylactic procedure that comes about from the practices of these scientists based on clinical trial research. The procedure provides protection to the penis, and its prophylactic effect is then transferred to the circumcised penis. The public health benefit of MC is clear, and supports the claim that MC should be covered by health insurance so that parents can make informed decisions based on research evidence, without having to worry about paying for the procedure.

It follows that scientists are an integral part of the process of evidence-based medicine and that their research influences policy. Drs. Chaw, Denault, Shirey all agreed that scientists should be part of the public discourse as to how best implement and apply scientific results; the degree to which they can effectively do this, varied. Dr. Chaw was more conservative in his perceived role:

I think the role is to conduct the most rigorous science we can honestly and clearly present the evidence to policy makers, and then to do our utmost to provide the interventions that we believe on the basis of evidence to be of benefit of individuals.

Dr. John Shirey sees his research as more influential. He believes that scientists are better positioned to engage in public policy because of their limited engagement with special interests that most of the time muddles politics:

I think we should be integral to the process...if our common goal is to have evidence-based, or science based policy in this country we should have the people who know better about the evidence than anybody else, which is the scientists...I don't work on circumcision policy, but I work on antibiotic use policy all the time, I spent I talk to legislator assistants I do congressional hearings and briefings and I run a class here on teaching scientists how to communicate science. I think it's funny, it's not like...people like Joseph (Denault) and Guss (Chaw), those guys don't make money of this, their goal... those guys make less money because they're working in academic institutions, they could make more money working in private practices, I mean their whole goal is to protect people's health on a population basis...when I think about...the people who I don't think should be shaping policy necessarily are the people who are financially conflicted.

Dr. Denault feels that the time for scientific discourse has to be timed with public opinion. His engagement with the public was spurred by the anti-MC activists groups, and knowing that states were defunding MC from Medicaid. It's very important to him that scientific arguments get a fair reception when heard in the public sphere; since it is really important to him that the ultimate message of the scientific evidence is heard:

So when we release studies I'm very happy to talk to the press. So, Guss Chaw and I had a commentary in this journal...its called the medical benefits of MC. So, and part of the reason we felt it was important to write that piece, is that during that same time was the San Francisco ballot initiative, the increasing number of states were eliminating insurance coverage for MC, we thought it was important for the public to know, although there are very vocal anti-Circumcision activists, that the medical evidence is very clear...We did a press release when we wrote that commentary, when the AAP released their policy statement at the same time, the week before our study...the cost effectiveness of male circumcision in the US that we previously discussed was released, and you know that generated a fair amount of press and I do not go out of my way to talk to the press, but if there are

questions I am happy to answer them, to make sure that both sides of the arguments are heard.

The scientists have engaged with the public through press releases, research/journal articles, and through work in government agencies. Viv Weker's work relies on this evidence to inform and advise a variety of organizations and policy-making bodies to better utilize resources and work on better designed interventions. Weker's work is exemplified by how procedures such as MC are enacted by science, and its scientists. Policy in this case, can be a direct practice on the kind of work she does:

Our work here at the World Bank is to improving the efficiency and effectiveness of HIV responses in general so we are really focused in ensuring that we use the best possible science, help governments make most use of the available resources that they have... We influence policy by providing using the evidence in the science that is available, the economic arguments of why HIV, why MC programs are essential... governments are coming to us, its a demand driven model where governments come to us saying listen we have a billion dollars to spend on HIV in the next five years, can you please help us what to spend that money on. And we then use the evidence that we have, around cost effectiveness of different HIV prevention programs and we use that evidence to make the case for what governments should focus on.

Yet, the dissemination of scientific knowledge is a challenge in itself. Scientists are not necessarily trained to translate their scientific knowledge in ways that are palatable to non-scientists. Research on MC is not excluded from this, and is a characteristic of its enactment; MC as a procedure is enacted through research, so its enactment is laden in scientific jargon.

Dr. Denault admits his own shortcomings to disseminate knowledge beyond other scientists: *"I think the research side of people looking at MC, we have not done as well spreading the information, the medical benefits of MC probably as we could have."* Dr. Shirey believes this should be rectified, and puts this into practice by engaging with the

public and teaching his own students how to “write science better”: *“I think with that comes the responsibility of the scientists to learn how to communicate their research more clearly, to be able to simplify it, while remaining accurate. I think it's part of our responsibility. We should take that on.”*

Dr. Shirey asserts that this is the way scientific knowledge is produced and disseminated at research institutions. There is very little flexibility in the dissemination of research that will count towards tenure-track requirements, as well as other appointment related requirements. Dr. Shirey even admits the constraints of lingering modernist influences in the natural sciences:

I think that is a problem with the scientific literature, that the journals that I have tried to publish in, and my favorite journal is in Bio, and that one does has an importance section and we usually do elaborate a bit more. We know, scientists are always told to not go beyond the science, and stay focused...but yeah. I always want to talk about the bigger picture of this thing because that's why I do this research I hope to have a positive impact in people's health.”

MC is enacted as a public health benefit, but then this benefit must be done within the constraints of science. The “big picture” as Dr. Shirey mentions, is to go beyond what the science and its practices suggest. The journals in which these scientists publish clearly constrain how much they can elaborate on the implications of their research. So, they have to do so in other forums (e.g. Press releases, talking to press, etc.).

During my conversation with Dr. Denault, I was amazed at how different the discourses of the scientists were in their journal articles, as compared to when I talked to them during interviews. In general, talking to these five scientists provided more nuanced responses than the ones that come across in their journals. Their articles and communications to the public about their research can be interpreted as authoritative;

scientific knowledge allows them to talk confidently about their scientific knowledge as the last word on the topic of MC. When I interacted with them,³¹ it was not like that. Their responses were balanced, and did not seem to be charged with the ultimate authority of scientific knowledge that permeates their interactions, even more marked when dealing with anti-MC groups. The conversation follows:

***Interviewer:** Talking to scientists have been more... you have given so much more context, and I understand why because of the discipline its a way and that's how you need to write for your peers, but form an outside perspective, non epidemiologist, I can see some difference as to how the message is conveyed on the research articles, than for example talking, than the press release, and how you mentioned the other article how it's more summarized. Cause there is so much more context, like when you say right now that this is not a mandate, that this is about making informed decisions, I think not that's not communicated in the articles, but it's better articulated when you actually talk to people, and that's more of a discipline thing and it's not something I'm trying to fix.*

***Joseph Denault:** And if you're publishing in journal, they don't want to get into any of that. It's a randomized trial, what are the data."*

The articles are focused on the “data”, and as such require this perspective that I have perceived as authoritative. The enactment of MC in this way is dictated and constrained by institutional and economic practices that go beyond these actor-networks. The demands of research institutions regulate the work of these scientists—except for Viv Weker—and so when they talk with the public and reach others, they have to abide by their own institutions language and modes of communicating this research. Even more so, they personally have to respect their own time and limit their own voluntary work—like engaging with the public—because it is not remunerated, and is not compensated in any other way through their academic appointments. Dr Denault added: *“Well that's (laughs) my salary and 80% of my salary is from research grants, 20% of my work I do clinically,*

³¹ Except with Dr. Chaw, which I will elaborate on that experience later in the chapter.

I do not have a ton of free time to (laughs)... for other activities ”; by other activities, he was referring to engaging with the public and public policy on MC, beyond what he has already done through research articles and press releases.

Male Circumcision as a Prevention Strategy is a “New Paradigm”

Enacting MC as a prophylactic procedure and as an intervention strategy constitutes a new paradigm in prevention. Before the clinical trials, and the ensuing interventions in Eastern and Southern Africa, it was unheard of to use a surgical procedure to prevent an infectious disease. Dr. Chaw said it as such: *“This is a new paradigm, we have never used surgery to prevent disease with people.”* As any new paradigm, there are challenges. Dr. Claire Ripley suggested that the largest challenge lied on asserting MC as a public health benefit—both for adult men, and newborn males—while alerting that the procedure itself did not come without its risks. In the case of adult males in the clinical trials, Dr. Ripley mentioned:

Now over time we have encountered challenges in getting circumcision to be widely accepted, this is a new paradigm because you are using a medical/surgical procedure to prevent an infectious disease and strictly speaking... and it's still preventive, and a much more intensive procedure... circumcision depending on the procedure it takes 15-20 minutes to do and then we ask the men not to have sexual intercourse for 6 weeks.

During my conversations with Dr. Ripley she mentioned that the healing period was the largest challenge of the interventions. She recounted how, normally the healing period can be counted on to be completed at approximately four weeks after surgery, but that surgeons are conservative in their estimates and tell the men six weeks after they undergo the procedure. This way, they minimize the risk of men engaging in sexual relationships before they are completely healed. In my interview with Dr. Denault, I prompted him for

his opinion about the procedure in the context of this new paradigm. He responded that the benefits of MC when outweighed the risk of the surgery itself:

Dr. Denault: *It is a new paradigm....*

Interviewer: *What is the appropriateness of surgery in terms of prevention? In regards to...since you're talking about a new paradigm in these specific cases in sub-Saharan Africa.*

Dr. Denault: *So, it's a very minor surgery. You know, it's a medical intervention and in theory, as a physician I try to avoid any medical interventions that are not necessary. As a neonate, MC complications rates are between 0.2 and 0.6 percent, so it's extremely low in the US. So, it's an extremely low complication rate, and it's usually treated with antibiotics or pressure support. The complication rate of this intervention is extremely extremely low, and it's a safe procedure. If you think about your overall risk of benefit ratio, and then you start saying ok you got a fairly easy medical intervention, you decrease UTI as a neonate by tenfold, you decrease HIV acquisition, you decrease genital herpes, you decrease genital ulcers, you decrease HPV, you know...so there are all those benefits for the men, and then you have benefits for the female partner. I think it's a very easy decision to make on a medical basis.*

Dr. Denault referred back to the principles of evidence-based medicine, and how any procedure should be compared with itself in terms of the benefits it can yield. This way, enacting MC as a practice that intervenes as a prevention procedure assures that its benefits outweigh its risks; or how Dr. Denault refers to it “overall risk of benefit ratio”. When I asked about the appropriateness of the new paradigm, my intention was to probe into how Dr. Denault had come to think of MC as a new prevention method. Like Dr. Denault, Dr. Ripley also mentioned the safety of the procedure and its benefits:

MC is a procedure that can be done very safely, very low discomfort for the guy, and a procedure that we and others have shown that has definite and profound positive health effects. At this point we have not found any long-term negative health effects.

And Dr. Shirey echoed Dr. Denault’s statement on the benefits outweighing any potential burden: *“And I think there are clearly risks and probably some slight drawbacks to circumcision, but that in comparison with the burden of HIV seems minor to me, but*

that's just a judgment call.” Dr. Denault addressed it further by further pointing out that the benefits of the trial he participated in extended to other STIs, including HPV:

We have gone on, I've been associated with the Country C trial, and we have gone on to look at secondary end points, are there other benefits of MC besides reduced HIV acquisition, and we've shown that MC reduce genital herpes, or what is called herpes simplex virus type 2, by about 30%, it also reduces human papilloma virus, HPV, by about 30%, and HPV is associated with penile cancer, it also reduces genital ulcers by about 30%

Their responses enforce the ideas behind the practice of MC research, including its risks and benefits. Even more so, Dr. Denault emphasized that MC is an easy medical decision to make. But how easy? And why care about this new paradigm at all then, if there are alternative preventative methods? MC is enacted as a public health benefit in regards to HIV prevention, and a host number of other STIs. Its benefits transcend the benefits to males, and extend to females. Dr. Denault added that:

Many people in the US, might say why do you care about HPV and cervical cancer there's a vaccine. But in the third world, our "developing world", where vaccines are very expensive and not largely available, if you are performing male circumcision for areas of high HIV epidemics, or areas with HIV epidemics, this is clearly an added bonus, and it also reduces all oncogenic HPV genotypes, not just 16 and 18.

The link of HPV is another reason to enact MC as such a strong public health benefit based on the research being conducted; the link to penile cancer makes this procedure even more relevant (Morris, et al. 2014a). Though the benefits are clear, the effectiveness and cost-effectiveness of the procedure depend on a multitude of social-ecological factors at a particular setting. The first clinical trial touted this among its benefits and even suggested that in the face of the high costs of the HPV vaccine in the country of the trial, MC could supplant the implementation of the vaccine (Auvert, et al. 2009).

Dr. Shirey alluded to this as she mentioned the difference in MC rates and HIV/AIDS in the US and Europe; a common argument brought upon by the anti-MC groups as a way to discredit the research and its benefits.

European men are not particularly...circumcision is not common among European men and HIV transmission is not super high, and so... circumcision is not going to be a cost-effective way of reducing HIV there...I don't know though what do herpes medication cost there, or what is the effect on quality of life on having herpes, or what are the medical associated costs of HPV, hopefully the vaccine will knock down a lot of the cancers, and I'm sure vaccines are better...

This would mean that the enactment of the procedure is dependent on the context in which it is being implemented. As a surgical procedure, MC might not be beneficial by itself but to the extent it can be a public health benefit in a particular country/setting. A way to lessen the impact of this new paradigm is to compare it to a current one that is well known and implemented. In our interview, Dr. Ripley compared MC to vaccines when referring to its prophylactic effect:

Because if there was a vaccine this effective people would be dancing in the street, condoms can be very effective, but it's something you have to do over and over again, with circumcision once you're circumcised you are that protective effect that we know see, persists for years after the procedure, so it's a long term protective effect.

In this way, comparing vaccinations to MC emphasizes the importance of disease prevention. MC as a preventive procedure is blurred; as it is compared to a tested way of preventing disease, it challenges the arguments of those skeptical of the benefits of the procedure. Even more so, vaccines are undermined when compared to MC as a short-term solution, since they have to be reinforced; MC is touted to offer benefits for a lifetime. This enactment of MC does not mean to underscore the success of vaccines, but to advance the acceptance of MC within this new paradigm. The scientific literature has

examples of scientists who are eager to promote MC and compare it to vaccines (see Morris, et al. 2012; Stephen 2007) in that they both demonstrate adult responsibilities to children (Johns Hopkins Medical Institutions 2011). These arguments have not gone without their criticism (see Forbes, et al. 2011; Green, et al. 2008).

Condoms are also underscored in the plight to normalize the procedure, since they have been used in behavior-change interventions, though these have not been as successful as MC interventions. Dr. Denault bemoaned the fact that after all these years of behavior change interventions and promotion of condom use, HIV and other STIs are not close to being eradicated:

In theory if you could, prevent HIV and sexually transmitted infections by education and condom use, I be fully supportive, but we have 33 million in this world that are infected with HIV. We have 30-40% of women in childbearing age with bacterial vaginosis, we have like 30 million people who have been infected with genital herpes in the united states. These are sexually transmitted infections with 30 years of education, still are highly rampant in the US, and thorough the world.

As an anthropologist, I found this reasoning to be reductionist since it did not account for the inconsistency in funding and the political agendas that have underscored prevention efforts through the existence of the HIV pandemic. Yet to an extent, the purpose of such a statement can be rationalized within the enactment of MC as a new paradigm that is validated through scientific research. This new research on MC is more effective at preventing HIV than previous education methods, and that is what the gold standard encourages.

Results are not transferable to the US

One problem is that while the penis itself is multiplied in its enacted realities where the countries were conducted, those realities do not necessarily hold true in the context of the US. I argue that this might account for the fact that the scientists have enacted MC in a way that provides a health benefit to the whole population, is cost effective, provides benefits to women, is an effective and novel means of prevention, is comparable—arguably superior?—to current prevention methods, and is very similar to vaccines; all of this in order for the procedure to fall within the guidelines of evidence-based medicine in the US. MC is enacted this way so that comparisons between the disease’s modes of transmission and the actors that carry out risky—and other behaviors—can be made comparable in the abstract, but not in direct comparisons. Dr. Denault explained to me that:

You cannot make easy country comparisons. It's... epidemiology 101, that we have a very different population than Europe. You can't be saying, oh we have a higher circumcision rate, Europe does not, if you look at our population demographics they are extremely different and you cannot be making those comparisons.

To those opposed to the procedure, as Ben Bertrand—an anti-MC activist—is, this argument albeit backed by scientific knowledge, do not hold true in the US. The modes of transmission are different, and do not lend themselves to country comparisons for the sake of promoting MC in the US. Ben Bertrand added that these arguments do not justify promoting MC in the US as an HIV prevention method.

In Africa one of the best places to get HIV is in the health clinic, and in our country it is typically injected drugs and homosexual sex, and that to me, the situation... I'm a little uncomfortable saying that bit, but it happens to be the fact [male to male HIV transmission], that they are very different modes of transmission, and it doesn't make sense, and the case hasn't been made in Africa

either... the means of transmission are totally different in the US... it is the only procedure that is done without any medical rationale for it to justify the practice, and is also the most common medical procedure in the US.

So if MC is being enacted in all these different ways to frame it within the realities of the US, how does it fit within the current services being offered in the US? Of the five scientists I interviewed, I received two uncomfortable and jarring answers on the topic of services. Dr. Guss Chaw took issue with the way I framed the question, in as much as that I was asking about MC within the context of sexual and reproductive health services. His response first dismissed that MC should be an intervention strategy with important repercussions in the US. He did not think that MC is—or should—be part of reproductive and sexual health services, even though my fieldwork indicated otherwise. Our conversation follows:

Interviewer: *In your opinion, what is the importance of circumcision within the scope of reproductive and sexual health services?*

Dr. Chaw: *I don't see it as part of the services per se. I don't see it from a US perspective as a major service question. We are not going to do massive amounts of circumcision for adolescents in this country... Because 60 or 59 percent of the US population is already circumcised, and secondly there is insufficient risk of hazardous consequences, of being uncircumcised that would warrant circumcision programs that would be part of reproductive services. Circumcision programs should be available to adolescents or adult males who have medical indications or particular risk of HIV, or STI, but I don't see it as part of the routine service availability in this country.*

Viv Weker, shared her view without making the same assumptions as Dr. Chaw. I argue that since she is part of the group of scientists in this study who are enacting MC as a prevention procedure, this is the way that she sees it being integrated into reproductive and sexual health services:

The thing is for you too look at what happens with MC at the local level, I don't think that the local health clinics in the US are promoting MC for HIV prevention programs, except in the high, in populations with high prevalence. And I think

MC is, has until the 1970's been fairly universally applied in America, currently around 60% of American men are circumcised.

Circumcision was not seen as part of the standard of care of the clinic offering the services. Standard of care being defined as “primarily a legal concept that refers to the level of medical care that can reasonably be expected from a skilled practitioner in a particular situation” (Timmermans and Berg 2010: 26). These standards are not uniform, and obviously exhibit regional variation. As such, it might be that for the community clinics, these particular scientists do not see MC as part of the standard of care of reproductive and sexual health services. I thought that these two responses exhibited the disconnect between the different strata of health care. These scientists as, influencers of policy and EBM, come to enact MC in a way that alienates service delivery given that they know little about it. Their expertise on MC as an enactment of scientific knowledge, does not allow to bring the experiences of practitioners as to how to integrate their research into service. Dr. Chaw added in regards to my question about services:

My point is, you couch it (the interviewer's question) in terms of reproductive health services, a very broad, I think if you are going to make suggestions, you should be highly specifics about the nature of the services you are talking about, so these are antenatal and intrapartum services, well the issue being circumcision been considered. What is known as reproductive health services tends to be from cancer screening to STI, slightly different... and infant circumcisions are usually done following birth by the pediatrician, or sometimes by the obstetricians... so it's not part of reproductive health services per se, it's a part of delivery care, so you have to be very specific in the way you couch that question.

In my research, I use the WHO's approach to reproductive and sexual because it holistically links sexual and reproductive services (World Health Organization 2007). In my own fieldwork, I observed how a healthcare provider would provide prenatal care to a client, together with a host of other sexual health services including basic gynecological

exams and tests. Reproductive and sexual health services were part of prenatal care in the clinics where I conducted research in; MC however, was not salient though it was in private and for-profit clinics.

Viv Weker suggests how research findings can be translated into service. She argued that MC is not warranted at present as a public health benefit in the US, except for those high-risk populations. If MC were to become an intervention strategy in the US, it would be focused on those groups that are at high-risk of infection:

So if you were to ask me from a public health perspective do we need to promote universal MC in the US, from a public health HIV prevention perspective I probably say no, because I don't think we have evidence, I don't think in all the populations in America are there necessarily epidemiological grounds to justify MC as an HIV prevention strategy. If you have HIV prevention, if you have less than 1% of the population infected with HIV and you have HIV infection being very much focused on the key, more at risk populations you don't really want to focus your attention on the entire rest of the population, you really want to focus your attention on that key group that has HIV that is transmitting. And the immediate kind of circle that they interact with, cause if we can stop HIV there, it's never going to get at the general population. And that's really where we are in a country like the US, were already dealing with a concentrated epidemic.

An enactment of MC as a prevention procedure cannot exist in a vacuum but related to policy, services, and evidence-based medicine. All the scientists I interviewed, were sympathetic to the topic of parental choice. They backed the AAP statement, in that MC should be offered, explained, and covered by insurance.

Countering arguments by anti-MC groups, Dr. Denault clarified that the AAP recommendations, and their research does not entail a mandate. The research was done in a particular setting, and given the way MC has been enacted by these scientists, one of the tangible policy recommendations is that MC should be fully explained to parents so they have a choice in accepting or rejecting this new paradigm:

We aren't mandating everyone needs to be circumcised...I think it should be an option, and something that parents should be informed of the potential risks and benefits... it does seem to me that the potential benefits outweigh risk, but I understand that it is a personal choice and that a lot of people are adamantly opposed to it, and one hand I can understand why people are adamantly against it, but to be... but I think that, adamant even has its boundaries... but I firmly believe when new parents go to the doctor to say, they telling their ob/gyn or their pediatrician they are trying to have a baby, what are the risks and benefits of the procedure, they should be properly informed about both the risks and the benefits and make an informed decision.

In this statement, Dr. Denault shifts from the authoritative nature of scientific knowledge and offers alternative viewpoints in regards to parental choice. In the scenario that he mentions, choice does not have to yield to a MC that is enacted through clinical trials, and ensuing research; service provision should enact MC in a way that is informed by the research, yet still yielding to parental choice. Dr. Ripley echoed this statement by emphasizing the fact that choice does not mean possessing knowledge about the benefits and risks of this procedure. But if in fact this old, yet novel prevention method can provide benefits in the way predicted by scientists, it has to be covered by insurance; parents should have a true choice when presented with the procedure:

Now they (AAP) are saying that benefits outweigh any potential risks and that parents should be informed so that they can make an informed decision, in that sense the research done in Africa has influenced policy here and hopefully it will also make that more insurance companies covered it, so that parents really have a choice. Because the parent wants the circumcision but can't afford it and the insurance doesn't cover it, in effect they don't have a choice, and I think it has to be a choice... anyway anywhere in the world people have to be given a choice, told what is known, and that information has to be presented very straightforwardly, parents, and then later on, adults can make a choice.

Viv Weker on the other hand understood the AAP circumcision statement in terms of recommendations to parents, and not as a broad public health statement:

I think the AAP, their statement is not, they're not making a public health statement right, their only statement was to do, at least my interpretation of it and

some of the discussions around were circulated when that study was published is that they're really aren't trying to get at, they're really trying to inform parents, that in addition to all the other benefits MC has, it also has an HIV prevention benefit.

This group of scientists enacted MC as a new paradigm with several challenges to its implementation. As a prevention method, it uncovers the multiplicity of realities by which it aspires to prevent, but also the practices involved in doing so. MC as the product of scientific knowledge from clinical trials, and as a prevention method, serves to identify the ways in which scientific knowledge attempts to answer problems outside the messy variables of real life settings; such as in reproductive and sexual health clinics.

Anti-Circumcision Movements

Believing in the accuracy and the validity of the results from the clinical trials, the scientists believe that anti-MC activists are misinterpreting the data. Anti-MC groups have directly and indirectly targeted the scientists that participated in this study. While they all agree in that they disagree with anti-MC activists, they responded to my questions regarding the anti-MC groups in different ways. To question the validity of the clinical trials is unethical because it suggests that the science was not thorough. Dr. Chaw's opinion is that the anti-MC activists are not interpreting the data the same way:

My point is that that is a crap argument and you refute it, but you refute it by the specify of which services you are talking about. These (anti-MC) people make all sorts of claims that are totally invalid... Many of the people opposing male circumcision in this country, are prone to misrepresent the scientific data...

Dr. Chaw's response was particularly angry because he thought that I was part of the anti-MC movement; especially he took issue with the way I constructed my interview question by linking MC to prenatal care and reproductive and sexual health services.

Regardless, I argue that Anti-MC activists are not enacting MC through the golden standard. They are looking at the same results from the clinical trials, and coming to different conclusions. Dr. John Shirey, on the other hand had a more nuanced view, and thought that the anti-MC were simply misguided: *“The people who are activists against Circumcision in sub-Saharan Africa where it can have a really positive impact on decreasing HIV rates, I think that they're misguided.”*

The activists and anti-MC groups are simply not interpreting the data in a manner that is congruent with the golden standard that the scientists are enacting MC. The reticence of MC to accept EBM when they oppose MC makes them similar to other groups such as anti-vaccine activists, as Dr. Denault mentioned:

Although there are very vocal anti circumcision activists, the medical evidence is very clear. I consider many of these vocal activists against circumcision, somewhere [like the] individuals who are activists against vaccines. It is not based on medical evidence, it is more based of feelings and you know, gut impressions.

Dr. John Shirey, shared his own experience with anti-MC activists. He told me how he discerns between those who hold extreme opinions and those who are not enacting MC in a scientific manner, and simply hold different beliefs about their bodies:

I get virulent hate mail from these people. And I study the fucking microbiome. I've never circumcised anybody, or come out and said everybody should be circumcised or anything like that... you know, what's the guy in Australia, who was very extremely pro circumcision...but I get anti-Semitic email messages, when we published this paper that you were talking about, when I opened my email first thing in the morning I had two really horrible emails, one of them was super ... it's pretty amazing... It's a real mixed bag, of people that are against it. I do see, some fascist type, anti-Semitic, I dunno, psychotic types, and then you also see very liberal naturalists who just don't see why you would remove a foreskin...and I can relate to those people, but I can't relate to those other ones...

In order to get a sense of the view of anti-MC activists, I interviewed a known activist in the anti-MC movement. He was able to give me a different perspective in regards to how the scientists were enacting MC. I contrast the arguments of the scientists' responses in my research to Mr. Bertrand's views. Mr. Ben Bertrand, a lawyer by profession, felt that "science" does not have the authority to impose itself into the lives of individuals in an authoritative manner; science should not have that power.

If you go back to, the historical perspective, 150 years ago, when people medicalized circumcision so that people who weren't Jewish or Islamic weren't performing it and thought it was going to make their child healthier, that thought with this idea of reflex neurosis, you have to take out the areas... paraphrasing here, you have excise the areas of excitability because excitability is bad for children. There are all these problems, all this laundry list and syphilis and all these things you're supposed to cause by having a foreskin. You start from that and then you come up to a more modern era, and they called it venereal disease, that you used to say that venereal disease could be stopped by circumcision, and then it was urinary tract infections have been suggested, cervical cancer has been suggested, and all these things have been disproven but each time one gets disproven, another one gets suggested it's like we have this compulsion as a culture to finding reasons for this thing.

I argue that his view on science and power is dependent on the context. Scientific knowledge—gold standard and evidence-based medicine knowledge—does not have the power to impose itself as a dominant discourse. If this knowledge has spread is because there were actors with power heralding the clinical trial research results who associated themselves with this knowledge and disseminated it (Mol 2002: 64). As Bertrand noted, the university that houses one of the research teams of the clinical trials is well known for its public health research. The academic prestige, as well as the funds they have to conduct said research, further legitimizes the enactment of MC as a preventative procedure.

The discourse on MC as a medical procedure has been transformed throughout the 19th and 20th century to accommodate the medical paradigms of the time. As of recently, the gold standard dictates the supremacy of knowledge based on clinical trial data. However, those medical arguments as Mr. Bertrand argued, have been decontextualized from the social symptoms of the time. He pairs them with what he calls the medical institutions' "laundry list" of problems: medicine, and more specifically epidemiology in this case, enacts the foreskin as a problem, and as the most probable cause of a long list of those problems. Anti-MC activists have voiced their concerns as to how scientific knowledge is picked apart in a piecemeal manner.

Bertrand understood that the context of the clinical trials in Eastern and Southern Africa are different from in the US, and believed that that needs to be taken into account. According to him, the AAP statement did not address this:

But read the AAP horrible position statement from last year, even they can see, even if you can show that this works in Africa on these different populations, the means of transmission is totally different in the US.

Anti-MC activists have argued that MC is a painful procedure, and that it inhibits sexual pleasure. Dr. Ripley (earlier in this chapter) already expressed her about the fact that MC causes minimal pain to the patient. Mr. Bertrand however emphasized the pain caused by the procedure and conflates it with the issue of neonatal MC. He does it to highlight a problem that intactivists–anti-MC activists–believe is really important in MC: the issue of consent by a male neonate:

But it is sorta of an odd thing to even apply the quote unquote the consent model because the patient is an infant, as the sign says, 10 of 10 infants oppose circumcision because it's done typically with children screaming without pain relief, it's very painful, and you can't numb give them pain relief, you can't numb all the pain.

But distinguishing between neonatal and adult circumcision is an important distinction to make because otherwise the lines become blurred, and how these different actors come to enact MC becomes very different. The scientists did not necessarily see this discounting their pro-circumcision views; Viv Weker had this to say in our interview:

I think the whole, the other issue is looking at neonatal vs. adult circumcision. Cause I think the primary concern, as I understood it with anti circumcision groups is not anti male circumcision per se, is anti neonatal circumcision. I think that's where the big concern is, is circumcising infants before they have the ability to make choice whether they want to be circumcised or not... And, I think the challenge there is weighing up, waiting until the infant is grown up and can make a decision, vs. how hard it is to get circumcised when you're older, compared to when you're younger.

More than enactment, the arguments behind Bertrand's intactivist perspective seemed to be epistemologically different than that of the scientists. His argument point to issues of medicalization, and how research is used to rationalize a procedure that is thrust upon newborn males—and to intactivists interpretation of the research data—without a valid rationale to do so. Bertrand argued that we should not be doing this to newborn males if they are not consenting to a surgery. After all, this is a new practice that relies on a surgery to prevent disease.

Dr. Ripley gave his perspective on this manner in our interview. To perform MC in children brings a lot of benefits that would not be possible with adult men.

And it's (MC) much safer to do it in infancy, because an infant is not going to go and have sex. And an infant is much less likely to have preexisting genital ulcers, or genital inflammation, and also even in infants who have been circumcised, less balanitis, less infections...

The scientists brushed aside the issue of consent, and four of them mentioned how making a decision about their child's circumcision is just another one that parents make

for their children; along with vaccinations, and other medical procedures. In our conversation, Mr. Bertrand interrupted me to provide an opinion on the issue of consent:

I got a quick response for that, I don't mean to interrupt to, but your freedom to impose rights and duties on your child ends at the boundaries of their body, unless there is a medical reason, the only reason parents are allowed to authorize medical procedures on their children is for their child benefit. There's been a few cases where it's for a siblings benefit, and there's a circuitous discussion by the court, well is this beneficial enough to the child that it can justify, those cases are outliers, the rock bottom point is that you are a custodian, you're a guardian I mean you're doing this on the kid's behalf, you don't get to come in and say, I just joined this cult on the internet last night and it says I should amputate my child's third finger, so I'm going to do it, it's his body or her body.

The issue of consent with a child and MC is far from over, as there have been several conflicting instances by which this issue has been debated. In 2012 a German court banned “involuntary male circumcisions on boys” after a botched surgery on a four-year old (MSNBC.Com); and the recent case of a Florida woman, who after a lengthy court process was ordered to circumcise her four year old son, after her estranged husband wanted the procedure done, in opposition to the mother of the child (see Freeman 2015). The issue of consent though is a contested issue, and beyond the scope of this work, but there are even proponents of MC who still understand that the new paradigm does not come with its challenges, especially thinking of surgery as a sexual preventative measure on children (see Edouard and Okonofua 2007).

With regards to the claim of sexual pleasure Dr. Ripley mentioned that the claims of decreased sexual pleasure could not be ascertained through scientific means. As such, the opposition of anti-MC groups in regards to the policies that recommend MC for prevention of HIV and other STIs is unfounded. Dr. Ripley said:

The problem with individuals in the US or Europe who say circumcision reduces sexual pleasure, we don't ...nobody has done a good survey as to what is the

degree of sexual satisfaction on circumcised or uncircumcised men. Because, nobody has actually done population based survey where you could get an honest comparison.

This further strengthens the argument of the ways that scientists come to enact MC; scientific data and its methods trumps opinions, and other beliefs that cannot be verified through their own scientific methods. Especially, since the clinical trial in which Dr. Ripley participated did indeed use some qualitative methods to investigate the question of sexual pleasure:

With our randomized trial it's the first time anybody was able to ask men who had previously had sex before circumcision and then ask them after circumcision, what is your degree of sexual pleasure, in the men they report no reduction in sexual pleasure, the women partners report more sexual pleasure because of improved genital hygiene, their partners had better genital hygiene, particularly where we worked in Country C, access to clean water is difficult, its much more of a challenge to keep up one's hygiene. There is still resistance among people who don't want to believe that it can possibly reduce sexual pleasure, and we had some men in focus groups that said I actually like it better because it takes me longer to ejaculate so I have a longer erection and I find that much more pleasurable. That's from the qualitative research. From the quantitative research where we asked several thousand men, comparing the men who were circumcised versus the ones who weren't, asking them before after circumcision we found no decrease in sexual pleasure... We asked the question on sexual pleasure and sexual satisfaction in the southwest of Country C, the Country B group also had the same kind of questions and found the same results as ours, so you have two different populations. I think if people were... we had no problem eliciting health complaints from individuals in our various surveys. Is it possible that there could be some social desirability, no one could remove that but the women saying they like it better.... I'm pretty confident at the very least, sexual pleasure didn't plummet, and that is in two different populations.

Yet, commenting on recent complaints from the US with regards to decrease of sexual pleasure after undergoing circumcision, she said:

Among circumcised men in the US, report less satisfaction... we don't know what percentage of circumcised men in the US report that, we only know the ones who are complaining, and we don't know what proportion they are representing. And there are two problems with interpreting the US data; one is that of the men that were circumcised because of some previous penile pathology, so what degree is

there is lack of satisfaction because of underlying health problems that led them to have circumcision in the first place; the ones who were circumcised in infancy, all they know is that, they never had sex before being circumcised, what do they know what it feels like for other men, and if you have been circumcised and you had some sexual dissatisfaction you are more likely to attribute that to circumcision whereas a guy who's uncircumcised, he might attribute it to other things, so its very difficult to interpret those data. Whereas the US in Country C where we actually had men who previously had sex and were randomly assigned to circumcision, and were asked and these were men who knew what it was like before. And they're not saying I wish I hadn't done this.

The clinical trials provided her and her colleagues with the understanding that sexual pleasure was not something to take into account when recommending MC as a preventive procedure. I would argue that while the clinical trial within the understandings of the gold standard of research aims to survey an objective measure, the rate of HIV infection among circumcised men, sexual pleasure lends itself to more context specific understandings. I do think that the topic of sexual pleasure deserves a debate that goes beyond this scientific conceptualization. In their arguments all the scientists operationalized sexual pleasure in the aforementioned manner, with the differing opinion of Mr. Bertrand.

Expanding on the appropriateness, as well as the benefits and risks based on scientific methods, Dr. Ripley dismissed the idea that female genital mutilation is in any way comparable to MC:

One of the challenges we have faced, in the US in particular there are some groups that are very strongly against male circumcision cause they consider equivalent to female genital mutilation except that this is male genital mutilation...we believe that this is a very inappropriate analogy, female circumcision, female genital mutilation has no positive health effects and reduces sexual pleasure, it can be deleterious to health, it can make pregnancy much more difficult in women, depending on the type of circumcision they had, whereas male circumcision is a procedure that can be done very safely, very low discomfort for the guy, and a procedure that we and others have shown that has definite and profound positive health effects.

Dr. Ripley sees the analogy ill suited given MC provides health benefits, whereas female circumcision does not. Interestingly enough, she used similar language when rejecting female circumcision, like mentioning reduction of sexual pleasure. Though research exists that documents the obstetrics complications of female circumcision (see Silverman 2004), there is also research that documents circumcised women not reporting any decrease in sexual pleasure (Okonofua 2002; Okonofua, et al. 2002).

The differences—as well as similarities—between female and male circumcision are highly contested (Bell 2005; Darby and Svoboda 2007; Silverman 2004). Mr. Bertrand shared his opinion regarding how they are both compared:

If you look at the issue of opposition to MC, in a way you can say we're fortunate that female genital cutting exists, because if it didn't then male circumcision could just be the sole issue, that...oh why do you complain about this minor or sort of thing. The inconvenient fact is that both exists in different places in the world, does lead to why is that? And why is it conceptualized so differently? Why are they even two terms for it? Even the fact that there are different terms it's not obvious, it's not like male murder, and female murder why there should be male genital cutting, and female genital cutting. It's not necessarily self-evident that it has to be that way, there are certain types as I pointed in the article, there are forms of female genital cutting that are equivalent in terms of the tissue that is being removed, if you go back to the functions of the tissue, of what part of the embryo the feature came from that its basically equivalent to, it's logically equivalent in words to FG cutting, you then query, is there in fact a basis for this great difference in treatment, sure the worst forms of female genital mutilation are worse than male circumcision. I totally agree with that, totally agree with that. Clear! There is no issue. I'm not really interested in comparing and equating them. Human rights say that you can't make a small violation ok, by comparing it to a larger violation. The only reason I even mention them in the same sentence, it's because it's instructive and because it does raise questions about, why do we do them so differently? And I think there is a view of gender that is underlying all this... I just think that there is some sort of idea that it's in ...at how to look at things. I see how like FGM seems worse to me than MC, (laughs) it's just natural reaction, I think it's conditioned by what we get that how males are supposed to strong and invulnerable, and their bodies can be attacked without worrying about it too much, but you know women are supposed to be the carriers of new life, just a different role, in terms of the psyche that comes to our survival...

As can be seen from the above quote, Mr. Bertrand stressed the gender differences in the ways that scientists enact MC. But he also points out the social discourses that affect the supposed objectivity of the scientists' enactment. Bertrand argues that performing circumcision on children is a human rights violation with regards to consent and body integrity. As I mentioned earlier, epistemologically MC is enacted differently by anti-MC activists and scientists: scientists rely on the biomedical model informed by clinical trial research; anti-MC activists claim that such research does not warrant an intrusion in the realm of what they perceive is a human right to consent and to protect body integrity. And while he feels the scientists do not take his stand seriously, Mr. Bertrand holds an informed perspective on the multiple realities embodied in MC by our society:

While I was in Law school, the summer of 1900, I first got exposed to the issue then... I thought it was such a weird issue, and it was interesting but I didn't really think much of it, but in the next 4 or 5 years I learned more about it, and thought about it some more. So I sort of started really as an activist, when I moved back to California in the 1995, and then I founded the organization that I now run in 1997... I've written so many articles and there's so many more that could be written and other people have written, and it so combines so many issues of sexuality, psychology, children, human rights, and medical ethics...

The perspective held by the scientists then, might not incorporate the socio-cultural context of MC. The scientists take a strict view of science as authoritative in the realm of HIV/AIDS prevention. This is a complex issue, because non-US based scientists have ascertained a cultural bias in US MC research, given the high prevalence of MC of the country (Frisch, et al. 2013). But the back and forth between scientists across the Atlantic, where they critique each other's research—and its ensuing policies—as biased is not recent (see Novicki 2006).

US scientists claim that the critiques from international scientists are biased, and defend the soundness of the clinical trial data (Morris, et al. 2014f); which seems like a

stalemate with no evident solution from a biomedical standpoint. The scientists and proponents of this approach—enacting MC through pure scientific means—continue using language that assumes objectivity and superiority over those who question or criticize the appropriateness of the scientific paradigm of the gold standard (De Camargo Jr, et al. 2013; Morris, et al. 2014f; Novicki 2006).

Conclusion

This chapter presented four main findings based on the group of scientists interviewed, and the anti-MC activist.

First, scientists make assumptions about how research can be implemented into clinical practice. The authority of clinical trial research eclipses any type of concern that challenges implementing recommendations based on international research, especially if these challenges represent concerns from anti-MC groups that are described as “misrepresenting the data”. Two scientists in this group did not believe that MC should be part of sexual and reproductive health services and prenatal care. Whereas the majority thought that MC should be part of interventions the target specific at risk groups, and should be offered to parents having male children given the breadth of data that supports that the procedure has clear benefits.

Second, because of the suggested benefits of MC, scientists believe that health insurance should cover the procedure. They claim that their research has informed policy-makers who should recommend and inform clinical practitioners to inform parents about MC’s benefits and risks, so that parents can make an informed decision about MC. If the

procedure is not covered by health insurance, then it might not be accessible to the populations that need it most.

Third, clinical trial research yields the most reliable data for epidemiological studies. Thus, service provision and practice should be based on this research evidence. The gold standard in public health informs evidence-based medicine; any ensuing clinical guidelines should be based solely on research, regardless of the country setting where it was originally carried out.

Fourth, scientific knowledge trumps nonscientific arguments brought up by anti-circumcision activists. MC is enacted as a prophylactic procedure within a biomedical paradigm that believes in the gold standard of research; the clinical trial data resulting from the three clinical trials in Eastern and Southern Africa are indisputable. Clinical trials are assumed to yield the most reliable data.

The scientists crafted their arguments based on MC as a prophylactic procedure that should be offered at the moment of delivery. It was a challenge for me to initially figure out how those arguments were sustained by their practices as scientists. The data and the analysis, allowed me to link their practices as researchers and disseminators of knowledge, as the ways in which MC came to be enacted.

The anti-MC groups have been in existence before these clinical trials were conducted and concluded that the procedure was linked to HIV prevention. This gives credence to Bertrand's statement as he calls the "*compulsion as a culture to finding reasons for this thing(MC)*" as American researchers continue to conduct research that rationalizes a cultural procedure through scientific data. Like other authors discussed before, it seems that circumcision is a diseases looking for a cure (Darby and Svoboda 2007). Experts—

such as these scientists—are not necessarily neutral about the topics they engage in, especially in the scientific conflicts they are required to solve (Mol 2002).

The view that the scientists held of science, was unyielding to arguments that were not scientific. Any argument against scientific data has to be backed up by data. These scientists held a positivistic view of the science behind the data, and by relying on evidence-based medicine they do not account for the social construction of knowledge in scientific endeavors; in contrast they aim for some level of uniformity and control (Timmermans and Berg 2010).

Science experts do not represent reason, as they have inherited the dominant discourses of science as to how they approach these particular problems (Mol 2002). Arguments based on scientific data are being used as trump cards that tries to silence the anti-MC groups. Standards and guidelines are not thought to be political by the scientist group, though they have behaved as such (Timmermans and Berg). The sin is to raise these political issues and to talk about an epidemiology, and an evidence-based medicine that has political implications. Evidence-based medicine is not apolitical, since governments have been using it to make decisions about all kinds of things within its means.

My research was critiqued by Dr. Chaw and Viv Weker during my interviews. My interview with Dr. Chaw was tense at times because even though I assured him of my intentions, he thought my questions were biased favoring the anti-MC groups:

(MC) is not part of reproductive health services per se, its a part of delivery care, so you have to be very specific in the way you couch that question...If the question is should infant circumcision be made readily available and fully covered by insurance in this country and should all parents be informed of the risks and

benefit and offered a free choice to their infant, then I would say absolutely, but that is not the question you raised...

On the other hand, Viv Weker thought that my focus on the scientists was misguided because I was not interviewing local stakeholders:

So, I mean, and I realize you're not interviewing me to ask me my view on your research but it seems to me that one main gap is you're asking me, if you spoke to Guss Chaw for example, Guss' work is working in developing countries, we actually worked quite closely in Country C, but the local stakeholders that you want to interview, are local stakeholders in some of those developing countries.

Criticism against the scientists view points out that further research is necessary to address the challenges and the supposed facts that this new paradigm establishes. A blind belief in science, does not escape criticism of the same fundamentalism that science itself criticizes, since biomedicine is itself by definition a type of ethnomedicine.

Policies and interventions tend to focus on individual behaviors, and the eventual transformation of those behaviors to less problematic ones in a public health scale; this is a problem of the body politic. As such, we need to be utilizing science studies to understand how complex scientific statements can be incorporated in sound policy-making and eventual clinical practice (De Camargo Jr, et al. 2013; Mol 2002; Timmermans and Berg 2010).

Scientists and anti-MC proponents hold two distinct arguments regarding MC; each group holds views that diverge on the ontological approach to the problem. The anti-MC groups are enacting MC as human rights issue as it pertains to the consent of newborn males and their body integrity. The scientists are enacting MC as a prophylactic procedure which benefits the health of the public, and see MC performed on newborns aligned with other medical procedures that parents consent for their children.

Chapter Six

Conclusion

My research argued that the practices of international research, service provision, and service seeking address different realities of MC. Circumcision is enacted by different sobering realities that denote the complexity of society itself. MC is related to budget issues, healthcare, religion, culture, ethnicity, medical care, sexual and reproductive health, scientific validity and authority, among others factors.

My research aimed to explain the enactment of MC as it radiated from the community clinics in Maryland. My findings though demonstrate that MC is not isolated from the larger society. In Mol's words (1999: 150) "*It interferes with the reality of many others*"; my research has shown that the enactment of MC reaches patients, providers, scientists, policy makers, discourses of biomedicine in service delivery, among others.

Both patients and staff believe the lack of circumcision is "cultural" yet neither relies on information that could help individuals assess the available information to make an educated decision.

My dissertation makes major contributions to the discipline of anthropology:

One contribution is to the discipline's major concept of culture. The notion of culture that we as anthropologists deal with, and pretend to capitalize on, is not actually ours to 'own'. Non-anthropologists that are the subjects of our studies interpret and deal with the concept of culture in their own ways. My research has demonstrated that cultural beliefs embed responses from the different groups I interview and influenced their behaviors and practices. Culture was construed by each group as abstract notions related to bodily

practices in the networks of information. Culture was also offered as an explanation of practices and beliefs that are deeply held, and as explanations for phenomena that lack concrete reasonings. MC was enacted as a cultural procedure by both Latina women and healthcare providers study groups. I argue that the strong ties to Latina women's countries of origin, their ethnic and residential communities, and their identities demonstrate that there is a belief in MC as a foreign procedure. This research provides pragmatic information that can lead to the development of alternative educational models exploring the role of circumcision in HIV/AIDS prevention among Latino families.

Another contribution of the study is to a more dynamic view of culture. Culture is not a static conduit of transmitting information that does not allow for change. Culture is seen as the way information is transmitted and enacted as habitus by the Latina women. Healthcare providers encounter lack of resources, time constraints in their work, and unclear recommendations from research and policy-makers; meanwhile they are aware that their Latina patients do not enact MC in the way that is prescribed by current research and clinical practice. The healthcare providers restrict the provision of information about MC to situations when it is medically necessary, and not as part of regular prenatal care services. Conversely, the concept of culture becomes a sort of recycling bin of sorts when unexplained structural phenomena are perceived as 'culture' by the clinic's providers. Transmission of medical information thus gets hampered and becomes static because of these assumptions.

A third contribution of the study relates to how informed decisions about MC denote power relationships. The power of Latinas to make informed-decisions is affected by the differing notions about beliefs and practices among scientists and healthcare providers.

This study adds to the body of knowledge about STS about understanding the politics of standardization of service and politics of evidence-based medicine and epidemiological research in clinical practice.

Fourth, the study contributes to understanding that assumptions pervade all levels of the health care process. Research-informed assumptions—as opposed to guidelines and research informed by practice—are made at all levels of the health care process. Scientists make assumptions about how their research will be put into practice, yet they do not know whether their recommendations are actually being acted upon at the clinics. On the other hand, the health professionals make assumptions about the cultural practices and networks of information amongst their Latina patients. Scientists and policy makers uphold a view of science that only admits their singular perspective. When MC is viewed as a complex phenomenon, their view of science gets complicated; especially if one adds the experience of providers whose knowledge is based on their experience in clinics, or if one adds the view of European researchers who disagree with the “cultural bias” of US researchers and policy makers regarding MC.

Fifth, this study contributes to policy-making and evidence based medicine. The research results were based on an analysis of evidence-based medicine and thus have broader implications for informing clinic guidelines. This research provided pragmatic information that could potentially lead to the development of alternative educational models and interventions on the role of circumcision in HIV/AIDS prevention among Latino families.

To conclude, I have argued for MC as a marker of acculturation into US society and, given that my discussion is centered on the reproductive healthcare access of low-income

immigrant women, I also argue that MC is an embodiment of social inequality. These women are not receiving information about the procedure, which would possibly steer them more towards accepting the procedure than not. As a result, the women's male children have visible markers of service inequality that scientists—including those in this study—have asserted as a preventative measure. In a country such as the U.S. with a high number of circumcised men, the penis aesthetic can be construed as a signifier of immigrant parent's acculturation and belonging status.

A final thought—in line with future research as well—is how the practices described in this study can lead to an analysis of embodiment of social inequality. I have already argued that MC can be a marker of acculturation into US society. In addition, for this female immigrant low-income study population seeking reproductive and sexual health care services, I argue further that MC could be enacted as an embodiment of social inequality. The women are not receiving the necessary information that scientists in this study claim can have positive health benefits. Therefore, the male children of these women are embodied with penises that have not been subjected to a procedure that is deemed to have positive health outcomes. This marker can be a physical and visual indicator of the services their mothers did or did not receive.

Appendices

Appendix 1-Interview questions for health care providers

Examples of Questions to be asked in semi-structured interviews with clinic staff and health care professionals

1. What is your role as a service provider when an expectant mother/mother seeks services?
2. Is circumcision discussed in the services you provide to your clients? Is it discussed in the context of the birthing process?
3. Why do you recommend circumcision as part of your services to your clients?
Why not?
4. Is HIV prevention mentioned at all as the reasons for the recommendation of circumcision?

Appendix 2-Interview questions for Latina Mothers

Examples of the questions to be asked in semi-structured interviews with the expectant mothers and Latina women seeking services in the clinics

1. Did your health provider talk about circumcision at any stage during pre-natal care for your child in the case it was a boy? What was the context of this?
2. What reasons did the provider give you to circumcise your newborn baby boy?
3. Was HIV and other STD's mentioned for the reasons of the procedure?
4. Where you convinced? Were you not convinced? Why or Why not?
5. What do you think is the role of circumcision?
6. What does your family think about circumcision on boys? Is this discussed at all with some members of your family?
7. Have you talked about this with your husband/partner or father of your child?
8. What does he say about this matter?
9. Do you think if you were in your country of origin, would you have been provided with the same information?
10. Did your direct access and interactions with the health system affected your decision? In example, do you think if you didn't agree with the provider's recommendation of circumcision your access to health care would be affected?
- 11.

Appendix 3-Interview questions for Scientists

Examples of questions to be asked to policy makers and scientists

1. How long have you been working on reproductive and sexual health issues?
2. How does your work get translated into local state/national policy?
 - How does this process happen? Can you elaborate?
3. What is the importance of circumcision within the scope of sexual and reproductive sexual health services?
4. How familiar are you with the process of circumcision?
 - Is that something that is discussed within your job responsibilities/research?

Appendix 4- IRB Approval Letter



UNIVERSITY OF
MARYLAND

INSTITUTIONAL REVIEW BOARD

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DATE: February 11, 2013

TO: Colon-Cabrera David, MAA

FROM: University of Maryland College Park (UMCP) IRB

PROJECT TITLE: [400385-2] Understanding Male Circumcision among Latina Expectant Mothers in the context of Reproductive and Sexual Health Services

SUBMISSION TYPE: Response/Follow-Up

ACTION: APPROVED

APPROVAL DATE: February 11, 2013

EXPIRATION DATE: February 10, 2014

REVIEW TYPE: Expedited Review

REVIEW CATEGORY: Expedited review category # 7

Thank you for your submission of Response/Follow-Up materials for this project. The University of Maryland College Park (UMCP) IRB has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. All research must be conducted in accordance with this approved submission.

This submission has received Expedited Review based on the applicable federal regulation.

Please remember that informed consent is a process beginning with a description of the project and insurance of participant understanding followed by a signed consent form. Informed consent must continue throughout the project via a dialogue between the researcher and research participant. Federal regulations require each participant receive a copy of the signed consent document.

Please note that any revision to previously approved materials must be approved by this committee prior to initiation. Please use the appropriate revision forms for this procedure which are found on the IRBNet Forms and Templates Page.

All UNANTICIPATED PROBLEMS involving risks to subjects or others (UPIRSOs) and SERIOUS and UNEXPECTED adverse events must be reported promptly to this office. Please use the appropriate reporting forms for this procedure. All FDA and sponsor reporting requirements should also be followed.

All NON-COMPLIANCE issues or COMPLAINTS regarding this project must be reported promptly to this office.

This project has been determined to be a Minimal Risk project. Based on the risks, this project requires continuing review by this committee on an annual basis. Please use the appropriate forms for this procedure. Your documentation for continuing review must be received with sufficient time for review and continued approval before the expiration date of February 10, 2014.

Please note that all research records must be retained for a minimum of three years after the completion of the project.

If you have any questions, please contact the IRB Office at 301-405-4212 or irb@umd.edu. Please include your project title and reference number in all correspondence with this committee.

This letter has been electronically signed in accordance with all applicable regulations, and a copy is retained within University of Maryland College Park (UMCP) IRB's records.

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