



## Framing Male Circumcision as a Human Rights Issue? Contributions to the Debate Over the Universality of Human Rights

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# **Framing Male Circumcision as a Human Rights Issue? Contributions to the Debate Over the Universality of Human Rights**

DEBRA L. DELAET

*The international community has not framed male circumcision as a violation of human rights in the same way that it has condemned female genital mutilation. Although this article acknowledges sharp differences between the most extreme forms of female genital mutilation and male circumcision as it is most widely practiced, this article concludes that the most common forms of male and female circumcision are not sufficiently divergent practices to warrant a differential response from the international community and that there are more similarities between the two practices than is typically acknowledged. The article seeks to illuminate cultural and ideological tensions that are at stake in any effort to develop and apply universal norms in a world of difference. The comparison of global responses to male and female circumcision in this article sheds light on the cultural obstacles to global consensus on human rights as universal principles and underscores the difficulty of adopting “neutral” universalist rights claims devoid of cultural and ideological content.*

## **Introduction**

The international community has treated the practices of female and male circumcision in a fundamentally disparate manner. By the 1990s, international condemnation of female genital mutilation had become a well-established global norm. The United Nations Children’s Fund (UNICEF) condemned female genital mutilation as early as 1979. In 1993, the UN General Assembly, in Resolution 48/104, declared that female genital mutilation constituted violence against women. In 1997, UNICEF, in a joint statement with the World Health Organization (WHO) and the UN Population Fund (UNFPA), called for the reduction in the prevalence of female genital mutilation over ten years and for its complete

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eradication within three generations (The United Nations Children's Fund, 2). In addition to UNICEF, WHO, and the UNFPA, the Office of the UN High Commissioner for Refugees and the Office of the High Commissioner for Human Rights have condemned female genital mutilation.<sup>1</sup> A variety of non-governmental organizations with global agendas and reach, including Amnesty International, the International Commission of Jurists, and the World Medical Association, have also condemned female circumcision. (Abu-Sahlieh, 2001: 307–312) A range of countries, including Switzerland, France, the United States, and numerous African countries, have passed legislation prohibiting female genital mutilation and allowing for the criminal prosecution of individuals who perform procedures that constitute FGM. (Abu-Sahlieh, 2001: 299–303; 487–489).<sup>2</sup>

In stark contrast, there has been no comparable condemnation of male circumcision at either the international or domestic level. UN agencies and human rights NGOs have not made statements or taken positions that explicitly condemn male circumcision. For example, whereas the Office of the High Commissioner for Human Rights identifies female genital mutilation as a harmful traditional practice affecting the health of women and children, it does not include male circumcision on its list of harmful practices. (United Nations Office of the High Commissioner for Human Rights 2005). Another example is reflected in a recent World Health Organization (WHO) report on male circumcision. This report describes male circumcision in strictly medical terms, referring to it as “one of the oldest and most common surgical procedures worldwide,” and focuses almost exclusively on evidence from recent scientific studies indicating that circumcised males have lower rates of HIV infection. (WHO and JUNP on HIV/AIDS 2007: 15–16) The report does not mention any human rights considerations that are at stake in global discussions of male circumcision.

States across the globe also treat male circumcision differently than female circumcision; none of the countries that have adopted legislation prohibiting female genital mutilation have adopted national legislation prohibiting male circumcision.<sup>3</sup> Although a relatively small number of specialized advocacy groups opposed to male circumcision have emerged, they have not fundamentally altered discourse or practice in the human rights community, in states, or in the UN system. In short, while international opposition to female genital mutilation appears to be consolidating, the virtual silence of the international community on the issue of male circumcision suggests widespread global acceptance of this practice.

The international community's differential treatment of these practices begs a couple of important questions. Are male and female circumcision fundamentally different practices requiring divergent responses from the human rights community? Or does the disparate treatment of male and female circumcision reflect a cultural bias that is more deferential to male circumcision, a practice that is relatively more common in “the West,” in comparison to female circumcision which is more common in non-Western societies?

Ultimately, this article concludes that the most common forms of male and female circumcision are not sufficiently divergent practices to warrant a differential response from the international community. Despite the fact that the international community treats female circumcision as a fundamental violation of human rights and male circumcision as an acceptable cultural practice, there are more similarities between the two practices than is typically acknowledged. To be sure, there are sharp differences between infibulation, the most extreme form of female genital mutilation, and the less invasive form of male circumcision that is most widely practiced. However, that comparison is not necessarily the most appropriate comparison that can be made. As will be discussed subsequently, there are extremely invasive forms of male circumcision that are as harsh as infibulation. It is true that

these extreme forms of male circumcision are rare, but it is also the case that infibulation is much less common than the less invasive variants of female circumcision. Indeed, female circumcision as it is commonly practiced can be as limited in terms of the procedures that are performed and their effects as the most widespread type of male circumcision.

Furthermore, there are striking parallels in the evolving rationales for both female and male circumcision, rooted in a combination of restrictive sexual mores, religious rituals, and medical justifications, again suggesting that common variants of the practices may be more alike than they are different. Thus, the empirical evidence suggests that there is not a clear and bright line differentiating male from female circumcision that warrants a significantly differential international response.

This article does not compare and contrast female and male circumcision merely for the sake of exploring whether or not a human rights framework should be applied consistently to each practice. Rather, the article is intended to illuminate cultural and ideological tensions that are at stake in any effort to develop and apply universal norms in a world of difference. Thus, an underlying objective of the article is to explore what the differential treatment of male versus female circumcision illustrates about the tension between universalist and relativist perspectives on human rights. As such, the article does not take a strong normative position on whether or not male circumcision *should* be framed as a human rights issue. Rather, it seeks to explore how cultural bias shapes our perspectives on social practices and whether or not we view such practices as involving fundamental human rights.

This comparison of male and female circumcision ultimately reveals the significant role that culture plays in shaping the positions, strategies, and agendas of various actors involved in global efforts to identify, promote, and implement universal human rights. Acknowledging the influence of culture on one's perspective on this topic does not require taking a relativist position. Nevertheless, the application of a human rights frame to the practice of male circumcision, in comparison with female circumcision, sheds lights on the ideological and cultural complexities that shape the larger debate over the universality of human rights. Ultimately, this comparison underscores the difficulty of adopting "neutral" universalist rights claims devoid of cultural and ideological content.

### **Genital Mutilation or Circumcision? the Importance of Language in the Construction of Human Rights Norms**

When is a practice a human rights abuse? Because debates over the universality of human rights involve contested political and social practices, linguistic choices are a central part of the process of defining and gaining support for the norms that become part of the evolving human rights regime. Linguistic choices signal relative support of or opposition to certain practices.

The debate over whether to refer to the various procedures used to remove or alter female genitalia as "female circumcision," "female genital mutilation," "female genital operations," "female genital alterations," or "female cutting" illustrates the cultural obstacles that currently hinder global consensus on the identification and implementation of universal human rights. Using the terminology "female circumcision" suggests a more accepting view of what may be deemed a relatively benign procedure whereas "female genital mutilation" has been the phrase favored by many women's rights advocates opposed to the procedure. Other scholars have used the phrase "female genital operation" in a way intended to soften opposition to the practice and to frame it as a medical procedure comparable to male

circumcision. People from inside cultures who engage in this practice have sometimes simply referred to “female cutting,” and UNICEF and other agencies have intermittently used this terminology (UNICEF 2008).

In comparison, the label “male circumcision” has been far more uniformly and consistently applied to the various procedures used to remove or alter parts of the male genitalia. Interestingly, even the few papers and books that have been written about male circumcision as a violation of human rights typically refer to “male circumcision” rather than “male genital mutilation” (Abu-Salieh 2001; Denniston et al. 1999). There is an emerging movement of anti-circumcision advocacy groups which refers to “male genital mutilation,” but male circumcision remains the dominant terminology in this debate. The implication of applying the term male circumcision, just as in the case of female circumcision, is that such language suggests that the practice is benign in nature. In contrast, applying the label “male genital mutilation” suggests that the procedures in question do unnecessary physical harm to boys and men by removing a natural part of their bodies in the absence of a compelling medical rationale.

A telling example comes from within the emergent movement opposed to the genital mutilation of both boys and girls. George C. Denniston, Frederick Hodges, and Marilyn Milos, activist scholars involved in this movement, have collaborated on an edited volume intended both to contribute to scholarly understanding of circumcision and to articulate an anti-genital mutilation position based on gender equity. In the introduction to this volume, the editors write the following:

*Stedman’s Medical Dictionary* defines mutilation as, ‘Disfigurement or injury by removal or destruction of any conspicuous or essential part of the body.’” Male circumcision clearly entails the removal of a conspicuous part of the body. It inflicts an irreparable injury and alters the appearance of the penis. The question, then, is not whether circumcision is mutilation, but whether it is productive to refer to it as a mutilation when discussing it. While the designation of mutilation is clinically accurate and objective, in practice, it is subjectively applied (Denniston et al. 1999: vi–vii.).

In the editors’ view, then, referring to male circumcision as mutilation is both empirically correct and objective. Yet, the excerpt also implies that it may not be productive to label circumcision in this way. Nevertheless, the editors subsequently state that they will choose to refer to circumcision practices as “mutilation” because they claim it is the term preferred by individuals who have undergone the procedures. (Denniston et al. 1999: vi–vii.) Despite this clear statement of their intentions, the editors opted to title the volume *Male and Female Circumcision: Medical, Legal, and Ethical Considerations in Pediatric Practice*. In drawing attention to this inconsistency, the point is not to be critical of the editors. Rather, this example illustrates the linguistically complicated choices at stake in the debate and the challenges involved in applying consistent language even among activists who have staked out a clear position on this issue.

An analysis of the discourse involved in ongoing debates over both female and male “circumcision” or “genital mutilation” reveals a fascinating tension. On the one hand, relativist defenders of practices that remove or alter parts of the female genitalia intentionally use the terms female circumcision or female genital operation, in part, to make the practice more understandable and sympathetic to a “Western” audience predisposed to condemning it. On the other hand, critics of practices that remove or alter parts of the male genitalia have adopted the language of human rights universalists in their campaign against male

circumcision by calling it male genital mutilation. In short, language plays a central role in this discussion and is used strategically by individuals and groups involved in the debate.

Every linguistic choice signals some orientation to the topic, and absolute neutrality is probably impossible. For example, Dena Davis uses the label “genital alterations” in her work on this subject and claims that this terminology is “assertively neutral.” (Davis 2001: 489–91) Yet, one could argue that there is nothing particularly neutral about the term “alteration.” The term alteration accurately and objectively captures the fact that the procedures in question involve a fundamental change to the genitalia. Furthermore, it is certainly true that the term is not inflammatory and, in this way, does not signal a bias against circumcision. However, although this terminology is not biased *against* circumcision, it may reflect a pro-circumcision bias. The term “alteration” might be interpreted to suggest that circumcision involves casual, harmless procedures akin to making alterations in one’s clothing—shortening the hem on a skirt, say, or replacing the buttons on a shirt. This criticism is *not* intended to argue that the terminology “genital alterations” is necessarily inappropriate but does suggest that it is no more or less neutral than other terminology that has been deployed in this debate.

This discussion underscores the difficulty in striving for some degree of neutrality when writing about culturally contested practices in the debate over universal human rights. Given this difficulty, it is important to acknowledge the impossibility of absolute neutrality. Nevertheless, in an effort to strive for some degree of objectivity, this article will alternate in its use of the terms “female circumcision” and “female genital mutilation” as well as “male circumcision” and “male genital mutilation.” This linguistic strategy is an imperfect one that risks eliciting charges of inconsistency. Yet, one advantage of using this terminology fluidly is that it accurately reflects the reality that there is no global consensus on this issue. Because this article is primarily concerned with exploring the tensions involved in efforts to identify, promote, and implement “universal” norms in a world of diversity rather than seeking to take sides in this debate, using these terms interchangeably is a concrete acknowledgement of this tension.

Moreover, the fluid use of language accurately represents the divergent perspectives of different actors involved in the debate. When the article discusses the positions of UN agencies that officially condemn *female genital mutilation*, it is appropriate to use the terminology that has been explicitly adopted by the United Nations. Medical associations that have taken positions on this issue tend to refer to circumcision; thus, when discussing the position of these organizations, it makes sense to adopt the language that they use. Similarly, when discussing the positions of advocacy organizations that oppose sexual mutilations, referring to female genital mutilation and male genital mutilation accurately reflects the perspectives of these groups. At the same time, as previously discussed, some activist scholars opposed to sexual mutilations nonetheless refer to these procedures as male and female circumcision. When discussing these arguments, it is appropriate to apply the same language used by these authors.

The article will not use the term “female genital operation” because this phraseology does not correspond to the historical reality of the procedure, which traditionally has been performed in non-medical, non-surgical settings (though this reality is changing as female circumcision is increasingly being medicalized in areas where it is practiced). One could argue that “male genital operation” might constitute appropriate terminology because male circumcision is so frequently performed by physicians in a medical, surgical setting. However, male circumcision is not universally treated as a medical procedure as indicated by the importance of ritual Jewish circumcision. For these reasons, neither “female

genital operation” nor “male genital operation” will be used to describe the practices under consideration in this article.

It is clear that the use of terminology throughout this article will not satisfy everyone with a position on this debate. It is likely that opponents of the practices under consideration would prefer the consistent incorporation of genital mutilation and, likewise, that defenders of these practices might prefer the uniform use of circumcision throughout the article. To the extent that these linguistic decisions reflect authorial biases, they have been articulated at the outset so that readers can render their own judgments about how to think and talk about this complicated topic.

## **Prevalence of Male and Female Circumcision/Genital Mutilation**

### *Prevalence of Male Circumcision/Genital Mutilation*

Estimates on the rates of male circumcision are imprecise due to the fact that governments, hospitals, doctors, religious figures and other practitioners who circumcise do not keep records, but one group of anti-circumcision scholars has estimated that approximately 13.3 million boys are circumcised each year (Denniston et al. 2001: v). The World Health Organization estimates that the global rate of male circumcision is approximately thirty percent (WHO and JUNP on HIV/AIDS 2007: 7).

Circumcision is a ritual practice in both the Jewish and Muslim faith traditions that is widely viewed in each of traditions as a religious requirement. In accordance with these religious beliefs, male circumcision is almost universal among Jewish and Muslim populations throughout the world (Abu-Sahlieh 2001: 27–28; 106–108). According to the World Health Organization, approximately two-thirds of the world’s circumcised males are Muslim (WHO and JUNP on HIV/AIDS 2007: 7). Israel has perhaps the highest prevalence of male circumcision in the world with nearly universal circumcision of newborn Jewish males. Circumcision rates among Jewish populations elsewhere in the world are estimated to be above ninety-eight percent as well (WHO and JUNP on HIV/AIDS 2007: 8) Within Christianity, there has been more widespread disagreement about whether or not male circumcision is a religious requirement (Abu-Sahlieh 2001: 85–92). Coptic Christians in Egypt and Orthodox Christians in Ethiopia practice almost universal male circumcision (WHO and JUNP on HIV/AIDS 2007: 4). Elsewhere, Christian teachings and practices are divergent.

The United States has the highest rate of male circumcision in the Western world—approximately sixty percent of male newborns in the United States are circumcised. Indeed, routine infant male circumcision is the most commonly-performed surgical procedure in this country. Canada also has relatively high rates of male circumcision, with a rate of about twenty-five percent. Australia’s national rate of male circumcision is approximately ten to fifteen percent. Most other Western nations have much lower rates of male circumcision (Abu-Sahlieh 2001: 12; Circumcision Reference Library, “History of Circumcision”).

Ethnicity is also a strong determinant of the prevalence of male circumcision within countries. There is a high prevalence of male circumcision among a variety of ethnic groups which do not practice male circumcision for religious reasons. Ethnic groups with high rates of male circumcision include the Xhosa in South Africa, the Yao in Malawi, and the Lunda and Luvale in Zambia (WHO and JUNP on HIV/AIDS 2007: 4). Male circumcision rates tend to be correlated with higher socio-economic status, perhaps because of the

medicalization of the procedure in most countries and the fact that groups with higher incomes are more likely to have private health insurance that covers the procedure (WHO and JUNP on HIV/AIDS 2007: 4).

### ***Prevalence of Female Circumcision/Female Genital Mutilation***

Despite a widespread popular misconception that this practice is limited to the Muslim world or to rural African tribes, female circumcision/genital mutilation has been practiced in a wide variety of cultures across the globe. Historically, the practice has been followed by Christians, Muslims, and one sect of Judaism (Toubia 1993: 21). Currently, it is most prevalent in various parts of Africa as well as among immigrant women and girls in Europe, North America, and other industrialized regions. Because states do not gather statistics on the procedure, estimates are imprecise. Nevertheless, the United Nations has estimated that perhaps two million women and girls are subjected to this practice annually (Abu-Sahlieh 2001: 13; Toubia 1993: 21). According to the WHO, between 100 million and 140 million of the current global female population has undergone some form of female circumcision (UNICEF 2005: 4).

Notably, the highest prevalence of female genital mutilation is concentrated in a few countries. According to UNICEF, the rates of female circumcision are over eighty percent in a handful of African countries: Egypt, Sudan (especially northern Sudan), Mali, and Ethiopia. Several additional African countries, including Burkina Faso, Mauritania, Chad, and Kenya have rates of female circumcision between twenty-five and seventy-nine percent. Additionally, the rates of female circumcision vary by generation and level of education, with younger, more highly educated women less likely to undergo the procedure. Ethnicity is also a strong determinant of the prevalence of female circumcision within countries (UNICEF 2005: 7–13).

### **Medical Procedures or Physical Mutilations? Comparing and Contrasting the Practice of Male and Female Circumcision/Genital Mutilation**

Before one can determine whether or not the differential treatment of male and female circumcision by human rights scholars and advocates is warranted, one must examine the similarities and differences between the two procedures as they are commonly practiced. This section will provide an overview of the various procedures that constitute male and female circumcision/genital mutilation and will discuss the ways in which these practices might be considered to violate fundamental human rights. Then, this section will compare and contrast these procedures in order to identify the degree of divergence or convergence between the practices.

#### ***Male Circumcision/Genital Mutilation***

The most common form of male circumcision involves the removal of the male prepuce, the skin surrounding the glans, or head, of the penis which contains high concentrations of neuroreceptors that are specialized for sexual sensation and expression (Scott 1999: 15–17; Toubia 1993: 3). This procedure is commonly performed on newborn infant boys in a hospital setting. Although this excision of the prepuce is the most common form of male circumcision, other more invasive types have been practiced in various cultures and time periods. One type of male genital mutilation involves peeling the skin of the entire

penis, sometimes including the skin of the scrotum and pubis. This form was practiced historically among some tribes in South Arabia and, according to one scholar of Arab and Islamic Law who studies the issue, may still be practiced today (Abu-Sahlieh 2001: 9). Another particularly invasive form of male genital mutilation is practiced by Australian aborigines and involves a subincision of the urinary tube from the scrotum to the glans (Abu-Sahlieh 2001: 9).

Historically, analgesia has not been used during various male circumcision procedures because the medical community incorrectly assumed that infants did not feel pain. Based upon a shift in established scientific knowledge about infant pain, anesthesia is now increasingly used in circumcisions carried out in hospital settings. The American Academy of Pediatrics now recommends that analgesia be used when physicians circumcise infant boys. Although male circumcision is commonly performed in hospital settings, this is not always the case. In the Jewish tradition, ritual circumcision (*brit milah*) is performed in a religious setting where a *mohel* (a religious leader who has been trained about the physical aspects of the procedure but also is grounded in the religious underpinnings of the ritual) completes the procedure (Katz n.d.).

Critics of male circumcision point out that the practice inflicts a variety of harms on boy children who undergo the procedure. Because male circumcision/genital mutilation has most frequently been performed without analgesia, it inflicts pain on infant males undergoing the procedure. The procedure, when it is performed on newborn males and young boys, is inflicted on boy children without their consent. Male genital mutilation involves a variety of basic health risks, including hemorrhage, lacerations, infection, urinary retention, the accidental amputation of the tip of the penis, and in *extremely rare* circumstances, death, in these cases, usually during complications from infection (Circumcision Reference Library, "Complications from Circumcision").

Critics of male genital mutilation charge that these physical and emotional harms undermine a range of basic human rights, including the right to be free from torture, the right to liberty and security of person, the right to privacy, the right to enjoy the highest standards of physical and mental health, and, in very rare cases, the right to life. Additionally, male circumcision represents a clear assault on bodily integrity. Although a right to bodily integrity is not explicitly identified in existing human rights treaties, it may be implied in prohibitions against torture and rights to privacy, security of person and health. For many critics of male circumcision, the right to bodily integrity is the most fundamental issue at stake. Even if other human rights, including the right to health or the right to be free from torture, are dismissed by defenders of male circumcision, critics of the practice vehemently argue that the practice unequivocally violates the human right to bodily integrity. Finally, opponents of male circumcision see it as a violation of the rights of children because it primarily performed on minors, most frequently infants, who do not have meaningful choice in deciding whether or not to undergo the procedure.

### ***Female Circumcision/Genital Mutilation***

Female circumcision involves the cutting and/or removal of part or all of the external female genital organs and has been practiced for thousands of years in a variety of countries and cultural contexts. The labels "female circumcision" or "female genital mutilation" do not describe a single procedure but are used to refer to a wide range of practices which vary significantly in terms of their invasiveness. The WHO identifies four categories of procedures that constitute female circumcision/genital mutilation.

The first WHO category involves the removal of the prepuce, or outer skin, of the clitoris (UNICEF 2005: 1). This variant of female circumcision is most comparable to the predominant form of male circumcision which involves the excision of the prepuce surrounding the glans of the penis. As in the case of male circumcision, this type of female circumcision removes a part of the genitalia with a dense concentration of neuroreceptors specialized for sexual sensation and expression (Scott 1999: 15–17; Cold and McGrath 1999: 19–24). UNICEF estimates of female circumcision prevalence rates by type indicate that this form of female circumcision is the most widely practiced globally (UNICEF 2005: 15).

The second WHO category includes practices that excise the clitoris coupled with partial or total removal of the labia minor, the inner folds of the vulva (UNICEF 2005: 1). This type of female circumcision/genital mutilation is more invasive than the most common type of male circumcision. Although male circumcision removes a particularly sensitive part of the male sexual organ and, thus, may reduce sexual pleasure, it does not prevent men from achieving sexual stimulation and orgasm. In contrast, the excision of the clitoris eliminates the possibility of clitoral stimulation and orgasm. Notably, UNICEF reports that this variant of female circumcision is the predominant form only in Burkina Faso (UNICEF 2005: 15).

The third WHO category describes practices that involve the partial or total excision of all of the external female genitalia followed by stitching intended to narrow the vaginal opening (UNICEF 2005: 1). This category, commonly known as infibulation, represents the most extreme and invasive form of female genital mutilation. Only two countries, the Sudan and Eritrea, have particularly high rates of infibulation. In the Sudan, estimates suggest that over seventy percent of circumcised women have undergone infibulation. In Eritrea, the estimated rate of infibulation among circumcised women is thirty-nine percent. The additional ten countries for which UNICEF reports rates of infibulation all have a prevalence of under ten percent, with Guinea having the next highest rate of prevalence at roughly eight percent and with Egypt at the bottom of the list with only approximately one percent of circumcised women undergoing infibulation (UNICEF 2005: 15).

The fourth and final WHO category is labeled “unclassified” and encompasses a range of practices, including cutting, nicking, piercing, or burning of the clitoris and surrounding tissue, the stretching of the clitoris and/or labia, and the cutting of or placement of caustic substances into the vagina (UNICEF 2005: 15). Some of the procedures covered by this fourth category involve the least invasive female circumcision practices, particularly the ritualistic nicking or cutting of the clitoris. Such practices do not permanently remove any part of the female genitalia and, thus, might be considered less invasive than male circumcision as it is commonly practiced.

All of these variants of female circumcision traditionally have been performed without anesthesia. However, all forms of the procedure have been medicalized in recent years, partly in response to global criticism of female circumcision as a violation of human rights. Thus, the use of analgesia and the performance of the various procedures in medical settings is becoming more common.

Critics of female genital mutilation have initiated a global campaign to eradicate the practice as a fundamental human rights abuse. These critics highlight the physical pain and damage that is done to the girls and women who undergo the procedure to make the case that it constitutes a human rights abuse. The procedure often has been carried out with “. . . kitchen knives, old razor blades, broken glass, and sharp stones. . .” (Slack 1988: 442). Even when the procedure is performed in health clinics with sanitary medical instruments and anesthesia, it can have lasting negative consequences for the girls and

women on whom it is practiced. These medical complications include hemorrhaging, infections, shock, difficulties with urination, incontinence, menstrual problems, sexual dysfunction, complications with later childbirth, psychological trauma, and even death (Slack 1988: 450–455). Many women who have undergone the procedure have noted a lack of sexual desire or sexual enjoyment. Dangerous health complications are most likely with infibulation. Indeed, some critics of FGM have attributed the high rates of infant and maternal mortality in the Sudan and Somalia to the prevalence of infibulation in these societies (Davis 2001: 490–493).

This range of female circumcision's negative consequences in both physical and emotional terms impinge on a variety of basic human rights, including the right to life, the right to be free from torture, the right to liberty and security of person, the right to privacy, and the right to enjoy the highest standards of physical and mental health. As in the case of male circumcision, female circumcision can be seen as an assault on bodily integrity, a right that, though unspecified in international human rights law, may be implicit in other fundamental rights enumerated above. As in the case of male circumcision, critics contend that the right to bodily integrity is unequivocally violated by female genital mutilation and cannot be rationalized on the grounds of purported health benefits or cultural or religious values. Critics of female genital mutilation also have pointed out that the practice especially constitutes a violation of the rights of children when it is performed on minors who do not have meaningful choice in deciding whether or not to undergo the procedure.

### ***Comparing the Procedures that Constitute Male and Female Circumcision/Genital Mutilation***

As the description of these procedures indicates, the question of whether or not male and female circumcision are more alike than different depends to a great extent on which form of female circumcision is being compared to which form male circumcision. The most commonly practiced form of male circumcision as described above is similar in many respects to the most common form of female circumcision; each of these procedures involves the removal of prepuce of the glans (in the case of male circumcision) and of the clitoris (in the case of female circumcision). Thus, if we rely on the prevailing type of each practice as the baseline for comparison, then the practices may be more alike than they are different.

However, male circumcision, as it is normally practiced, is less severe than other forms of female circumcision, including procedures that involve complete clitoral excision, a practice that is prevalent in at least some countries. Furthermore, male circumcision differs dramatically from infibulation. The procedural equivalent to infibulation for a male would involve the removal of the penis and testicles. It is essential that these differences are acknowledged. Even though the global prevalence of infibulation is low, it is practiced widely in a few countries. At the same time, it must also be noticed that the comparison can be made in the reverse direction as well. The least invasive forms of female circumcision are less severe than the subincision variant of male genital mutilation practiced by some aboriginal tribes in Australia and the form of male genital mutilation involving the peeling of the skin of the entire penis that may still be practiced by a small number of tribes in South Arabia (Abu-Sahlieh 2001: 9).

In any case, a strictly rights-based perspective would suggest that relying on prevalence rates is an inappropriate means of determining whether or not either practice constitutes a violation of fundamental human rights. Instead, a rights-based framework suggests that

when universal human rights are at stake, the numbers of individuals whose rights are being violated is irrelevant. In this regard, drawing distinctions between male and female circumcision is a distraction from the real issue—determining whether or not the practices in question, regardless of whether they are performed on boys or girls, or on men or women, violate fundamental human rights.

Ultimately, whether or not male and female circumcision/genital mutilation are viewed as comparable or divergent practices depends upon the specific procedures being compared. Male circumcision as typically practiced is *not* the physical or moral equivalent of infibulation, and it is not difficult to understand why either defenders of male circumcision or critics of female genital mutilation would resent the comparison. However, there are parallels between infibulation and the subincision form of male circumcision practiced among Australian aboriginal tribes. One might argue that more girl children and women have been subjected to infibulation than boys or men have undergone subincision as practiced among aboriginal peoples in Australia. Yet, the relatively low global rates of infibulation compared to other forms of female circumcision suggest that human rights activists disproportionately focus on this extreme form of female genital mutilation while largely ignoring a similarly harsh, albeit rare, form of male genital mutilation. At the same time, the differences between the most common forms of male and female circumcision are not nearly as stark. There are parallels in terms of the invasiveness of the procedures, on whether or not analgesia is used, and, increasingly, in terms of where the procedures are performed.

Despite the fact that there are striking procedural similarities between male circumcision and the most widely practiced form of female circumcision, there is a stark gap in terms of how each procedure has been treated by the human rights community. A plethora of articles has been written about female genital mutilation. In contrast, very little has been written to date about male circumcision. UN agencies have been highly active in creating and promoting anti-FGM norms whereas they have been essentially silent on the issue of male circumcision/genital mutilation. Similarly, FGM has been a high-profile target of human rights activism while many human rights advocates would likely still resist the idea of adopting male circumcision as an issue for a human rights campaign.

### **Health Measure or Cultural Practice? Contrasting the Rationales for Male and Female Circumcision**

In addition to contrasting female and male circumcision as *procedures*, one can contrast the various rationales that have been used to justify these practices. This comparison again identifies many similarities between the two practices that suggest that the differential treatment of these two practices in international human rights law and advocacy may not be warranted.

#### ***The Evolving Rationales for Male Circumcision***

Male circumcision/genital mutilation has been practiced in various regions of the world for thousands of years. Notably, the origins of the practice are cultural rather than medical. Male circumcision is a ritual practice in both Judaism and Islam.<sup>4</sup> However, even within cultures where male circumcision is the religious norm, there are individuals and groups who question whether or not the procedure is religiously mandated. For example, there is a small but increasingly vocal contingent in the Jewish community that challenges the “myth” that all Jewish men are or must be circumcised (Goldman 1997; Abu-Salih 2001:

41, 72–73). In Islam, as well, there is a disagreement about whether male circumcision is a religious requirement or is merely a recommended practice (Abu-Salih 2001: 99, 106–108, 126). Many Christians also practice male circumcision. However, there is significant disagreement among Christians about whether or not male circumcision is a religious requirement, and it is less clear that religious doctrine shapes circumcision practices among Christians in a fundamental way (Abu-Sahlieh 2001: 85–92). Rather, many Christians who practice male circumcision live in societies that have embraced secular, medical rationales for male circumcision.

The United States is an excellent example of a country with a majority Christian population that widely practices male circumcision. Notably, explicitly religious rationales for male circumcision have been less prominent in the United States than other social and medical rationales. Male circumcision did not become widespread in the United States until the 1870s when Victorian-era doctors adopted the practice as a “cure” for masturbation and as a procedure promoting good hygiene (DeLaet 2006: 15). Over time, doctors added medical justifications to what began as a cultural practice. Interestingly, medical rationales have evolved over time with one medical justification replacing another as the previous one has been debunked (Abu-Sahlieh 2001: 183–199; Toubia 1999: 3).

Claims of medical benefits from male circumcision have evolved over time. The medicalization of male circumcision gained force at the end of the 19th century, and the purported benefits of male circumcision during the Victorian period ranged from the belief that the practice cured everything from masturbation to epilepsy to bed-wetting. Early proponents of male circumcision also argued that it aided in the prevention of syphilis (WHO and JUNP on HIV/AIDS 2007: 15; Circumcision Reference Library, “History of Circumcision”). The belief that male circumcision was a procedure justified by medical necessity became culturally entrenched in the United States and, to a lesser degree, in Canada and Australia, by at least the middle of the twentieth century.

Although the medical rationales for male circumcision have shifted over time, the best medical evidence today asserts more modest claims than the all-encompassing medical rationales offered during the Victorian era. Currently, an evidence-based medical perspective suggests that male circumcision may somewhat lessen the risk of urinary tract infections during the first year of life, may diminish the risk of penile cancer (a very rare form of cancer), may lower the rates cervical cancer in the female partners of circumcised men, and may reduce the rate of HIV infection in men (Toubia 1999: 3).

With the exception of the risk of HIV transmission, most of these potential preventative benefits deal with relatively rare illnesses. Critics contend that male circumcision cannot be rationalized on medical grounds. For instance, in the United States, the probability of a man being diagnosed with penile cancer over the course of a lifetime is one in 100,000 (Davis 2001: 511). The lifetime incidence of breast cancer for women in the United States is one out of eight (National Cancer Institute n.d.). Despite the vastly greater probability that women will develop breast cancer at some point during their lives, no serious medical professional would suggest that doctors routinely remove the breast tissue of girl children as a cancer-preventative measure. Thus, critics of male circumcision contend that male circumcision is *not* driven by sound medical logic but by the cultural, religious, and/or ideological preferences of the populations which embrace the practice.

Even in the case of AIDS, a deadly and prevalent disease, male circumcision is not necessarily the most appropriate method for preventing the transmission of HIV. Indeed, one might argue that relying too heavily on male circumcision as a tool for decreasing the transmission of HIV might contribute to complacency about the importance of the use of

condoms as a preventative measure and, thus, might increase the probability that individuals engage in reckless sexual behavior due to an unsubstantiated belief that male circumcision will provide full or adequate protection from sexually transmitted illnesses.

At this point, the medical establishment has generally concluded that the potential benefits of male circumcision do not outweigh the costs, including the risks associated with surgery, infection, urinary problems, and a potential decrease in sexual pleasure. National medical associations across the globe now argue that routine male circumcision is not medically warranted. The American Academy of Pediatrics no longer recommends routine male circumcision. The American Medical Association shares the AAP's position on medical circumcision. Interestingly, the American Cancer Society has taken a firm position *against* routine male circumcision despite claims about the cancer-preventative benefits of the practice (Abu-Sahlieh 2001: 189–90). The British Medical Association contends that male circumcision is rarely necessary on medical grounds. Both the Australian Medical Association and the Australian Association of Pediatric Surgeons have discouraged routine circumcision, as has the Canadian Pediatric Society (Circumcision Reference Library, "Policy Statements by Medical Organizations").

Despite a growing consensus within the medical establishment that male circumcision is not medically warranted, most medical associations do not actively discourage, let alone condemn, male circumcision. The American Academy of Pediatrics' position on this procedure is instructive. The Academy's guidelines on the practice suggest that, despite the fact that routine male circumcision is not medically indicated, the decision regarding whether or not to circumcise is up to the parents in consultation with their physician. The AAP urges parents to make an informed decision in consultation with their doctor and notes that the *religious, cultural, and ethnic* background of the family should be considered (American Academy of Pediatrics n.d.). Thus, the AAP's statement ultimately defers to cultural preferences rather than asserting the priority of health considerations, much less human rights. Most medical associations embrace a similar deference to the belief that male circumcision is a valid cultural practice even when it is not medically warranted. Although most national medical associations do not recommend routine male circumcision, they do not actively condemn the practice or discourage physicians from performing male circumcisions when it is requested by parents (Abu-Sahlieh 2001: 198–199).

The medical community's movement towards this position of relative neutrality coupled with cultural deference towards male circumcision may again shift back more strongly in favor of routine medical male circumcision due to the recent scientific studies finding a correlation between circumcision and lower rates of HIV infection. For example, a recent study funded by the U.S. National Institutes of Health found that circumcision may reduce a man's risk of being infected with HIV in half (McNeil 2006). As an indication of the medical community's belief in the importance of these findings, the World Health Organization has endorsed the importance of the potential HIV-protective effects of male circumcision. At least partly in response to these findings, WHO has recently taken a generally favorable position on male circumcision on the grounds that it is an essentially quick, safe, and easy procedure that may have important protective health benefits, especially in preventing the transmission of HIV.

However, because previous studies have only found that male circumcision slightly reduces the risk of contracting sexually-transmitted diseases, the long-term impact of these most recent findings remain to be seen. Additionally, critics of these studies charge that they have been marred by limited sample sizes and biased design (Williams 1999: 33–34). Furthermore, despite the widespread media coverage of studies suggesting that male circumcision might lead to a decreased risk of HIV infection, other studies have suggested

that circumcised men may, in fact, be more susceptible to infection by HIV (Van Howe 1999: 99, 118–120). Additionally, another recent study found that male circumcision did not reduce the risk of women contracting sexually transmitted disease; in fact, this study showed that male circumcision *increased* the risk that female partners of circumcised men would contract HIV if the couples engaged in intercourse before full healing from the surgery was complete (Altman 2008).

In general, anti-male circumcision activists are dubious about the most recent research connecting male circumcision with diminished rates of HIV transmission because of the historic role that the medical establishment has played in rationalizing the procedure. The continuously evolving nature of the medical rationales for male circumcision has led many critics to doubt the validity of these medical claims on the grounds that male circumcision is being treated by medical professionals and scientists as a customary practice in search of a rationale (Denniston et al. 1999: vi). Skeptics also contend that the medical profession, as well as other traditional and religious practitioners who perform circumcision, have vested economic interests that lead them to defend circumcision even when evidence emerges about the practices negative consequences (Denniston et al. 1999: vii).

Defenders of male circumcision rely on numerous cultural justifications for continuing the practice. Circumcised males commonly view the practice as normal and support its continuation. Even if male circumcision is a cultural practice rather than a medically-necessary procedure, cultural relativists argue that the international community should respect traditional cultural practices of groups that support the procedure. Indeed, Article 12 of the UN Convention on the Rights of the Child refers to “. . . the importance of the traditions and cultural values of each people for the protection and harmonious development of the child. . .” Relying on this clause, defenders of male circumcision could argue that even international human rights law ultimately remains deferential to traditional cultural practices. The prominence of self-determination norms in international human rights law also reinforces this perspective. In addition, because male circumcision is almost universally practiced by Jews and Muslims, defenders of the practice argue that restrictions on male circumcision would impinge upon the right to freedom of religion. Moreover, it should be reiterated that some doctors continue to believe that the potential benefits of male circumcision outweigh the potential risks (Wiswell 1997: 1244–1245.) Thus, defenders of male circumcision might argue that the procedure provides a means of promoting a right to health, especially in regions where HIV is prevalent.

### ***The Evolving Rationales for Female Circumcision***

Despite a widespread popular misconception that this practice is limited to the Muslim world or to rural African tribes, female circumcision/genital mutilation has been practiced within a wide variety of cultures across the globe. Historically, the practice has been followed by Christians, Muslims, and one sect of Judaism (Toubia 1993: 21.) Although none of the texts of these religions requires female circumcision, it has been justified by religious elites within these traditions who have promoted the practice as a moral requirement intended to preserve the chastity of women (Slack 1988: 445–446.) Female circumcision/genital mutilation remains a common practice in numerous African countries, where there is often a strong connection between ethnicity and the prevalence of female circumcision. Female circumcision is especially prevalent among Muslim communities in these countries, and it is also supported by the traditional religious and cultural practices of a variety of ethnic groups (UNICEF 2005: 11). Often, female circumcision is part of a rite of passage for

adolescent girls, and it also has been used to promote the value of chastity (Slack 1988: 445–446). Myths, such as the belief that the procedure contributes to fertility, also have played a role in perpetuating the practice within some ethnic communities (Slack 1988: 447). As late as the 1940s and 1950s in the United States, doctors in the United Kingdom and the United States routinely used the practice as a “treatment” for “. . . hysteria, lesbianism, masturbation, and other so-called female deviances.” In fact, doctors continued to perform the procedure in the United States into the 1970s (Toubia 1993: 21).

Female circumcision has been defended on numerous grounds. In societies where female circumcision is commonly practiced, many women as well as men voice support for the practice (UNICEF 2005: 17–19). A solid majority of women in Guinea, Egypt, Mali, Sudan, Ethiopia, and Mauritania believe that female cutting should continue to be practiced in their societies. In both Mali and Somalia, approximately eighty percent of women support the continuation of female circumcision (UNICEF 2005: 17–19). Women in countries where there are high prevalence rates of female circumcision often indicate that they believe that circumcision is a religious and/or cultural requirement (Obiara 1997: 275–378; UNICEF 2005: 17).

Despite the high levels of support for female circumcision in countries where it is practiced, it should be noted that cultural arguments in favor of female circumcision do not represent a societal consensus—or even a majority viewpoint—in places where the practice is common. For instance, less than twenty-five percent of women support female circumcision in Burkina Faso, Kenya, Yemen, Nigeria, Benin, and Niger. Burkina Faso is a particularly interesting example in this regard. Although over seventy-five percent of women in Burkina Faso have undergone some form of female circumcision, fewer than twenty percent think the practice should be continued. Furthermore, survey data show that the prevalence of female circumcision is on the decline in countries where it is practiced and that opposition to female genital mutilation is on the rise. These effects are especially pronounced among younger generations (UNICEF 2005: 17–19).

Even if the sometimes significant opposition to female genital mutilation is acknowledged, defenders of female circumcision have continued to rationalize the practice on cultural grounds. The traditional importance of female circumcision as a rite of passage in many societies means that girls who have not undergone the procedure may not be considered good candidates for marriage. Because women’s roles are often defined in very traditional ways in societies where female circumcision is practiced, women’s ability to support themselves and to meet their basic needs often depends very much on their marriage prospects. In these contexts, external efforts to eradicate the practice are seen as threats not only to social order in general but to the traditional paths of pursuing economic well-being and social status for girls and women (Slack 1988: 463). The international campaign to eradicate female genital mutilation also is commonly seen as a condescending, paternalistic movement representing a form of neo-colonialism that is insufficiently attentive to the cultural contexts in which female circumcision/genital mutilation takes place (Obiara 1997: 275–378).

As this discussion indicates, female circumcision, unlike male circumcision, has been rationalized largely on religious and cultural rather than medical grounds. Although the practice of female circumcision is increasingly being relocated to medical sites, this shift represents a strategic response to the international condemnation of traditional female circumcision practices rather than the fulfillment of a belief that female circumcision is supported by evidence-based medicine.

Indeed, a search of the home pages of various medical organizations indicates that the medical establishment widely views female circumcision as a practice that is not

medically warranted and, in fact, is antithetical to sound medical practices. The American Academy of Pediatrics asserts that there are no benefits associated with female circumcision and strongly opposes the practice. Unlike in the case of male circumcision, the AAP does not qualify its position by asserting that families, in consultation with their physicians, should weigh religion, culture and ethnicity as well as medical indications in making decisions about whether or not to circumcise their daughters. The Australian Medical Association, in a 1994 statement, formally condemned female genital mutilation and rejects what it calls the euphemism “female circumcision.” It also asserts that any medical practitioner who engages in or condones *any form* (emphasis added) of female genital mutilation is guilty of professional misconduct. In accordance with British legislation prohibiting female genital mutilation, the British Medical Association takes a similarly strong stance against FGM. Despite opposition to FGM among many of its members, the American Medical Association does not appear to have taken a formal position on female circumcision.

### ***Comparing the Rationales for Male and Female Circumcision***

This overview of the rationales that have been used to justify male and female circumcision/genital mutilation suggests that they both can be characterized as primarily cultural practices rather than medically warranted procedures (Recent scientific findings about the HIV-preventative benefits of male circumcision do not change the fact that culture and religion have been driving forces leading to the prevalence of the procedure for most of the history in which it has been practiced). Both male and female circumcision originated in cultural and religious traditions. In the case of male circumcision, medical rationales were subsequently overlaid upon the cultural rationales of this practice to the point that medical rationales have often displaced the cultural rationales of the procedure except in the case of ritual Jewish and Muslim circumcision where the religious and cultural foundations of the practice remain central. In the United States, the belief that male circumcision is a medically beneficial procedure has become deeply entrenched despite much scientific evidence to the contrary.

Disentangling the influence of culture and medical considerations is more complicated in the case of female circumcision. In this case, it is very clear that cultural and religious justifications have been the driving force behind the practice in most places where it is common. Nevertheless, female genital mutilation has become more “medicalized” over time, *especially in response to external criticism of these procedures as human rights violations*. As FGM became the target of human rights campaigns condemning the negative health consequences of the procedure and especially of the unhygienic and dangerous conditions involved in traditional female cutting rituals, many societies which practice female circumcision sought to take on the human rights criticism *not* by banishing the practice but by medicalizing it, with doctors performing the procedure in medical settings rather than female cutters performing the procedure in traditional ritualistic ceremonies. Yet, female circumcision/genital mutilation has been medicalized primarily in an effort to rationalize the continuation of a cultural and religious practice—by making it safer, less painful, and more hygienic—rather than on the grounds that there are evidence-based medical benefits stemming from the procedure.

There are also differences in both *kind* and *degree* when considering medical versus cultural rationales for both male and female circumcision. Both originated as cultural practices. Both have been medicalized over time. But the medicalization of male circumcision

has been much stronger than the medicalization of female circumcision. As noted above, the medical rationale for male circumcision almost entirely displaced explicit cultural reasons for the practice among many groups that practice male circumcision. Furthermore, although the current state of medical knowledge on male circumcision suggests that the routine circumcision of male infants is not medically warranted, there are concrete potential medical benefits from male circumcision.

The same cannot be said of female circumcision. Some advocates of female circumcision suggest that genital “cleanliness” is a benefit of female circumcision (similar claims have been made about male circumcision). However, no medical studies have documented concrete health benefits for women associated with the procedure, whereas in the case of male circumcision, certain potential benefits, such as a slight reduction in the rate of penile cancer, have been documented for circumcised men. The potential health benefits of male circumcision are likely to be trumpeted even more in the face of recent studies suggesting that circumcision may significantly reduce the sexual transmission of HIV, especially in societies facing the staggering human and social costs of overwhelming high rates of HIV infection.

Moreover, the medical harms associated with the most extreme forms of female genital mutilation, including hemorrhaging, infections, shock, difficulties with urination, incontinence, menstrual problems, sexual dysfunction, complications with later childbirth, psychological trauma, and even death, are both more likely and extreme than the health costs associated with prevailing forms of male circumcision. Once again, however, it must be stressed that the health costs associated with the most common form of female circumcision, are very similar to the health risks of male circumcision.

One might argue that male and female circumcision/genital mutilation should be distinguished on the question of whether or not there is an intent to harm. However, from a rights-based perspective, the question of intent is not relevant. International human rights laws do not generally require that an intent to harm be established in order for a practice to constitute a violation of fundamental human rights. The Genocide Convention explicitly specifies that there must be an *intent* to destroy, in whole or in part, targeted groups for pertinent acts to constitute genocide. Other international human rights treaties do not identify intent to harm as necessary for acts to constitute human rights abuses. For example, the clauses of the International Covenant on Civil and Political Rights prohibiting torture do not specify that the intent of the person engaging in torture is relevant.

Even if international human rights law did require that an intent to harm was required to establish that human rights had been violated, it is not clear that this distinction would be helpful in a comparison of male and female circumcision/genital mutilation. In neither case are parents or practitioners motivated by an *intent* to harm children. Religiously-motivated circumcision, in each case, is driven by the belief that parents are acting on faith traditions and fulfilling their religious obligations to their children. In cases in which culture is the driving force behind male and female circumcision, parents believe that they are embracing and enacting the dominant cultural values of their communities. Religious and cultural actors who perform the procedures believe they are fulfilling an important religious and/or cultural function. Parents who circumcise their children for medical reasons believe that they are protecting the health of their children, not harming them. Medical practitioners who perform these procedures likely either believe that the protective benefits of circumcision outweigh its costs and/or that they are respecting the cultural wishes of parents. They are not motivated by an intent to harm children. In short, in neither the case of female circumcision nor male circumcision can it be clearly established that parents or practitioners

are motivated by an intent to harm children, however horrible opponents of male and female genital mutilation consider these practices to be.

### **Male “Circumcision” and Female “Genital Mutilation”: is Disparate Treatment Warranted?**

The disparate status of male circumcision versus female circumcision on the global human rights agenda highlights the importance of cultural norms as obstacles to a universalist perspective on human rights. Female circumcision is most widely practiced in the non-Western world and among minority populations in Western countries. The pattern in the case of male circumcision is different. Male circumcision is prevalent in Islamic countries but is otherwise not widely practiced in the non-Western world. Although it is not a widespread practice in Europe, it is a majority practice in the United States, a country that often espouses human rights as universal principles and where criticism of female genital mutilation is widespread. There are also relatively high levels of male circumcision in Canada and Australia. Whereas female genital mutilation has been routinely condemned by the United States, Canada, Australia, and many European countries, male genital mutilation has not been similarly prioritized by either human rights scholars, activists, or policy makers in these countries.

This differential treatment may be due, in part, to the genuine differences between the practices. In particular, if one uses infibulation as the point of comparison, it is not difficult to understand why the human rights community would give female genital mutilation greater attention than male genital mutilation. However, differences between the two practices can be exaggerated. It is undoubtedly true that the most prevalent form of male circumcision is not nearly as painful, invasive or threatening to men’s health or bodily integrity as infibulation is to women. Nevertheless, it is worth restating that the most common form of female circumcision involves the removal of the prepuce of the clitoris, a procedure that is directly comparable to the predominant form of male circumcision. Moreover, the subincision type of male circumcision practiced by aboriginal tribes in Australia is comparable to infibulation in terms of its invasiveness, painful effects, and threats to the health of boys and men. Yet, the human rights community has condemned female circumcision/genital mutilation in all of its forms while failing to condemn even the most extreme variants of male circumcision/genital mutilation. This disparate treatment indicates a fundamental lack of consistency.

Critics of the disparate treatment of male and female circumcision argue that it reflects a “Western” double standard in which human rights activists in the West disregard sexual mutilations performed on boy children in their own societies. Instead, activists focus on human rights abuses in the non-Western world, especially in Africa (Abu-Sahlieh 2001: 271–273). In doing so, according to critics, these activists undermine rather than advance universal human rights by applying inconsistent, discriminatory standards—standards that discriminate not only on the grounds of gender but also ethnicity and religion. As several prominent critics put the argument, “Mutilation, then, is the stigma of ‘the other.’ It connotes cultural, religious, and racial boundaries” (Denniston et al. 1994: vii). In short, by embracing a disparate standard for male and female circumcision, the human rights community is perpetuating a relativistic double standard that masquerades as universalism.

A human rights framework based on gender equity suggests that a consistent standard should be applied to both male and female circumcision. A consistent human rights

standard might be manifested in a few different ways. A strongly relativist perspective might rationalize the most extreme variants of both male and female circumcision as cultural practices protected by self-determination norms and meriting tolerance. Conversely, a strongly universalist perspective might condemn all forms of male and female circumcision as practices that violate numerous human rights, including the right to bodily integrity, the right to health, and the right not to be tortured. Alternatively, the human rights community might opt to condemn the most extreme forms of both female and male genital mutilation (infibulation and subincision, respectively) and to call for tolerance of the less invasive—and more widespread—variants of each practice.

Of course, this list of alternatives does not exhaust the range of potential responses that would implement a consistent human rights standard, and the human rights community might draw the lines more narrowly or more broadly than has been suggested above. The fundamental point is that there is a serious inconsistency in the way that the human rights community—both in terms of scholarship and practice—has treated male and female circumcision. Both consistency and gender equity suggest that human rights activism and scholarship should reflect more critically on the disparate treatment of female circumcision and male circumcision and should take steps to reduce this disparity.

### **The Importance of a Culturally Sensitive Rights-Based Movement Against Circumcision/Genital Mutilation**

To date, human rights organizations and activists have not widely embraced male circumcision as a human rights issue. Nevertheless, some individuals and groups are seeking to make male circumcision a priority on the global human rights agenda. A number of non-governmental organizations, including NOCIRC (an anti-sexual mutilation organization based in the United States), Nurses for the Rights of the Child, Doctors Opposing Circumcision, and Attorneys for the Rights of the Child, have taken strong positions condemning male as well as female circumcision (Abu-Sahlieh 2001: 140–141, 307–312). To the extent that these organizations succeed, they will be well-served to take lessons from the transnational movement against female genital mutilation. Critics of efforts to eradicate female circumcision have argued that the movement against the practice has been culturally insensitive and, indeed, that cultural arrogance has limited the effectiveness of the efforts to limit the practice. Opponents of male genital mutilation likely will be more successful if they show sensitivity to the cultural settings that have sustained the practice.

In the case of female genital mutilation, reform efforts framing the practice as a health issue have been more successful than campaigns that condemn the practice as an immoral violation of basic human rights (Slack 1988: 479–481). Yet, the fact that such campaigns have had some degree of success does not necessarily mean that they should be replicated in the case of male circumcision. For one, there is evidence that health-based campaigns against female genital mutilation have simply contributed to the medicalization of female circumcision; in this regard, not only are girls and women still being circumcised, but the power over this cultural practice is being displaced from largely female traditional cutters to a largely male medical establishment, which raises an entirely new set of human rights considerations. Moreover, from a rights-based perspective, whether or not health-oriented campaigns “work” is not the underlying issue. A strict human rights orientation suggests that consequentialist reasoning that focuses on the health effects of female genital mutilation risks diluting attention to the fundamental human rights that are at stake.

In any case, a health-based strategy may or may not work in the case of male circumcision. On the one hand, parents may be less likely to react defensively to campaigns that clearly lay out the relative costs and benefits of the practice in terms of health. On the other hand, male circumcision has been justified primarily in terms of health benefits, especially in the United States. As a result, it may be that a health framing strategy will be less successful in the United States and other Western countries with relatively high rates of male circumcision.<sup>5</sup> In the United States, then, because Americans widely embrace the ideal of human rights, framing male circumcision as a human rights issue *may* be a more successful strategy for eradicating the practice.

Regardless of the strategy adopted, an awareness of and sensitivity to the cultural context that drives male circumcision will be required for any meaningful progress to be made in reforming this practice. As this comparison of male and female circumcision/genital mutilation has shown, practices that advocates of human rights view as abusive often are deeply entrenched in culture. Even proponents of universalism need to be aware of and sensitive to the strength of cultural norms if they truly seek to advance global human rights as universal principles.

## Conclusions

A juxtaposition of the relative neglect of male circumcision in human rights scholarship and activism to the high-profile human rights campaigns against female circumcision sheds light on the cultural obstacles to global consensus on human rights as universal principles. Numerous UN-affiliated agencies have condemned female genital mutilation, as have many human rights organizations, activists and scholars. In contrast, male genital mutilation has not been treated as a human rights priority by international organizations, NGOs, or most human rights activists and scholars.

Is the differential treatment of male and female circumcision/genital mutilation in international human rights discourse and practice warranted by the variations between these practices? Or should male circumcision be viewed as a violation of fundamental human rights? This article has sought to offer preliminary answers to these questions and to initiate a dialogue that encourages human rights scholars and activists to thoughtfully consider the complicated ways in which cultural biases and ideological predispositions can color even the most earnest and well-intentioned efforts to formulate and advance “neutral” conceptions of universal human rights norms.

This article is not intended primarily as an advocacy piece. Strong advocacy scholarship on this subject already exists, and readers interested in exploring some of the most strongly articulated arguments against male circumcision should consult the work by Abu-Salieh and Denniston, Hodges, and Milos cited herein. Although there are compelling human rights arguments against both male and female circumcision, this article develops a comparison of male and female circumcision as a lens for viewing the tensions inherent in efforts to identify, promote, and implement universal human rights in a world fundamentally characterized by religious, cultural, ideological, political and other forms of difference. As such, it is intended to illuminate the ways in which cultural biases and relativist tendencies undermine the ostensible neutrality of efforts to promote global human rights.

To the extent that this article of a piece of advocacy, it is a call for consistency and introspection on the part of human rights scholars and practitioners more than it is a call for the condemnation of male circumcision. A fundamental objective of the article is to generate not only introspection but also renewed discussion among scholars and practitioners about

how to confront their own biases in their laudable efforts to advance the cause of universal human rights, not only in the case of male and female circumcision but also in the case of other issues involving fundamental human rights.

## Notes

1. Abu-Salih (2001: 293–299) provides a comprehensive overview of the evolution of the international condemnation of female circumcision that has taken place largely within the UN system.
2. Notably, these laws are not vigorously prosecuted in most places where FGM has been criminalized. Even in France, where anti-FGM legislation has been prosecuted, few convicted individuals have actually been imprisoned for these crimes (Davis 2001: 500–503). Furthermore, it should be noted that national efforts to criminalize female circumcision may lead to unintended harms to girl children. For example, in the United States, some physicians have sought to offer minor, medically safe genital circumcision procedures to immigrant parents of girl children who might otherwise send their daughters back to their home countries for more invasive procedures. State and national legislation prohibiting female genital mutilation has defined these procedures so broadly that these physicians risk criminal prosecution for their efforts. As a result, these laws make it more likely that at least some of these girl children will be subjected to more harsh variants of FGM (Davis 2001: 487–489). In general, legal prohibitions against FGM risk creating a backlash, especially in previously colonized countries where female circumcision was historically embraced as a way to express nationalist pride in the face of oppressive colonialism (Davis 2001: 490–498).
3. Historically, bills were introduced in several state legislatures in the United States that would have banned ritual Jewish circumcision by mohels, but these bills were defeated and probably reflected anti-Semitism and the economic interests of physicians more than a rights-based opposition to genital mutilation (Davis 2001: 518–519).
4. It is important to note that even within cultures where male circumcision is the norm, there are individuals and groups who question whether or not the procedure is culturally or religiously mandated. For example, there is a small but increasingly vocal contingent in the Jewish community that challenge the “myth” that all Jewish men are or must be circumcised. (Ronald Goldman, *Questioning Circumcision: A Jewish Perspective* [Vanguard Publications, 1997]). See also Abu-Salih 2001: 41, 72–73. In Islam, as well, there is a disagreement about whether male circumcision is a religious requirement or is merely a recommended practice.
5. I am grateful to R. Charli Carpenter for this insight.

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