Fearful Symmetries

Essays and Testimonies Around Excision and Circumcision

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AFTERWORD

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A Rose By Any Other Name?

Symmetry and Assymmetry in Male and Female Genital Cutting[1]

ABSTRACT

The essay offers a critical examination of the tendency to segregate discussion of surgical alterations to the male and female genitals into separate compartments – the first known as circumcision, the second as genital mutilation. It is argued that this fundamental problem of definition underlies the considerable controversy surrounding these procedures when carried out on minors, and that it hinders objective discussion of the alleged benefits, harms and risks. The variable effects of male and female genital surgeries are explored, and a scale of damage for male circumcision to complement the World Health Organization's categorization of female genital mutilation is proposed. The origins of the double standard identified are placed in historical perspective, and a brief conclusion makes a plea for greater gender neutrality in the approach to this contentious issue.

> "By this it appears how necessary it is for any man that aspires to true Knowledge, to examine the Definitions of former Authors; and either

[1] This is a revised and substantially expanded version of the article originally published as "A Rose by any other Name: Rethinking the Similarities and Differences between Male and Female Genital Cutting," *Medical Anthropology Quarterly* 21 (September 2007). We are grateful to the editors and publishers, Blackwell Publishing, for permission to reprint.

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> to correct them, where they are negligently set down; or to make them himselfe. For the errours of Definitions multiply themselves, according as the reckoning proceeds; and lead men into absurdities, which at last they see, but cannot avoyd, without reckoning anew from the beginning; in which lyes the foundation of their errours."
> — Thomas Hobbes, *Leviathan*

> "The cutting of healthy genital organs for non-medical reasons is at its essence a basic violation of girls' and women's right to physical integrity. This is true regardless of the degree of cutting or the extent of the complications that may or may not ensue."
> — Anika Rahman & Nahid Toubia, *Female Genital Mutilation: A Guide to Worldwide Laws and Policies*

> "Some of you have seen what they did at Bolvangar. And that was horrible, but it is not the only such place, not the only practice. Sisters, you know only the north: I have travelled in the south lands. There are churches there, believe me, that cut their children too, as the people of Bolvangar did – not in the same way, but just as horribly – they cut their sexual organs, yes, both boys and girls – they cut them with knives so that they shan't feel. That is what the church does, and every church is the same: control, destroy, obliterate every good feeling."
> — Philip Pullman, *The Subtle Knife*

Introduction

THE HUMAN BODY, and the genitals specifically, are characterized by bilateral symmetry; both male and female sets develop from the same embryonic tissue, and the male genitals are anatomically homologous with the female: glans penis, foreskin, scrotum, and testicles correspond to clitoris, clitoral hood, labia, and ovaries. This biological symmetry is not, however, reflected in Western cultural discourses on the genitals, which tend to be extremely asymmetrical, regarding and evaluating the male genitals (especially the part of the penis known as the foreskin) very differently from the female genitals. The asymmetry is most strikingly expressed in the contrasting discourses on surgical alterations to these organs that have evolved since the mid-nineteenth century. In this article, we make a critical examination of the tendency to segregate discussion of such genital modifications into separate compartments – the first known as male circumcision, the second as female genital mutilation. It is argued that this fundamental problem of definition underlies the considerable controversy surrounding these procedures, especially when carried out on minors, and that it hinders objective discussion of the alleged benefits, harms, and risks. The variable effects

of male genital cutting (MGC)[2] and female genital cutting (FGC) are explored, and a scale of damage for MGC to complement the World Health Organization's categorization of FGC is proposed. The origins of the double standard identified are placed in historical perspective, and there is a discussion of the respective roles of science and culture in promoting or discouraging these practices. We conclude by urging greater gender neutrality in the approach to this contentious issue.

An Odious Comparison?

'Comparisons are odious', says the proverb, and these days none more so than efforts to compare male and female genital cutting. Only recently has it become possible to speak in the same breath about such surgeries. Until the 1990s, it was generally assumed, at least in Anglo-American societies, that MGC was so trivial and FGC (sometimes called 'female genital mutilation') so horrific that any attempt to compare the two was offensive. When the Canadian ethicist Margaret Somerville began speaking out against circumcision of infant boys, she was attacked by feminists who accused her of "detracting from the horror of female genital mutilation and weakening the case against it by speaking about it and infant male circumcision in the same context and pointing out that the same ethical and legal principles applied to both."[3] The anthropologist Kirsten Bell similarly found that, when she drew comparisons between the two surgeries for her American college students, the reaction was "immediate and hostile":

> How dare I mention these two entirely different operations in the same breath! How dare I compare the innocuous and beneficial removal of the foreskin with the extreme mutilations enacted against females in other societies![4]

Both these groups would appear to be in agreement with Doriane Coleman, who has argued that any analogy between MGC and FGC "has been rejected

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[2] In this article, unless the context implies otherwise, MGC or male circumcision refers to medically unnecessary circumcision of minors at the behest of parents or other guardian.

[3] Margaret Somerville, "Altering Baby Boys' Bodies: The Ethics of Infant Male Circumcision," in *The Ethical Canary: Science, Society and the Human Spirit* (Toronto: Viking, 2000): 211.

[4] Kirsten Bell, "Genital Cutting and Western Discourses on Sexuality," *Medical Anthropology Quarterly* 19.2 (2005): 125.

as specious and disingenuous [since] traditional forms of FGM are as different from male circumcision in terms of procedures, physical ramifications and motivations as ear piercing is to a penilectomy."[5] There we have the conventional American view: MGC is no worse than ear piercing, while any form of FGC is the equivalent of penis amputation.

Despite this discouragement, a number of scholars have essayed such dangerous comparisons and, in the process, have done more to extend a sense of the horror of FGC to MGC than to trivialize the former with the alleged mildness of the latter. Jacqueline Smith (1998) has criticized the inconsistencies in the policy of the Netherlands government when dealing with the customs of Middle Eastern and African immigrants: on the one hand taking strong legal and educational action to stamp out any form of FGC, while encouraging MGC by subsidizing the training of traditional circumcisers. After an exhaustive review of the legal and human rights issues, she concludes that the degree of harm arising from the procedures is not relevant, and that circumcision of male minors is as much a "traditional practice prejudicial to health" as defined in the United Nations Declaration of the Rights of the Child as any form of FGC. "By condemning one practice and not the other, another basic human right, namely the right to freedom from discrimination, is at stake. Regardless of whether a child is a boy or a girl, neither should be subject to a harmful traditional practice," she writes.[6] Sirkuu Hellsten has argued that "male genital mutilation should not be considered in isolation from female genital mutilation," She observes that campaigns against the former have not been as vigorous or well supported as those against the latter, and she attributes this to the perception that FGC is "a more violent and socially suppressive practice," with "more serious and damaging physical, as well as psychological or social, implications." Since FGC, at least in contemporary Western societies, is not considered to confer any health benefits, it lacks the most compelling rationale in our health-conscious age. MGC, on the other hand, with its ever-changing panoply of advantages, has not only been tolerated as "a minor harm" but frequently encouraged "as part of a particular religious or cultural tradition, or as a measure promoting individual or public health." Hellsten concludes that, "from a human rights perspective, both male and female genital mutilation, particularly when performed on infants or defenseless small children [...] can be clearly condemned as a violation of children's rights,"[7]

Writing from an anthropological rather than an ethical perspective, Kirsten Bell provides a searching critique of the dominant discourses on MGC and FGC and argues that the terms in which the latter is condemned by international agencies require review, and that this scrutiny "must be accompanied by a similar willingness to scrutinize male circumcision and recognition that perceptions of one are fundamentally implicated in understandings of the other." Bell particularly notes the contradictory policies of international health organizations, "which seek to medicalize male circumcision on the one hand, oppose the medicalization of female circumcision on the other, while simultaneously basing their opposition to female operations on grounds that could legitimately be used to condemn the male operations."[8] A similar argument is put forward by R. Charli Carpenter in a brief critique of the double standard inherent in the United Nations' approach to "harmful traditional practices," which, while claiming to be concerned with children, focus exclusively on women and girls and ignore "the most obvious one of all – the genital mutilation of infant boys, euphemistically known as [...] circumcision."[9]

[5] Doriane Coleman, "The Seattle Compromise: Multicultural Sensitivity and Americanization," *Duke Law Journal* 47 (1998): 736.

[6] Jacqueline Smith, "Male Circumcision and the Rights of the Child," in *To Baehr In Our Minds: Essays in Human Rights from the Heart of the Netherlands*, ed. Miëlle Bulterman, Aart Hendriks & Jacqueline Smith (SIM Special No. 21; Utrecht: Netherlands Institute of Human Rights, 1998): 465–98. Available on-line at www.cirp.org /library/legal/smith/

The Dutch national health insurance service then covered circumcision of males, but coverage was withdrawn in 2004 when it was realized that 90 percent of the procedures were done for religious rather than health reasons (www.cirp.org/news /canadianpress12-17-04). At the same time, the Dutch government rejected a call from MP Ayaan Hirsi Ali (herself a Somalian refugee and a victim of FGC) to make male circumcision illegal. The Justice Minister Piet Hein Donner explained that there was a clear difference between the two operations: with male circumcision the foreskin was removed for religious, hygienic or medical reasons and was not a traumatic procedure. Female circumcision, on the other hand, was a form of genital mutilation with serious physical and psychological consequences and could therefore be classified as an abuse (Radio Netherlands, Hilversum, 7 October 2004; seen at www.cirp.org/news /radionetherlands10-07-04). Presumably, if it were shown that male circumcision was also "a traumatic procedure" with "serious physical and psychological consequences" it would also be classified as 'abuse'.

[7] Sirkuu Hellsten, "Rationalising Circumcision: From Tradition to Fashion, from Public Health to Individual Freedom – Critical Notes on the Cultural Persistence of the Practice of Genital Mutilation," *Journal of Medical Ethics* 30 (2004): 248–49, 247.

[8] Kirsten Bell, "Genital Cutting and Western Discourses on Sexuality," 140, 131.

[9] R. Charli Carpenter, "A Response to Bronwyn Winter, Denise Thompson and Sheila Jeffreys, 'The UN Approach to Harmful Traditional Practices: Some Conceptual Problems': Some Other Conceptual Problems," *International Feminist Journal of Politics* 6.2 (2004): 309.

Working along similar lines, but from a legal standpoint, Christine Mason has explored the paradox whereby an adult female (in Australia) cannot elect mutilating forms of cosmetic genital surgery for herself yet has the legal right to alter the penis of her son. She argues that "changes are required to educate against both male and female infant genital surgery whilst also amending the existing legislation in order to permit adult consent to such procedures" and concludes that this would both protect children and allow freedom of minority practices when a person is old enough to give informed consent.[10] Marie Fox and Michael Thomson have addressed what they see as the "problem" of MGC – itself a provocative approach, since most medical discourse on the subject has traditionally pictured the foreskin as the problem and circumcision as the solution. They argue that the reluctance to characterize medically unwarranted MGC as a legal or ethical problem is largely attributable to the way in which it has been defined in contrast to FGC, with the result that FGC of any kind is constructed as morally and legally unacceptable within a civilized society, while MGC is characterized as a standard or even benign medical intervention. As they point out, this dichotomy goes back to the debates over the propriety of genital surgeries as a response to nervous and behavioural problems in the mid-nineteenth century, when "both male and female circumcision were justified in terms of managing sexuality; yet while clitoridectomies soon declined, with other forms of female genital mutilation becoming a focus for domestic and international outrage, male circumcision became routinized."[11]

Central to Fox and Thomson's argument is the concept of the "harm/benefit assessment which lies at the heart of the male circumcision debate," and they suggest that the permissive attitude of legal and ethical authorities derives from traditional constructions of male bodies as resistant to harm or even in need of being tested by painful ordeals, and of female bodies, by contrast, as highly vulnerable and thus in need of greater protection. They criticize the fortress-like separation of MGC from FGC and suggest that the real issue in the debate is child protection: "whether we should be subjecting any children to [...] procedures involving the excision of healthy tissue."[12] In a further paper, Fox and Thomson develop these arguments and criticize

[10] Christine Mason, "Exorcising Excision: Medico-Legal Issues Arising from Male and Female Genital Surgery in Australia," *Journal of Law and Medicine* 9 (2001): 67.

[11] Mary Fox & Michael Thomson, "A Covenant with the Status Quo: Male Circumcision and the New BMA Guidance to Doctors," *Journal of Medical Ethics* 31 (2005): 464.

[12] Fox & Thomson, "A Covenant with the Status Quo," 463, 467.

medical and legal authorities for neglecting the rights of children and failing to undertake a full cost–benefit analysis of the harmful effects that routine circumcision have on males.[13] Oddly enough – and demonstrating the pervasive power of the 'tough male' stereotype – although Fox and Thomson emphasize that MGC is always risky surgery, with a high proportion of adverse outcomes relative to its needfulness, they neglect the most obvious and universally experienced harm of all: the harm of being deprived of an integral, visually prominent, and erotically significant feature of the penis.

A Definitional Issue

Part of the reason for the hostility encountered by Somerville and Bell is related to the problems of definition that hinder objective discussion of surgical modifications – whether forcible or voluntary – to the male and female genitals. This difficulty is vividly expressed in the fact that alterations to the genitals of girls or women are usually referred to as female genital mutilation, while comparable alterations to the genitals of boys and men are designated as circumcision – which sounds, and is evidently meant to sound, far less serious. As we have seen, many of those who deplore operations on women as FGC have no objection to similar surgery on boys. In the traditional African societies that practise these forms of initiations, however, FGC has cultural significance similar to the meanings ascribed to MGC of boys.[14] As Hellsten observes, "all forms of genital alteration" are derived from ideas of the place of human sexuality in society, are intended to alter sexual function in some way, and are performed in the belief that the procedure – no matter how physically injurious – will in some way improve the subject's life.[15] From an ethical perspective, the procedures look even more similar, for, as Bell comments, "each operation involves an unnecessary bodily violation that entails the removal of healthy tissue without the informed consent of the person involved."[16] Moreover, as ritual forms of MGC are medicalized under the influence of Western health agencies and educational institutions, defenders of

[13] Mary Fox & Michael Thomson, "Short Changed? The Law and Ethics of Male Circumcision," *International Journal of Children's Rights* 13 (2005): 161–81.

[14] T.O. Beidelman, *The Cool Knife: Imagery of Gender, Sexuality and Moral Education in Kaguru Initiation Ritual* (Washington DC: Smithsonian Institution Press, 1997), and Philip W. Setel, *A Plague of Paradoxes: AIDS, Culture and Demography in Northern Tanzania* (Chicago: U of Chicago P, 1999), ch. 2.

[15] Sirkku Hellsten, "Rationalising Circumcision," 249–50.

[16] Kirsten Bell, "Genital Cutting and Western Discourses on Sexuality," 130.

male circumcision justify the procedure with medical rationales that are strikingly similar to those used to support excision of female genitalia.

Several countries where excision is common have, under Western pressure, banned the practice, but diehard supporters are now as likely to defend it as a valid measure of health promotion as a cultural necessity. In the Gambia, women have demonstrated in favor of mothers' right to circumcise their daughters, declaring that "female circumcision is our culture"[17] while in Egypt Muslim doctors have stated that the health benefits of female circumcision include reduced sexual desire, lower risk of vaginal cancer and AIDS, less nervous anxiety, fewer infections "from microbes gathering under the hood of the clitoris," and protection against herpes and genital ulcers.[18] Less committed observers point out that proven sequelae include clitoral cysts, labial adhesions, urinary tract infections, kidney dysfunction, sterility, and loss of sexual feeling, but defenders of FGC are claiming no more than what advocates of MGC have asserted for decades.

Considering the similarities between the male and female genitals, the nature of the surgery, the justifications offered, and the support (in Western societies) for the principle that the genders should be treated equally, it may at first seem surprising that male and female circumcision enjoy such strikingly different reputations, at least in anglophone countries. The first is regarded as a mild and harmless adjustment that should be tolerated, if not actively promoted, the second as a cruel abomination that must be stopped by law, no matter how culturally significant to its practitioners. Although the term 'genital cutting' has been introduced in the hope of calming the debate, and while some culture-focused feminist critics have sought to "challenge western polemics,"[19] it is still generally true that not to call circumcision of women or girls female genital mutilation results in accusations of trivializing the offence, but to call circumcision of boys male genital mutilation is likely to elicit accusations of emotionalism, even by those who agree that routine circumcision of males is unnecessary and should generally not be performed.[20] While the World Health Organization (WHO) and other international agencies devote substantial resources on programmes to eradicate FGC, they have

[17] *Daily Observer* (2002).

[18] David Gollaher, *Circumcision: A History of the World's Most Controversial Surgery* (New York: Basic Books, 2000): 193, 195, 199.

[19] *Genital Cutting and Transnational Sisterhood: Disputing U.S. Polemics*, ed. Stanlie M. James & Claire C. Robertson (Chicago: U of Illinois P, 2002).

[20] Robert Nye, "Review of Robert Darby, *A Surgical Temptation*," *Journal of the American Medical Association* 294 (7 December 2005): 2771–72.

been conspicuously silent about the circumcision of boys. It is only in the current decade that male circumcision has been raised as a human rights issue at the United Nations, and to date no serious discussion of the topic has occurred, let alone any action.[21]

It might be thought that the reason for this double standard lies in the greater physical severity of FGC, but this is to confuse cause with effect. On the contrary, it is the tolerant or positive attitude toward male circumcision and the rarity of female circumcision in Western societies that promote the illusion that the operation is necessarily more sexually disabling, and without benefit to health, when performed on girls or women. A second reason for the double standard is that, while circumcision of males is mistakenly thought to designate a single surgical procedure, the term 'female circumcision' is expansive, referring to any one or more of several different procedures. These have been defined by the WHO (1996) as follows:

> Type 1: Excision of the prepuce with or without excision of part or all of the clitoris;
>
> Type 2: Excision of the clitoris together with partial or total excision of the labia minora;
>
> Type 3: Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation);
>
> Type 4: Unclassified (includes a wide variety of mutilations not falling into Types 1 through 3).

The severity of female circumcision depends on which of, as well as how crudely, these operations are performed, and it is true that the most extreme forms (involving the amputation of the external genitalia, with or without infibulation) are significantly worse than even the most radical foreskin amputation. But it should be remembered that the most extreme forms of female circumcision are comparatively rare, and that male circumcision in general is far more common on a world scale than female: about 13 million boys, compared

[21] See J. Steven Svoboda, "Male Circumcision," paper submitted to the Sub-Commission for the Promotion and Protection of Human Rights, 9 August 2001, United Nations Document No. E/CN.4/Sub.2/2002/1 (23 March 2002), and Svoboda, "Educating the United Nations About Male Circumcision," in *Flesh and Blood: Perspectives on the Problem of Circumcision in Contemporary Society*, ed. George C. Denniston, Marilyn F. Milos & Frederick M. Hodges (New York: Kluwer Academic/Plenum, 2004).

with two million girls annually.[22] Quantity is not the whole story, but the vigorous efforts to protect the two million girls contrast sharply with the absence of interest in protecting the larger number of boys.

But the effects of MGC are also highly unpredictable, depending on how much penile tissue is removed, on the skill of the surgeon, on the precise configuration of penile blood vessels and nerve networks, on the genetically determined length of the foreskin, and on the eventual size attained by the penis at puberty and maturity. The more tissue excised, the greater the damage to the penis and the greater the effect on sexual functioning and capability. Although equivalent quantities of tissue may be lost, outcomes will be worse in cases where the penis grows larger in maturity, where the infant or boy has only a short foreskin, or where the unpredictable locations of blood vessels and nerves mean that important connections are severed. Because the slack ('redundant') surface tissue is needed to accommodate the enlarged penis when tumescent, a severe circumcision will render erections painful or even impossible.[23] A further common outcome among boys circumcised in infancy, especially when the operation excises a large quantity of penile shaft skin (as is the American norm, particularly when the Gomco clamp is used), is that scrotal skin gets pulled up onto the penis shaft as the wound heals, and even more when the penis enlarges at puberty. Such men often present both sebaceous glands and pubic hair on their penis, sometimes growing as far up as the line of the former frenulum.[24]

[22] George C. Denniston, Frederick M. Hodges & Marilyn F. Milos, "Introduction" to *Understanding Circumcision: A Multi-Disciplinary Approach to a Multi-Dimensional Problem*, ed. Denniston, Hodges & Milos (London: Kluwer Academic/Plenum, 2001): v. Since accurate statistics on circumcision are not kept, these figures are the roughest of estimates, though it can be said that the vast majority of these boys are from Muslim families, most of whom probably undergo the operation between the ages of four and eight.

[23] Gregory J. Boyle, Ronald Goldman & J. Steven Svoboda, "Male Circumcision: Pain, Trauma and Psychosexual Sequelae," *Journal of Health Psychology* 7.3 (2002): 329–43; Tim Hammond, "A Preliminary Poll of Men Circumcised in Infancy or Childhood," *BJU International* 83 (Supplement 1; January 1999): 85–92; Shane Peterson, "Assaulted and Mutilated: A Personal Account of Circumcision Trauma," in *Understanding Circumcision*, ed. Denniston, Hodges & Milos, 271–90; John Warren et al., "Circumcision of Children," *British Medical Journal* 312 (1996): 37; and N. Williams & L. Kapila, "Complications of Circumcision," *British Journal of Surgery* 80 (1993); 1231–36.

[24] Such men experience further discomfort with erections and find particular difficulty using condoms. The hair can also inflict abrasion and discomfort on sexual partners. For graphic illustrations of just how much damage routinely circumcised penises commonly sustain, and how different they look from uncircumcised penises, see the images at www.circumstitions.com/Botched1.html and www.circumstitions.com/comparison.html. If a man presented at his General Practitioner with these sorts of injuries – scarring, granulated tissue, skin bridges where raw tissue surfaces have fused, distortion – on any part of his body other than his penis, he would be referred, urgently, to a plastic surgeon. But so normal are these results that many of the images have been taken from pornographic magazines and personal ads on sexual contact websites. See Christopher J. Cold & John R. Taylor, "The Prepuce," *BJU International* 83 (Supplement 1, January 1999): 34–44, John Money & Jackie Davison, "Adult Penile Circumcision: Erotosexual and Cosmetic Sequelae," *Journal of Sex Research* 19 (1983): 289–92, John R. Taylor, A.P. Lockwood & A.J. Taylor, "The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision," *British Journal of Urology* 7 (1996): 291–95, and Gérard Zwang, "Functional and Erotic Consequences of Sexual Mutilations," in *Sexual Mutilations: A Human Tragedy*, ed. George C. Denniston & Marilyn F. Milos (New York: Plenum, 1997): 77–84.

Is It Possible to Classify the Types of Male Genital Cutting?

Selecting appropriate terminology to discuss genital alteration may at first appear a straightforward task, but, while much effort has gone into categorizing the types of female genital alteration, surgeries on the penis are classified by a single term. Because MGC, even when non-therapeutic, is construed as harmless, there have been few efforts to provide male circumcision with a classification system similar to that constructed for female circumcision; yet in principle such a project should be no more difficult than devising a scale to measure damage to female genitals. Some attempts have already been made: Hanny Lightfoot-Klein has set out the similarities,[25] and the Swiss/Palestinian authority, Dr Sami Aldeeb, has offered the following:

> Type 1: This type consists of cutting away in part or in totality the skin of the penis that extends beyond the glans. This skin is called foreskin or prepuce.
>
> Type 2: This type is practiced mainly by Jews. The circumciser takes a firm grip of the foreskin with his left hand. Having determined the amount to be removed, he clamps a shield on it to protect the glans from injury. The knife is then taken in the right hand and the foreskin is amputated with one sweep along the shield. This part of the operation is called the *milah*. It reveals the mucous membrane (inner lining of the foreskin), the edge of which is then grasped firmly between the thumbnail and index finger of each hand, and is torn down the center

[25] Hanny Lightfoot-Klein, *Prisoners of Ritual: An Odyssey into Female Genital Circumcision in Africa* (New York: Harrington, 1989).

> as far as the corona. This second part of the operation is called *periah*. It is traditionally performed by the circumciser with his sharpened fingernails.
>
> Type 3: This type involves completely peeling the skin of the penis and sometimes the skin of the scrotum and pubis. It existed (and probably continues to exist) among some tribes of South Arabia. Jacques Lantier describes a similar practice in black Africa, in the Namshi tribe.
>
> Type 4: This type consists in a slitting open of the urinary tube from the scrotum to the glans, creating in this way an opening that looks like the female vagina. Called subincision, this type of circumcision is still performed by the Australian aborigines.[26]

Dr. Aldeeb deserves credit for venturing into terra incognita, but such a mixture of broad and specific categories fails to include the full range and variety of circumcision procedures, yet also identifies operations that are vanishingly rare. The vast majority of circumcision procedures today, especially those performed in hospitals and clinics, fall under none of these headings, while Types 3 and 4 are confined to a very few traditional (tribal) societies and are little more than anthropological curiosities. If the intention was to include all types of penile mutilation, mention should have been made of infibulation, piercing, and the various 'enhancements' found in Southeast Asia.[27] The classification also leaves out the relatively mild forms of penile mutilation, such as slitting of the foreskin without excision of tissue, that are

[26] Sami A. Aldeeb Abu-Sahlieh, *Male and Female Circumcision among Jews, Christians and Muslims: Religious, Medical, Social and Legal Debate* (Warren Center PA: Shangri-La, 2001): 9.

[27] See Terence Hull & Meiwita Budiharsana, "Male Circumcision and Penis Enhancement in Southeast Asia: Matters of Pain and Pleasure," *Reproductive Health Matters* 9 (2001): 60–67. It is an interesting sidelight on anglophone attitudes that, while anthropologists have devoted much time and ink to the origins and meaning of genital cutting rites, they have neglected the equally (and possibly more) numerous societies that practised various forms of foreskin elongation or otherwise sought to conceal rather than uncover the glans – anything from the penis sheaths and gourds of New Guinea and Melanesia to the infibulation of slaves in classical Rome and the modesty-preserving *kynodesme* in ancient Greece. See Eric Dingwall, *Male Infibulation* (London: John Bale, 1925), and Frederick M. Hodges, "The Ideal Prepuce in Ancient Greece and Rome: Male Genital Aesthetics and their Relation to Lipodermos, Circumcision, Foreskin Restoration and the Kinodesme," *Bulletin of the History of Medicine* 75 (2001): 375–405.

(or were) found in the Philippines[28] and certain Pacific islands, such as Samoa and Fiji. We write "were found" because as these procedures are medicalized (no longer performed as a traditional rite, but as minor surgery in a clinic by trained medical personnel), it is apparent that they are becoming more severe: no longer a mere dorsal slit, but a full-scale foreskin amputation on the US model – that is, tearing or otherwise separating the foreskin from the glans, stretching it to a lesser or greater degree, and cutting roughly at the line of the corona. Although the setting may be more hygienic and complications such as bleeding and infection reduced, the effect of medicalization is a more damaging surgical outcome. In the developed world, the great diversity in surgical outcomes is the result of the differing techniques applied, the instruments used, and the preferences of the surgeon or other operator.

More seriously, Aldeeb's classification neglects the vital fact that there is no precise definition of the foreskin and thus no precise definition of what is removed by MGC. The foreskin is not a discrete organ like a finger or pancreas, but a double-layered extension of the surface tissue of the penis; where the foreskin starts and the rest of the penis ends is a matter for judgement. The foreskin is generally described as a cap that fits over the glans, but the foreskin often extends beyond the glans (it always does so in juveniles), and the point at which the doubling of the tissue begins can be anywhere along the penis shaft and shifts according to the degree of tumescence. On average, the doubling of tissue begins well beyond the corona of the glans, as the position of the circumcision scar on cut men (usually seen at about half an inch to an inch below the glans) testifies. Moreover, the length of the foreskin varies enormously from one individual to another, meaning that the same 'standard' cut will be more severe on a boy with a short foreskin than on one who had more tissue to begin with. Since the severity and harm of the surgery depends primarily on how much of the loose penile tissue is removed, and whether it is mainly the outer (skin) layer or the inner (mucous membrane) layer, MGC Types 1 and 2 listed above can easily be broken down into an indefinite number of divisions (10, 20, 30 percent, etc., of the foreskin), with both the visible damage and the impact on sexual sensation and sexual function increasing at each step.

The severity of the operation is also affected by whether it removes the frenulum, the sensitive 'bridle' on the underside of the penis, adjoining the cleft in the glans. This is now known as the frenular delta and is understood to

[28] Romeo B. Lee, "Filipino Experience of Ritual Male Circumcision: Knowledge and Insights for Anti-Circumcision Advocacy," *Culture, Health & Sexuality* 8.3 (2006): 225–34.

support one of the body's densest concentrations of fine-touch nerve receptors, whose specific function is to detect and transmit pleasurable touch.[29] Because the ridged band is also uniquely ridged or corrugated, retraction and stretching of this accordion-like structure may play an important role in penile reflexes, including urination, erection, and ejaculation.[30] Where the foreskin is still adherent, as it is in nearly all infants and commonly in boys up to the age of about eight, forcibly tearing it from the glans adds a further dimension of both pain and injury (including skin bridges and adhesions). The damage often extends to the parts of the penis that remain, and the pain is severe.[31] Nor is it just a matter of losing nerve-endings: the destruction of the sliding mechanism of the foreskin back and forth over the glans, and thus of the stimulation and lubrication it affords, is another serious effect of MGC. Yet it is a harm that cannot be picked up by the sort of 'sensitivity studies' that have appeared in the wake of Masters and Johnson's much cited but deeply flawed study (1966).[32]

In order to assist the development of an objective measuring stick for MGC damage we suggest the following provisional five-point scale:

> Type 1: A nick to or slitting of the foreskin; or premature or forcible separation of the prepuce from the glans, without amputation of tissue.
>
> Type 2: Amputation of the portion of the foreskin extending beyond the glans.

[29] See Christopher J. Cold & John R. Taylor, "The Prepuce," *BJU International* 83 (Supplement 1, January 1999): 34–44, Kenneth A. McGrath, "The Frenular Delta: A New Preputial Structure," in *Understanding Circumcision*, ed. Denniston, Hodges & Milos, 199–206, and John R. Taylor, A.P. Lockwood & A.J. Taylor, "The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision," *British Journal of Urology* 7 (1996): 291–95.

[30] See John R.Taylor, "The Forgotten Foreskin and its Ridged Band," *Journal of Sexual Medicine* 4.5 (September 2007): 1516.

[31] See Anna Taddio, Joel Katz, A. Lane Ilersich & Gideon Koren, "Effect of Neonatal Circumcision on Pain Response During Subsequent Routine Vaccination," *Lancet* 349/9052 (1997): 599–603.

[32] For critiques of Masters and Johnson, see John M. Foley, *The Practice of Circumcision: A Revaluation* (New York: Materia Medica, 1966); Frederick M. Hodges & Paul Fleiss, "Letter," *Pediatrics* 105.3, Part 1 (2000): 683–84; Morris L. Sorrells, James L. Snyder, Mark D. Reiss et al., "Fine-Touch Pressure Thresholds in the Adult Penis," *BJU International* 99 (2007): 864–69, and the incisive deconstruction by Hugh Young, "Like Being Hugged by the Venus de Milo: The Foreskin, Circumcision and Sexuality," online: www.circumstitions.com/Sexuality.html (accessed 6 July 2006).

> Type 3: Amputation of the foreskin at a point partway along the glans; some foreskin and all of the frenulum left; some sliding functionality retained.
>
> Type 4: Amputation of the foreskin at or below the corona of the glans.
>
> Type 5: Other forms of penis mutilation, including meatotomy, subincision, infibulation, piercing and implants.

Type 2 corresponds to the original Judaic operation of *bris* (before the institution of *periah* – tearing the foreskin from the glans – in the Hellenic period);[33] most of the foreskin and all of the frenulum left; a fair degree of sliding functionality retained. When this procedure is performed after infancy, after separation of prepuce from glans, more of the preputial tissue and some of the frenular tissue tends to be cut.

Because there is no agreed understanding of circumcision and the results are highly variable, depending on the quantity of tissue removed, the degree to which the foreskin is stretched during the operation, and the instruments used, it is useful to break Type 4 into three subtypes.

> Type 4A: Amputation of the foreskin at the corona of the glans, leaving glans fully exposed, but retaining frenulum; little or no sliding functionality; frenular nerves retained.
>
> Type 4B: Amputation of the foreskin at the corona of the glans, also excising frenulum; little or no sliding functionality; no frenular nerves left.
>
> Type 4C: Amputation of the foreskin beyond the corona of the glans, at any point along the penis shaft; all foreskin and variable quantities of shaft skin excised; all frenular nerves lost; zero sliding functionality; high risk of insufficient slack tissue for accommodating tumescence.

It would be interesting to know the proportion of MGC operations falling into each of these categories. The vast majority would probably be the most severe, Type 4, and possibly Types 4B and 4C, particularly in the USA, where the 'high and tight' look is favoured by the obstetricians and urologists who perform most of the procedures, and whose preference is facilitated by

[33] See Leonard Glick, *Marked in Your Flesh: Circumcision from Ancient Judea to Modern America* (New York: Oxford UP, 2005): 31, 43–45.

the infamous Gomco clamp, a device that ensures maximum loss of tissue, as well as a slow and painful operation.[34]

With respect to FGC, it is also possible to break the WHO's definition down more precisely into at least seven procedures: a nick to the clitoris; separation of the clitoral hood or prepuce, without amputation of tissue; removal of the clitoral hood; excision of part or all of the labia minora; excision of part or all of the labia majora; excision of part or all of the clitoris; stitching up the vaginal orifice.

The main difference between female and male genital cutting can now be seen to consist in the fact that the severity of FGC increases as the number of procedures rises, thus bringing more parts of the genitals under the knife; while the severity of MGC primarily depends on how much of a single element of the genitals is amputated. It is the variety of the procedures constituting FGC, in contrast to the unitary nature of MGC, which promotes the illusion that the first is a cruel and injurious form of torture called mutilation, while the second is a mild surgical adjustment called circumcision.

Effects on Sexual Function

The effects of female circumcision and male circumcision on sexual function are variable and uncertain. It is commonly said by opponents of female circumcision that the operation, especially in its extreme forms, destroys all sexual sensation and can even reduce or eliminate sexual desire. The dominant view would still be that of Ruth Macklin: "Most (but not all) women permanently lose the ability to achieve sexual pleasure."[35] This assertion was originally questioned by Lightfoot-Klein, and her doubts have been confirmed by others.[36] Lightfoot-Klein has documented that many infibulated

[34] See Leonard Glick, *Marked in Your Flesh*, 196–97, R.L. Miller & D.C. Snyder, "Immediate Circumcision of the Newborn Male," *American Journal of Obstetrics and Gynaecology* 65 (1953): 1–11, and Julian Wan, "Gomco Circumcision Clamp: An Enduring and Unexpected Success," *Urology* 59 (2002): 790–94.

[35] Ruth Macklin, *Against Relativism: Cultural Diversity and the Search for Universals in Medicine* (New York: Oxford UP, 1999): 67.

[36] Lightfoot-Klein, *Prisoners of Ritual* (1989). See, for example, I.O. Orubuloye, Pat Caldwell & John C. Caldwell, "Female 'Circumcision' Among the Yoruba of Southwestern Nigeria: The Beginning of Change," in *Female "Circumcision" in Africa: Culture, Controversy, and Change*, ed. Bettina Shell-Duncan & Ylva Hernlund (Boulder CO & London: Lynne Rienner, 2000): 73–107; Bettina Shell-Duncan, W.O. Obiero & L.A. Muruli, "Women Without Choices: The Debate Over Medicalization of

women (i.e. women who have had the most severe form of FGC performed on them) retain a significant capacity for sexual pleasure.[37] In the case of FGC, some Kenyan Rendille women insisted that sex was actually better after being circumcised; among the Rendille[38] and the Yoruba of Nigeria,[39] few women believed their capacity for enjoyment had been reduced.

A study by F.E. Okonofua and colleagues (2002) in Nigeria examined 1836 women who had been subjected to FGC of type 1 (71 percent) or type 2 (24 percent). They found no significant differences between cut and uncut women in the frequency of reports of sexual intercourse in the preceding week or month, the frequency of reports of early arousal during intercourse, and the proportions reporting experience of orgasm during intercourse. There was also no difference between cut and uncut women in their reported ages of menarche, first intercourse, or first marriage in the multivariate models controlling for the effects of socio-economic factors. The authors accordingly concluded that female genital cutting did not attenuate sexual feelings, though the practice could render women more vulnerable to adverse health outcomes, particularly reproductive-tract infections. The final conclusion – that "female genital cutting cannot be justified by arguments that suggest that it reduces sexual activity in women and prevents adverse outcomes of sexuality"[40] – will probably seem curious to Western readers. Okonofua and colleagues are saying that arguments in favour of female circumcision on the grounds that it curtails sexual activity and inhibits the inclination to promiscuity are invalid, because female circumcision does not have these effects. It must be assumed that, although their article was ultimately published in a British medical journal, they were primarily addressing a Nigerian audience who believe that female sexual activity should be restricted and that FGC is an efficient means to this end. The contrast between this perspective and Western discourse is striking: Articles in American medical journals or mass media that find or

Female Genital Cutting and Its Impact on a Northern Kenyan Community," in *Female "Circumcision" in Africa* (2000), ed. Shell-Duncan & Hernlund, 109–28; F.E. Okonofua et al., "The Association Between Female Genital Cutting and Correlates of Sexual and Gynaecological Morbidity in Edo State, Nigeria," *BJOG: An International Journal of Obstetrics and Gynaecology* 109.10 (October 2002): 1089–96.

[37] Lightfoot-Klein, *Prisoners of Ritual*, 80–102.

[38] Shell-Duncan, Obiero & Muruli, "Women Without Choices," 118.

[39] Orubuloye, Caldwell & Caldwell, "Female 'Circumcision' Among the Yoruba of Southwestern Nigeria," 84.

[40] F.E. Okonofua et al., "The Association Between Female Genital Cutting and Correlates of Sexual and Gynaecological Morbidity in Edo State, Nigeria," 1089.

report that circumcision makes little or no difference to male sexual activity often present this as a positive reason why the procedure should be performed.

There is even evidence that female genital cutting may sometimes have 'health benefits'. A study of immigrant Somalian and Ethiopian women in Sweden found that women who had undergone severe FGC (excision of clitoris, labia minora, and parts of the labia majora, followed by infibulation) had significantly shorter labour times than an uncircumcised control group.[41] A culture that wanted to promote female circumcision for religious or other customary reasons could claim this result as proof of a health benefit from circumcision, and thus as a medical or even 'scientific' reason why it should be performed. The authors' conclusion, that "prolonged labour does not seem to be associated with female genital circumcision in affluent societies with high standards of obstetric care," emphasizes the point that these women were giving birth in a modern Western maternity hospital and had been de-infibulated before delivery. It would no doubt be a different story in their home village.

In contrast to the conventional view of the sexually 'blinding' effects of FGC, advocates of male circumcision insist that the procedure has no meaningful impact on sexual sensation, or even that it improves a male's sex life.[42] Much of the latter argument is based (by analogy with the clitoris) on the anatomically erroneous assumption that the most intense innervation of the penis is in the glans. It is now known that the densest concentrations of blood vessels and nerves is found in the foreskin itself, while the glans is relatively insensitive and equipped mainly to detect discomfort and pain – as Henry Head and colleagues discovered nearly a century ago:

> The glans penis is an organ endowed with protopathic and deep sensibility only. It is not sensitive to cutaneous tactile stimuli [...]. Sensations of pain evoked by cutaneous stimulation are diffuse and more unpleasant than over normal parts.[43]

[41] Birgitta Essén et al., "No Association Between Female Circumcision and Prolonged Labour: A Case Control Study of Immigrant Women Giving Birth in Sweden," *European Journal of Obstetric and Gynecological Reproductive Biology* 121 (2005): 182–85.

[42] It can, in certain rare cases, such as severe tightness or shortness of the frenulum, though less drastic or even nonsurgical methods of treating these problems are now readily available.

[43] See Henry Head et al., *Studies in Neurology* (London: Oxford U P, 1920): 274–77.

Head also found that the sensitivity of the glans was not significantly affected by MGC, a finding that largely nullifies many of the studies since Masters and Johnson, most of which have sought to do no more than this.[44]

The overwhelming consensus from ancient times until the eighteenth century, however, has been that the foreskin makes a major contribution to sexual sensation and function.[45] In fact, it is precisely the erotic significance of the foreskin that explains the determination of nineteenth-century doctors to remove it in order to discourage unauthorized forms of sexual activity, such as masturbation. Observing that boys masturbated by manipulating their foreskin and girls by stimulating their clitoris, the physicians concluded that male circumcision and clitoridectomy were the appropriate responses to stop these forms of behaviour. Sander Gilman has noted that the late-nineteenth-century German authority Hermann Rohleder advocated circumcision for male masturbators and burning of the clitoris with acid for female; Gilman comments that "circumcision and clitoridectomy were seen as analogous medical proce-

[44] For a sample of recent research, see Kenneth S. Fink, Culley C. Carson & Robert F. DeVellis, "Adult Circumcision Outcomes Study: Effect on Erectile Function, Penile Sensitivity, Sexual Activity and Satisfaction," *Journal of Urology* 167.5 (May 2002): 2113–16, Clifford B. Bleustein, Haftan Eckholdt, Joseph C. Arezzo & Arnold Melman, "Quantitative Somatosensory Testing of the Penis: Optimizing the Clinical Neurological Examination," *Journal of Urology* 169.6 (June 2003): 2266–69, and Shikohe Masood, H.R.H. Patel, R.C. Himpson et al., "Penile Sensitivity and Sexual Satisfaction after Circumcision: Are We Informing Men Correctly?" *Urologia Internationalis* 75.1 (2005): 62–65. It will be noted that most of these studies refer to circumcision in adulthood, the effects of which cannot necessarily be extrapolated to circumcision in infancy or childhood, when neuronal pathways that depend on nervous stimulation are not developed; Ronald S. Immerman & Wade C. Mackey, "A Biocultural Analysis of Circumcision," *Social Biology* 44 (1997): 265–75, and "A Proposed Relationship Between Circumcision and Neural Reorganisation," *Journal of Genetic Psychology* 159 (1998): 367–78. Given the minuteness of the parts in infancy, and the adherence of foreskin to glans, the operation is both riskier and more damaging the earlier it is done; M. Machmouchi & A. Alkhotani, "Is Neonatal Circumcision Judicious?" *European Journal of Pediatric Surgery* 17 (2007): 266–69. Circumcision in the Philippines was traditionally done at any age from nine to sixteen, but never before the foreskin was found to be fully separated and retractable – see Samuel Ramos & Gregory J. Boyle, "Ritual and Medical Circumcision Among Filipino Boys: Evidence of Post-Traumatic Stress Disorder" (2001), in *Understanding Circumcision*, ed. Denniston, Hodges & Milos, 253–70. In this requirement, tradition showed far better medical sense and humane consideration than 'scientific' medicine.

[45] See Robert Darby, *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain* (Chicago: U of Chicago P, 2005): ch. 2.

dures."[46] The inescapable conclusion is that, while the glans/clitoris and foreskin/clitoral prepuce may be anatomically analogous, the correct analogy in functional or physiological terms is foreskin/clitoris.

It is stretching common sense and ignoring all we know about biological form and function to propose that circumcision does not affect sexual functionality. As Sorrells et al. have shown,[47] circumcised men have significantly reduced fine-touch sensitivity compared with intact men. Male circumcision will usually reduce the pleasure of fine touch and gentle manipulation by excising the relevant nerves, found only in the part of the penis that circumcision removes – the foreskin. Sexual pleasure is a highly subjective experience, and it is proving very difficult to measure it any quantitative way, but it seems reasonable to conclude that MGC, like FGC, does not typically eliminate the capacity for sexual pleasure, and that in most cases it does not inhibit erection or ejaculation, though a severe operation will result in these outcomes. These points are sometimes presented as a positive reason for male circumcision, but much the same can of course be said of female circumcision.

Toward Gender Equity?

Given the respective numbers affected and the fact that some male circumcision outcomes are worse than some instances of female circumcision, there is no justification for perpetuating the gender discrimination that has characterized discussion of these issues. Indeed, a female victim of forced circumcision during a 'holy war' by Islamic extremists in Indonesia commented afterwards that what was done to the men was worse than what the women suffered:

> I know the men suffered more than us women. The circumcision hurt them more that it did to us because their scars could not heal fast. Several of the men I knew got serious infections after suffering from severe bleeding.[48]

[46] Sander Gilman, *Freud, Race and Gender* (Princeton NJ: Princeton UP, 1993): 65.

[47] Sorrells, Snyder, Reiss et al., "Fine-Touch Pressure Thresholds in the Adult Penis."

[48] The men experienced greater harm – the women suffered only nicks to their clitoris, while the men had their entire foreskin amputated. See Lindsay Murdoch, "Victims Tell Harrowing Tales of Forced Circumcision in the Growing Holy War in Indonesia's Maluku Islands," *Sydney Morning Herald* (27 January 2001).

Such a statement would come as a shock to Kirsten Bell's students, who "did not think that carving up male genitalia had any damaging effects on male sexuality so long as [...] the man retained the ability to ejaculate"; the only procedure they considered at all equivalent to any form of FGC was amputation of the penis.[49]

Since male circumcision is amputation of part of the penis, such an attitude is possible only if the foreskin and the rest of the penis are regarded as separate entities. Before the nineteenth century, the penis was seen as a unitary structure consisting of an erectile and a non-erectile element, corresponding to the corpus cavernosa and the foreskin respectively. The first element penetrated, the second conveyed the pleasurable sensations that preceded orgasm. By the end of the nineteenth century, with the rise of male circumcision, the penis was seen as consisting only of the erectile portion, and the foreskin as an extraneous and redundant accretion.[50] As Juliet Richters points out,[51] this figurative circumcision was facilitated by the conceptualization of the penis as a battering ram only (something rock-hard and actively 'masculine'), not an organ that was expected to receive pleasurable sensation (implying something suspiciously soft and passively 'feminine'). In this way, 'scientific' medicine converged with the mythology of tribal societies such as the Dogon of Mali, who regard male circumcision and clitoridectomy as necessary measures to destroy femininity in the male and masculinity in the female.[52] By contrast, in Western discourse even the slightest interference with the female genitals is likely to be regarded as disabling, or at least as an intolerable violation, as illustrated by a revealing episode in Seattle in the early 1990s. Confronted by demands from African immigrants to circumcise their little girls, the Harborview Medical Center sought to demonstrate both its cultural sensitivity and its concern for child welfare by finding a middle course, and a group of doctors agreed to consider making a nick in the clitoral hood, without removing any tissue. But even this mild compromise proved unacceptable to the local community: After being flooded with protests, the hospital abandoned its plan.[53]

[49] Kirsten Bell, "Genital Cutting and Western Discourses on Sexuality," 127.

[50] See Robert Darby, *A Surgical Temptation*, 67, 167-72, 324 n.78.

[51] Juliet Richters, "Circumcision and the Socially Imagined Sexual Body," *Health Sociology Review* 15 (2006): 248–57.

[52] See David Gollaher, *Circumcision: A History of the World's Most Controversial Surgery* (New York: Basic Books, 2000): 70.

[53] Ruth Macklin, "Ethical Relativism in a Multicultural Society," *Kennedy Institute of Ethics Journal* 8 (1998): 14.

Boys have often been treated with less solicitude. If, as Fox and Thomson argue, the male body in general is regarded as less susceptible to injury than the female, the penis seems to be the most invulnerable part of all, nearly any injury to which (short of amputation) is construed as harmless. The authors report a British legal case from 1974 in which a Nigerian woman was convicted of assault occasioning actual bodily harm for having scarred her two sons (aged fourteen and nine) by making incisions with a razor on their cheeks in accordance with the scarification custom of the Yoruba tribe to which she belonged. The court held that this practice carried the potential for serious injury to the eyes if the boys had moved their heads, and suggested that it was this risk that distinguished the practice from the ritual male circumcision also practised by the tribe, which it accepted as perfectly lawful.[54] Yet there are many reported cases in which a boy undergoing MGC has not merely faced the potential of losing his penis but really has lost it, either by amputation during the surgery or from subsequent infection.[55] On the basis of the court's reasoning, MGC should thus be considered at least as unlawful as the slashing of cheeks, assuming that loss of a penis is at least as harmful as reduced vision.

The Lessons of History

To compare female and male circumcision is not to trivialize the enormity of the first, as some feminists seem to fear, but to recognize that the physical similarities between the two are real and that they share a similar cultural logic – so much so that they deserve equally rigorous ethical scrutiny. Since

[54] Mary Fox & Michael Thomson, "Short Changed? The Law and Ethics of Male Circumcision," *International Journal of Children's Rights* 13 (2005): 178 n.12.

[55] See John Colapinto, *As Nature Made Him: The Boy Who Was Raised as a Girl* (New York: HarperPerennial, 2001). In South Africa, ritual circumcision among the Xhosa is responsible for dozens of deaths each year, as well as for hundreds of horrific penile injuries, leading to a plea from the South African Medical Association for action "to halt the carnage" (South African Medical Association 2003). See also Pat Sidley, "Botched Circumcisions Kill 14 Boys in a Month," *British Medical Journal* 333 (8 July 2006): 62. Willis reports that the extreme penile mutilations (entailing subincision as well as circumcision) practised by the Pitjantjatjara people of the central Australian desert have severely inhibiting effects on the men's sex lives. The frequent bloodletting required must also pose grave risks of infection. See Jon Willis, "Heteronormativity and the Deflection of Male Same-Sex Attraction Among the Pitjantjatjara People of Australia's Western Desert," *Culture, Health and Sexuality* 5.2 (2003): 137–51.

many feminists come from countries where male circumcision is tolerated or even the norm, such as the USA, campaigners against female circumcision are inclined to stress how much worse it is than male circumcision, and in the process they tend to excuse or even affirm the latter.[56]

It is remarkable how closely the terms of the current discussion re-create debates surrounding Isaac Baker Brown, the mid-Victorian exponent of clitoridectomy as a cure for masturbation and nervous complaints. Brown's opponents similarly chose to isolate the case against clitoridectomy from the case for male circumcision, playing up the harm of the former while minimizing the impact of the latter; as the *Medical Times and Gazette* editorialized, clitoridectomy was infinitely worse than male circumcision because "Instead of taking away a loose fold of skin it removes a rudimentary organ of exquisite sensitiveness, well supplied with blood vessels and nerves, and the operation is [...] occasionally attended with serious bleeding; in these respects it differs widely from circumcision."[57]

Nobody today would agree with Brown's insistence that clitoridectomy was no more than circumcision of the female, but his assertion that "as certainly as that no man has been injured in his natural functions, so it is equally certain that no woman who has undergone the operation of excision of the clitoris has lost one particle of the natural function of her organs" shows that he was at least consistent: so long as a male or female remained capable of impregnating or conceiving, neither had been mutilated. The *Medical Times and Gazette* did not, however, produce a very convincing argument for the distinction between male circumcision and clitoridectomy: the foreskin is also an organ endowed with "exquisite sensitiveness, well supplied with blood vessels and nerves," and MGC, too, is "occasionally attended with serious bleeding," sometimes resulting in death, even today. Because the debate over clitoridectomy was conducted in terms of its difference from or similarity to male circumcision, the medical profession's rejection of the former cleared the way for the widespread adoption of the latter. The result has been a double

[56] We support the efforts of feminists to combat FGC, and we appreciate that FGC holds its prominent place in feminist discourse because it has become the symbol par excellence of patriarchy and the cruellest instance of male power over and violence toward women. But we would point out that in patriarchal societies it is not only the women who are oppressed, but also the young men, who can attain adult (oppressor) status and access to women only by completing arduous and often painful initiation ordeals. This is the main reason why young men in societies that practise circumcision around puberty look forward to the rite.

[57] "Editorial: Clitoridectomy and Medical Ethics," *Medical Times and Gazette* (13 April 1867): 391.

standard on genital alteration that has endured to this day.[58] So persistent has it been that we now find the WHO conducting two quite separate research projects: one to find evidence for the harm of female circumcision, another to find evidence for the benefits of male circumcision. Naturally, each comes up with the goods, since the result is guaranteed by the starting assumption.

This is the fundamental reason why Western agencies like the United Nations and the WHO have defined FGC as an atrocity that must be stopped, while ignoring the comparable operation on boys. The answer is historical, relating to our comfort with the familiar, the example of the Jewish people, and the relentless devaluation of the foreskin as a body part. Millennia of Semitic custom and a century of routine MGC in English-speaking countries have desensitized us into seeing the procedure as a mild adjustment and the result as acceptably normal. It took decades for pro-circumcision doctors to institutionalize MGC, but it was always easier to win acceptance for that procedure than for similar operations on females because it was mentioned in the Old Testament. While the Jews were seen as proto-Christians, and (both in the USA and Britain) increasingly admired as exemplars of sanitary wisdom as the nineteenth century advanced,[59] circumcision of girls was perceived as an outlandish rite, performed by obscure barbarians whose example did not warrant emulation. This was despite the fact that some Victorian authorities condemned masturbation by girls nearly as vigorously as among boys, and a variety of genital surgeries was recommended and sometimes performed.[60] By the 1890s, however, a British enthusiast was reluctantly forced to conclude that these remedies had been found "ineffectual and unsatisfactory" (Yellowlees 1892). In the USA, by contrast, doctors performed a variety of operations on the female genitals to cure nervous and other complaints until the 1950s,[61]

[58] See Ornella Moscucci, "Clitoridectomy, Circumcision and the Politics of Sexual Pleasure in Mid-Victorian Britain," in *Sexualities in Victorian Britain*, ed. Andrew H. Miller & James Eli Adams (Bloomington: Indiana UP, 1996): 60–78, Robert Darby, "The Benefits of Psychological Surgery: John Scoffern's Satire on Isaac Baker Brown," *Medical History* 51 (2007): 527–44, and Darby, *A Surgical Temptation*, ch. 7.

[59] See Leonard Glick, *Marked in the Flesh*, ch. 6.

[60] See Frederick M. Hodges, "A Short History of the Institutionalization of Involuntary Sexual Mutilation in the United States," in *Sexual Mutilations: A Human Tragedy*, ed. George C. Denniston & Marilyn F. Milos (New York: Plenum, 1997): 17–40.

[61] For example, Benjamin E. Dawson, "Circumcision in the Female: Its Necessity and How to Perform It," *American Journal of Clinical Medicine* 22.6 (1915): 520–23, Belle C. Eskridge, "Why Not Circumcise the Girl as Well as the Boy?" *Texas State Journal of Medicine* 14 (May 1918): 17–19, C.F. McDonald, "Circumcision of the Female," *General Practitioner* 18.3 (September 1958): 98–99, and W.G. Rathmann,

while as late as the mid-1970s female circumcision (here meaning excision of the clitoral hood) was being recommended as an enhancement by some medical journals[62] and popular magazines.[63]

Changing attitudes to the body also played a role in promoting MGC. Where the foreskin (at least up until the mid-nineteenth century) had been valued as "the best of your property,"[64] Victorian doctors succeeded in "reconfiguring the phallus,"[65] thereby demonizing it as a source of moral and physical decay. They fully appreciated the importance of the mobility of the loose penile tissue (foreskin) for sexual functionality.[66] The clitoris, by contrast, was so highly regarded that many obstetricians considered it part of their duty to enlighten women as to its importance: Regretting that so few women seemed alive to its potential, one of Baker Brown's opponents commented:

> I am sorry that females have not as much knowledge of the clitoris as we have, for if that were the case I am sure there were very few who would consent to part with it, and when questioned about it afterwards say, "Oh, I have only had a little knot removed," verily they know not the nature of that little "knot."

He thus thought it perfectly proper for doctors to educate patients about the sexual function of body parts about whose potential they were ignorant or misinformed.[67] The case of the foreskin is rather different. Although there is an increasing body of medical literature attesting to its anatomical and physio-

"Female Circumcision: Indications and a New Technique," *General Practitioner* 20.3 (September 1959): 115–20. Even in recent times, there are cases of girls being subjected to trimming operations in the interests of parental concepts of genital normality; for a disturbing personal account, see Patricia Robinett, *The Rape of Innocence: One Woman's Story of Female Genital Mutilation in the U.S.A.* (Eugene OR: Aesculapius, 2006).

[62] L. Wollman, "Female Circumcision," *Journal of the American Society of Psychosomatic Dental Medicine* 20.3–4 (1973): 130–31.

[63] S. Isenberg & L.M. Elting, "A Guide to Sexual Surgery," *Cosmopolitan* 181.5 (1976): 104, 108, 110, 164.

[64] Darby, *A Surgical Temptation*, ch. 2.

[65] Geoffrey Miller, "Circumcision: Cultural-Legal Analysis," *Virginia Journal of Social Policy and the Law* 9 (2002): 497–585.

[66] Edgar Spratling, "Masturbation in the Adult," *Medical Record* 48 (1895): 442–43; D. Yellowlees, "Masturbation," in *A Dictionary of Psychological Medicine*, ed. D. Hack Tuke (London: Churchill, 1892): 784–86.

[67] Harry Gage Moore, "Clitoridectomy," *Lancet I* (23 June 1866): 699.

logical significance,[68] Margaret Somerville is surely right to remark that, while we would be horrified at the suggestion that girls' breasts should be removed as a precaution against later breast cancer, we scarcely blink at the suggestion of removing the foreskin as a prophylactic against cancer of the penis or HIV. The reason is simply that "we value breasts – we see it as a serious harm to women to lose them – and we do not value foreskins, in fact they are often devalued – spoken of as ugly, unaesthetic and unclean. Yet both are part of the intact human body, and both have sexual and other functions."[69]

A trace of this attitude may be detected even in such effective critics of MGC as Fox and Thomson, who touch only lightly upon the most basic human rights consideration of all in the MGC debate: All mammals have foreskins; males are what they are because that is how they have evolved. The objective of some circumcision evangelists seems to be nothing short of trying to reconstruct human anatomy, perhaps secretly hoping that, if they circumcise enough newborns, future generations will be born prepuce-free. Evolution, however, appears to be favouring ever-longer foreskins in males,[70] suggesting that they improve survival chances and reproductive health rather than the reverse. Instead of trying to rewrite nature, the medical profession could more usefully examine how males can best protect their health and enjoy their sexuality with the standard equipment nature has given them. When

[68] Generally, Taylor, Lockwood & Taylor, "The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision" (1996) and Cold & Taylor, "The Prepuce" (1999). More recently, Kim and Pang found significantly reduced sexual satisfaction after circumcision, while Sorrells et al., using a light-touch test, concluded that a circumcised penis is markedly less sensitive than one with its foreskin in place. Dai Sik Kim & Myung-Geol Pang. "The Effect of Male Circumcision on Sexuality," *BJU International* 99.3 (March 2007): 619–22; Sorrells, Snyder, Reiss et al., "Fine-Touch Pressure Thresholds in the Adult Penis" (2007).

[69] Margaret Somerville, "Altering Baby Boys' Bodies," 204. For a discussion of the logic and ethics of prophylactic breast removal compared with prophylactic foreskin removal, see Frederick M. Hodges, J. Steven Svoboda & Robert S. Van Howe, "Prophylactic Interventions on Children: Balancing Human Rights with Public Health," *Journal of Medical Ethics* 28 (2002): 10–16.

[70] Christopher J. Cold & Kenneth A. McGrath, "Anatomy and Histology of the Penile and Clitoral Prepuce in Primates: Evolutionary Perspective of Specialised Sensory Tissue in the External Genitalia," in *Male and Female Circumcision: Medical, Legal and Ethical Considerations in Pediatric Practice*, ed. George C. Denniston, Frederick M. Hodges & Marilyn F. Milos (New York: Kluwer Academic/Plenum, 1999): 19–29.

we accept the fact that foreskins are as integral to males as breasts are to females, and that males have as much right to a complete penis as women to their clitoris or labia, then we can formulate strategies to combat sexually transmitted and other diseases that are both effective and ethically based. Violating the genital integrity of a child or poorly informed adult as a prophylactic against avoidable diseases is, at best, putting the cart before the horse, and at worst a breach of human rights.

The Problem with Double Standards

Despite what some activists claim, refusal to confront male circumcision actually makes the task of eradicating female circumcision more difficult. Supporters of female circumcision in cultures that still practice it are quick to identify the double standard in the attitude of Western agencies that seek to eradicate female circumcision while tolerating, or even promoting, male circumcision. They point out that "American parents circumcise their newborns so that the sons will look like the fathers [...]. What, they ask, gives Americans the right to apply a different standard to African women"?[71] As Peter Clark remarks, the arguments used to justify culturally-motivated circumcision of boys can just as easily be applied to culturally-motivated FGC.[72] The American Academy of Pediatrics (AAP) opposes all forms of female circumcision as examples of genital mutilation that members are advised they should refuse to perform and should actively discourage.[73] This position contrasts sharply with the AAP's equivocating disapproval of the equivalent procedure on boys. The remote possibility of a potential health benefit to male circumcision is regarded by the AAP as sufficient to justify categorizing the operation as a medical precaution rather than a culturally mandated mutilation.[74] In its 1999 policy statement, the AAP acknowledged that MGC was

[71] David Gollaher, *Circumcision: A History of the World's Most Controversial Surgery*, 200.

[72] Peter A. Clark, "To Circumcise or Not to Circumcise?" *Health Progress* 87.5 (2006): 30–39.

[73] American Academy of Pediatrics, Task Force on Circumcision, "Committee on Bioethics, Female Genital Mutilation, Part I," *Pediatrics* 102 (July 1998): 153–56.

[74] American Academy of Pediatrics, Task Force on Circumcision, "Committee on Bioethics, Female Genital Mutilation, Part II" *Pediatrics* 102 (July 1998): 172–73, 200, and Lawrence Dritsas, "Below the Belt: Doctors, Debate and the Ongoing American Discussion of Routine Neonatal Male Circumcision," *Bulletin of Science and Technology* 21 (2001): 297–311.

"not essential to the child's well being," but went on to say that it was "legitimate for parents to take into account cultural, religious and ethnic traditions [...] when making this decision," Objecting to this concession, Dr Thomas Bartman drew attention to the AAP's policy on female circumcision, issued by its Committee on Bioethics in 1998, and commented:

> Although female genital mutilation (FGM) exists in many horrendous variations, that statement clearly included within its definition of FGM "excision of the skin surrounding the clitoris" [paragraph 6]. In that report the Committee also clearly stated that pediatricians should "decline performing all medically unnecessary procedures to alter female genitalia" [paragraph 41]. Furthermore, under the heading "Cultural and Ethical Issues" the Committee stated that the parents' cultural, societal, and religious beliefs do not give them the right to consent to a medically unnecessary procedure for their child.[75]

In reply, the chair of the Circumcision Task Force, Dr Carole Lannon, stated: "The critical distinction between female genital mutilation and male circumcision is the potential medical benefits of male circumcision. These potential benefits warrant a parental role in decision making about this procedure."

No other medical association that has issued a policy on MGC has found sufficient "potential benefits" to justify the procedure. Where Americans call neonatal circumcision "not essential" for health, the Royal Australasian College of Physicians (2004) states that "there is no medical indication for routine male circumcision"; the Canadian Paediatric Society (1982, 1989, 1996) has called it a "mutilative" and "obsolete" operation; and the British Medical Association (2006) points out that there is rarely any clinical need for circumcision, and that "parental preference alone is not sufficient justification for performing a surgical procedure on a child." It warns that "to circumcise for therapeutic reasons where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate," and suggests that, if it were shown that MGC without clinical need was prejudicial to a child's well-being, it is likely that a legal challenge on human-rights grounds would be successful.[76]

[75] Thomas Bartman, "Letter," *Pediatrics* 105.3 (2000): 681.

[76] Note that the BMA doubts the validity of therapeutic circumcision of minors (to correct a problem); it does not even consider the possibility of circumcision as a prophylactic against conceivable future problems. See also Finland Central Union for Child Welfare, *Position Statement on the Circumcision of Boys* (Helsinki, 2003), online: www.cirp.org/library/statements (accessed 6 July 2006). Past and current policy statements of most organizations that have issued policies on routine circumcision are conveniently collected at www.cirp .org/library/statements/

Considering these judgments, it is difficult to know what to make of this extraordinary leap from cultural imperative to speculative ("potential") health advantage. Dr Lannon states that it is the possibility of a "medical benefit" that authorizes submission to parental wishes in the case of boys, and that it is the absence of any such possibility that forbids any surgical procedure on the genitals of girls, no matter how significant it may be to the cultures that have traditionally practised such rites. But one wonders whether it is culture or medical science that is really in the driver's seat here. The evidence thought to show a "potential health benefit" for MGC may in fact be an artifact of its cultural acceptability and long history in American society. As Miller (2002) and Waldeck (2003) have eloquently argued,[77] MGC in the USA, despite the medicalized setting, is more often a cultural ritual than a health precaution; most parents who seek or agree to the operation do so out of habit: because other people do it; because they are used to the appearance of the circumcised penis; because they do not want their boys to look different. By the same token, the absence of any culturally conditioned demand for female circumcision has discouraged researchers from seeking evidence of the potential advantages of such surgery.[78] It is the cultural demand for male circumcision that generates the research which appears to implicate the foreskin in whatever disease is holding the public's attention.[79] In a culture that values science, medical (usually miscalled scientific) justifications for cultural rituals must be found, hence the numerous horror stories about the terrible risks of

[77] Geoffrey Miller, "Circumcision: Cultural-Legal Analysis" (2002), and Sarah Waldeck, "Using Circumcision to Understand Social Norms as Multipliers," *University of Cincinnati Law Review* 72 (2003): 455–526.

[78] There is, in fact, evidence that female circumcision reduces the risk of HIV infection in women – see Rebecca Y. Stallings & Emilian Karugendo, "Female Circumcision and HIV Infection in Tanzania: For Better or for Worse?" Abstract of paper given at the Third International AIDS Society Conference on HIV Pathogenesis and Treatment, Rio de Janeiro, July 25–27, 2005. Given Western cultural preferences, however, it is unlikely that there will ever be clinical trials to test the possibility. See next section.

[79] See Ronald Goldman, "Circumcision Policy: A Psychosocial Perspective," *Paediatrics and Child Health* (Canada) 9 (2004): 630–33.

retaining normal human anatomy.[80] As Lawrence Dritsas has eloquently argued, the cultural tail would appear to be wagging the scientific dog.

Science in the Service of Culture

Today the most striking asymmetries between male and female genital cutting lie in the fact that powerful international agencies are promoting the first as a "scientifically proven" health precaution while campaigning against the latter as a significant threat to health. In this scenario, if male circumcision is conceived of as harmful, it is harm only to genital sensation, sexual pleasure, and body image; but when female circumcision is conceived as harmful, it is harm to the reproductive and urinary functions, which are seen as far more important than mere happiness. US organizations such as the US Agency for International Development have been at the forefront of efforts to conceptualize MGC as an aspect of reproductive health, and thus as a routine measure that should be built into foreign aid programmes and health advice.

Alongside this development we find an asymmetry in the justifications offered for circumcision. Where it is defended at all, female circumcision is likely to be argued for in terms of tradition (by insiders) or cultural relativism (by Western commentators). Whether the original rationale is medical or cultural, the defence of male circumcision is now most often cast in terms of improved health and increased resistance to feared diseases. Say something critical of male circumcision these days and you are likely to be floored with one magic word: AIDS.

It might be thought, and it is often asserted, that mass circumcision as a strategy for AIDS control is a straightforward instance of applying the discoveries of modern science to human betterment, like clean water for the prevention of cholera. If only the genitals were as culturally neutral as the stomach! As David Hume pointed out, however, "reason is [...] the slave of the passions, and can never pretend to any other office than to serve and obey them",[81] by this he means that science cannot determine the ends to which it may be applied – these come from outside scientific discourse, from politics, ethics, religion, aesthetics and other cultural discourses. Often facts that are not mentioned are as critical as those that are introduced into a debate. The

[80] Robert S. Van Howe, J. Steven Svoboda & Frederick M. Hodges, "HIV Infection and Circumcision: Cutting Through the Hyperbole," *Journal of the Royal Society for the Promotion of Health* 125 (2005): 259–65.

[81] David Hume, *A Treatise of Human Nature,* ed. Ernest Mossner (Harmondsworth: Penguin Classics, 1985), Book II, Section iii: 462.

UNAIDS and WHO have failed to acknowledge the well-established fact that rates of new HIV infection have been declining for over a decade as the disease comes under increased control. AIDS is not, and never will be, a critical public health problem in developed countries, where the disease remains largely confined to the traditional sub-cultures: gay men and intravenous-drug users.[82] For those able to afford the needed medications or able to negotiate donated or subsidized products from the drug companies, AIDS is no longer the death sentence it once was. It may be true that human genital mucosa is vulnerable to penetration by HIV, and hence that reducing its surface area by excising the foreskin lowers a man's risk of getting AIDS. But to slide from such a biological fact (if fact it be) to the proposition that MGC is therefore desirable, necessary or mandatory is a non sequitur.

There are many possible responses to such news, and the response will be determined not by science, but by the values of the individuals and societies in question. Health itself is a cultural construct, and a preference for (say) longevity over fun or good looks is itself a culturally determined priority. Reporting the practice of self-circumcision among the many bizarre customs of ancient Egyptian priests, Herodotus observed disapprovingly that they valued "cleanliness over comeliness."[83] With their strong sense of bodily aesthetics and faith in self-control, the Greeks would never have endorsed circumcision for one moment, no matter how 'compelling' the medical evidence. In anglophone societies, where the foreskin has already endured a century of demonization, the news from Africa is likely to be interpreted as yet another reason to get rid of it. In societies that value the body unaltered, the response is likely to be to seek other means by which men can be protected, including such proven measures as safe sex and reduced promiscuity.

The evidence strongly suggests that the push for mass male circumcision as the answer to AIDS is driven more by culture than by science – or rather, by science in the service of culture. If the genital mucosa is the Trojan horse for HIV and its reduction by various forms of pre-emptive excision decreases a person's risk of becoming infected, it follows that the genital mucosa of the female (on the clitoral hood and labia, for example) might be as vulnerable as the male foreskin, and thus that certain forms of female circumcision might protect women in the same way as posthectomy is thought to protect men. There is, in fact, evidence that female circumcision does reduce the risk of

[82] See James Chin, *The Aids Pandemic: The Collision of Epidemiology with Political Correctness* (Oxford: Radcliffe, 2007).

[83] Frederick M. Hodges, "The Ideal Prepuce in Ancient Greece and Rome," 385.

HIV infection in women,[84] and at least one other study suggests that female circumcision can also *indirectly* protect women from HIV infection.[85] But so strong is the revulsion from any form of female genital surgery among the Western researchers and agencies that control AIDS policy that it is not considered proper even to ask the question, let alone conduct research into the possibility.

Like the obstetricians who shouted Baker Brown down, modern health policy makers prefer female genitals intact, no matter what health advantages might accrue from surgical intervention. If the male genitals were regarded with the same respect as the female, MGC would be held in the same abhorrence as FGC, and experiments involving foreskin removal would be unthinkable.

The sudden resurgence of demands for routine circumcision of boys as a health precaution in some developed countries (notably the USA and Australia) has a similarly cultural explanation. Paradoxically, it can be traced back to developments in the 1980s that sought to improve the legal mechanisms for child protection and reduce all forms of child abuse. These were expressed most dramatically in the United Nations Convention on the Rights of the Child (1989), Article 24 (3) of which required parties to take "all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children." This looked promising, but a startling procedural fact that Svoboda (2004) unearthed shows that it did not take long for "children" to mean "girls only." As late as 25 June 1997, one document pertaining to the UN's work on traditional practices referred to the responsible official, known as "Special Rapporteur on traditional practices affecting the health of women and children."[86] But by the time the pertinent meeting was nearing its conclusion and had issued its report on the session, the special rapporteur's mandate had been changed to cover "traditional practices affecting

[84] See Rebecca Y. Stallings & Emilian Karugendo, "Female Circumcision and HIV Infection in Tanzania: For Better or for Worse?" Abstract of paper given at the Third International AIDS Society Conference on HIV Pathogenesis and Treatment, Rio de Janeiro, July 25–27, 2005.

[85] Kathryn M. Yount & Bisrat K. Abraham, "Female Genital Cutting and HIV/AIDS Among Kenyan Women," *Studies in Family Planning* 38.2 (2007): 73–88.

[86] *United Nations Commission on Human Rights*, Sub-Commission on Prevention of Discrimination and Protection of Minorities, Forty-Ninth Session, provisional agenda item 5(a): The implementation of the human rights of women – traditional practices affecting the health of women and children – Follow-up report of the Special Rapporteur on traditional practices affecting the health of women and children, Mrs. Halima Embarek Warzazi. UN Doc. No. E/CN.4/Sub.2/1997/10 (25 June 1997).

the health of women and the girl child."[87] There had never been any substantive discussion of this highly significant change, which excluded all male children at the stroke of a pen, nor was the change of title ever alluded to in any known UN document.

Other pertinent child-protection developments include the rise of a vocal intact-rights (anti-circumcision) movement in the only Western country where routine MGC remained common (the USA); a hesitant but visible tendency for secular and reforming Jews to question the necessity for the rite; and, in places where MGC was unusual and abhorred (such as Scandinavia), measures to regulate ritual circumcision as performed by ethnic and religious minorities. Given that the wording of the UN Convention on the Rights of the Child protected all children without discrimination, it is curious but symptomatic of assumptions about gender and sexuality that many governments passed legislation to make all forms of FGC unlawful, but none prohibited any form of MGC. Although some jurisdictions (such as the Australian States of South Australia and Queensland) looked seriously into the question of whether circumcision of boys should also be restricted, no current government has moved far in this direction. Sweden has placed mild restrictions on the practice, and the South Africa's Children's Act 2007 makes the circumcision of male children under the age of sixteen unlawful except for religious or medical reasons – which are, of course, the two principal categories of justification for the practice. As Jacqueline Smith found,[88] however, the Convention on the Rights of the Child clearly referred to genital mutilation of children, without discrimination on the basis of gender, and there could be no valid or effective response, in terms of human rights or medical ethics, to the argument that circumcision of minors was a violation of accepted principles of human rights and medical ethics.

Since all the arguments deployed against FGC applied just as strongly to MGC,[89] the persistence of the practice was an anomaly that demanded atten-

[87] *United Nations Commission on Human Rights*, Sub-Commission on Prevention of Discrimination and Protection of Minorities, Forty-Ninth Session. Report of the Sub-Commission on Prevention of Discrimination and Protection of Minorities on its forty-ninth session. UN Doc. No. E/CN.4/1998/2, E/CN.4/Sub.2/1997/50 (29 August 1997).

[88] Jacqueline Smith, "Male Circumcision and the Rights of the Child."

[89] See Elisabeth McDonald, "Circumcision and the Criminal Law: The Challenge for a Multicultural State," *New Zealand Universities Law Review* 21 (2004): 233–67, Suzanne Bouclin, "An Examination of Legal and Ethical Issues Surrounding Male Circumcision: The Canadian Context," *International Journal of Men's Health* 4.3 (2005): 205–22, and Ranipal Narulla, "Circumscribing Circumcision: Traversing the

tion. But the Convention left a loophole in its reference to "practices prejudicial to health": i.e. *harmful* practices – if MGC could be shown to be not harmful or, even better, beneficial in some way, then Article 24 would not apply to MGC, and those who wanted to continue the practice, whether for traditional or for medical reasons, could continue doing so with a clear conscience and little fear of restriction. It was the imperative to save MGC from the human-rights experts, lawyers, and ethicists that inspired the resurgence of research and advocacy, not only into the benefits of the procedure (old ones dusted up, new ones found), but a whole new research agenda, defying common sense and the consensus of the ages, aimed at proving that deleting the most densely innervated parts of the penis makes no difference to sexual experience.[90] This research flies in the face of results such as those obtained by Sorrells et al.[91]

To defend a customary practice with the discoveries or rhetoric of science is not a new strategy. Back in Roman times, the Jewish philosopher Philo sought to discourage his co-religionists from abandoning male circumcision (as some were doing, in the interests of integration) with several arguments, prominent among which was the claim that it conferred immunity against a kind of carbuncle on the penis that he called anthrax.[92] In mid-nineteenth-century Germany, a strong movement among reforming Jews sought to drop male circumcision along with many other oppressive observances; their campaign was defeated by the conservative rabbis, who cited new medical evidence from Britain and the USA that male circumcision was an effective defence against syphilis, masturbation, and other problems, and thus an example of modern science, not an ancient superstition at all.[93] But it was in the USA just before World War I that the strategy had its finest flowering.

Confronted with evidence that ritual circumcision was infecting babies with serious diseases (including diphtheria, tuberculosis, and syphilis), and

Moral and Legal Ground Around a Hidden Human Rights Violation," *Australian Journal of Human Rights* 12 (2007): 89–118.

[90] Brian Morris, *In Favour of Circumcision* (Sydney: New South Wales UP, 1999), and Brian Morris et al., "RACP's Policy Statement on Male Circumcision is Ill-Conceived," *Australia and New Zealand Journal of Public Health* 30 (2006): 16–22.

[91] Morris L. Sorrells, James L. Snyder, Mark D. Reiss et al., "Fine-Touch Pressure Thresholds in the Adult Penis," *BJU International* 99 (2007): 864–69.

[92] Robert Darby, "Where Doctors Differ: The Debate on Circumcision as a Protection Against Syphilis, 1855–1914," *Social History of Medicine* 16 (2003): 57.

[93] See John Efron, *Medicine and the German Jews* (New Haven CT: Yale UP, 2001): 189, and Leonard Glick, *Marked in Your Flesh*, ch. 5 and 6.

with a consequent campaign by paediatricians to ban or at least regulate the procedure,[94] the physician Abraham Wolbarst had the genius to perceive that the surest way to preserve male circumcision as a religious rite within the Jewish community was to generalize it throughout the whole of society as a necessary health precaution. Accordingly, he did not try to justify it on the culturally relativist ground of ethnic particularity, but on the modern, scientific ground that it was a valid measure of preventive health that should be imposed on every male. Far from spreading syphilis, Wolbarst asserted (and produced statistics showing) that male circumcision conferred high resistance, if not immunity, to syphilis, as well as curing or preventing a great many other problems, including herpes, cancer, and masturbation. He understood that a modern society that respected science needed modern arguments in defence of ancient customs.[95]

Although the rise of multiculturalism in recent times has permitted justification of rites such as circumcision (male or female) on the basis of cultural relativism, it is still the case that defenders of male circumcision are more likely to cite the alleged health benefits than its cultural significance. This was apparent in the submissions from Jewish and Muslim organizations to the inquiry conducted by the Queensland Law Reform Commission (1993) about whether circumcision of boys should be legally restricted, along with any form of FGC. A similar phenomenon is evident in the galloping medicalization of ritual male circumcision in many parts of the contemporary world.

Examples abound. In Africa, routine MGC is being called for as a panic response to AIDS. In Turkey and central Asia, the Turkish army carries out mass circumcisions of boys with no ceremony or ritual of any kind, but a high incidence of "complications."[96] In Britain, Muslims demand that circumcision be provided in public hospitals under the National Health Service, and some local health authorities provide the procedure free of charge in order to avoid the butchery that arises from kitchen-table jobs. In Thailand, village circumcision of Muslim boys, previously carried out by traditional practitioners, is

[94] See L. Emmet Holt, "Tuberculosis Acquired Through Ritual Circumcision," *Journal of the American Medical Association* 61.2 (1913): 99–102.

[95] Abraham Wolbarst, "Universal Circumcision as a Sanitary Measure," *Journal of the American Medical Association* 62 (1914): 92–97, and Robert Darby, "Where Doctors Differ," 57–78. Wolbarst is no mere historical curiosity. His opinion piece on circumcision as necessary to prevent cancer, published in the *Lancet* in 1932, is still regularly cited by circumcision advocates such as Brian Morris (*In Favour of Circumcision* [1999]: 41).

[96] See Emir Özdemir, "Significantly Increased Complication and Risks with Mass Circumcisions," *British Journal of Urology* 80 (1997): 136–39.

being replaced with group circumcisions under medical supervision. Group circumcision was the idea of a local doctor, concerned at the high incidence of infections, injury and other "complications" arising from the traditional method; "we have to find ways to integrate traditional beliefs with modern medical practices to keep villagers from illnesses," the doctor explained (*Bangkok Post*, 18 March 2006). He evidently did not think that MGC required any justification; it was simply something Muslims did.

There is evidence that mild forms of FGC are being medicalized in some places, such as Indonesia,[97] but on present indications the tendency is for asymmetry to intensify: the Western medical model will be applied to boys, locking generations of men into the circumcising habit;[98] while the Western human-rights model will be applied to girls and women, thus saving them from "harmful traditional practices."

Culture a One-Way Street?

A further instance of asymmetry lies in Western policies with respect to non-circumcising cultures. While it is regarded as quite wrong (unthinkable) to encourage them to adopt FGC, it is seen as perfectly okay to encourage and even pressure them to adopt MGC. This trend is most apparent in Africa and some other developing regions dependent on Western aid, where MGC is being foisted on non-circumcising cultures as the magic bullet against AIDS. It is also apparent in developed countries, where doctors tend to show exaggerated respect for the traditions of circumcising cultures and (in the USA at least) insufficient respect for the traditions of immigrants that do not practise MGC. Even medical personnel who regard MGC as unnecessary or harmful show little hesitation in cutting boys from traditionally circumcising cultures (mostly Islamic, these days) at the request of their parents.

The claims of culture are taken very seriously in this age of globalization, but the problem with this particular claim is that it is applied inconsistently. First, there is discrimination based on gender. No matter how important circumcision of girls may be to the cultural/ethnic/religious groups that practise it, world opinion has determined that girls' bodies are more important than tradition, and that any cutting of the female genitals is Female Genital Mutilation, now banned by law. Under the reigning paradigm, discrimination

[97] See Sarah Corbett, "A Cutting Tradition," *New York Times Magazine* (20 January 2008): 44, 50.

[98] See Gregory J. Boyle, "Issues Associated with the Introduction of Circumcision into a Non-Circumcising Society," *Sexually Transmitted Infections* 79 (2003): 427–28.

against men is regarded far less seriously than discrimination against women. Despite a blatant violation of the equal protection principles enshrined in the United States Constitution and human rights treaties, courts are reluctant to affirm claims of equal treatment not yet socially approved. A movement brought primarily or exclusively on behalf of males seems to cause discomfort to individuals, institutions, and society.[99]

Additionally, the issues raised by genital cutting are embarrassingly sexual in nature, all the more so with circumcision of men or boys, which requires references to the penis; there is always the danger that any discussion of the issues that is explicit enough to reveal the realities will be seen as pornography rather than ethics or science. Since circumcision is tied up with three of the most powerful discourses in modern society – science, medicine, and religion – genital integrity partakes of sex, religion, psychological denial, medical procedures, parental authority, and a variety of other uncomfortable, controversial and deeply emotional issues. No wonder there is so much argument.

Moreover, the cultural argument seems to be a one-way street, particularly in the USA. When faced by immigrant parents from circumcising cultures, doctors say they must respect their traditions and accede to their wishes, at least in relation to boys. But when it comes to non-circumcising cultures (the great majority), the argument is suddenly reversed: instead of enjoying automatic respect for their traditions, parents from non-circumcising cultures are pressured to conform to the American norm and to consent to have their sons circumcised, so that they will be 'like other boys'. Here it is not the traditional culture or the condition of the father's penis that matters, but American custom and medical ideology, to which the immigrants are expected to conform; and it is not unknown for them to be coerced into doing so.

When discussing this issue, defenders of children's rights have argued that doctors should not be cultural brokers, but this formulation does not quite grasp the complexity of the situation. What is really meant is that medical personnel should not enforce the rules of a given subculture against its members, particularly when the issue is one of conformity or outdated rituals. Concerns with identity are important in the traditional, monocultural societies where practices such as male and female circumcision originated; in such tribal situations, genital cutting functions as an age card and passport. But such rituals are unnecessary, and certainly do not need to be nurtured, in the

[99] See J. Steven Svoboda, "Genital Integrity and Gender Equity," in *Bodily Integrity and the Politics of Circumcision: Culture, Controversy, and Change*, ed. George C. Denniston, Grassivaro Gallo, Frederick M. Hodges, Marilyn F. Milos & Franco Viviani (New York: Springer, 2006): 149–64.

modern, multicultural societies to which these people have relocated, where identity and entitlements are registered in other ways. Immigrants from traditional societies do not expect to retain all their village customs when seeking to improve their condition in the industrialized world. In their new home, rituals such as genital cutting have no cultural significance; the main reason genital cutting, alone of many customs, tends to be retained is that those with power (the parents and other adults) would not personally benefit from dropping it, while those who would enjoy the benefit are only helpless children, who lack the power to voice, much less enforce, their opinion.

In practice, it is inevitable that doctors and other providers of professional services will act as cultural brokers when dealing with families from immigrant cultures, and this is not necessarily a bad thing. It is actually quite appropriate that they should help people from collectivist cultures (in which the rights of children as individuals and citizens are not recognized) to negotiate the transition to a culture based on the autonomy of the individual and respect for personal rights. The problem is not that doctors act as cultural brokers, but that they do so in an inconsistent and discriminatory manner, respecting the traditions of the circumcisers but not the traditions of non-circumcising cultures – American Indian, Hispanic, Catholic, Greek and Russian Orthodox, and other Christian, European, South American and most Asian, to name a few.

Circumcising cultures are a small minority: Islamic, some Africans, Jewish, and some Pacific islanders.[100] You might think that the one of the first acts of cultural retrieval performed by American Indian peoples, none of which ever practised genital cutting, would be to revive such historic traditions. If the 'respect for culture' policy were applied consistently, the vast majority of American immigrants and ethnic subcultures would not be circumcised, and half-drugged mothers would not be obliged to fight off the advances of scalpel-happy ob-gyns in maternity wards.

Conclusion

It is perhaps inevitable that one's opinions about male and female circumcision will be conditioned by one's own socialization and culture. In one study of five childhood mutilations (artificial cranial deformation, Chinese foot binding, female infanticide in nineteenth-century India, female genital cutting, and male genital cutting, both in North America and in developing

[100] In New Zealand, and Australia to a lesser extent, the issue arises with immigrants from some of the Pacific islands, notably Fiji, Tonga, and Samoa.

countries), surprising similarities were found in the reasons for these practices. Although it was claimed that they were intended to benefit the child, they resulted in overall harm to the child; the actual or imagined benefits are only for others: parents, surgeons, midwives, and/or 'society'.[101] Western observers have little difficulty in labelling the other four practices as violent human-rights violations, yet they have trouble objectively analyzing their own practice, male genital cutting. This form of cultural blindness is understandable. All over the world, as Richard Shweder has commented, people recoil and say "yuck" to each other's childhood body-mutilation practices while justifying their own practices and saying "yuck" to cultures that have *not* adopted their customs.[102]

Just how difficult it is to escape from cultural assumptions is revealed in an exchange between Ruth Macklin and Robert Baker that further highlights the problems inherent in claiming universal human rights as a basis for stopping female circumcision while ignoring the problem of male circumcision. Macklin sought to ground her critique of ethical relativism in an appeal to universally held standards of human rights – or, at least, rights that she believed ought to be universally held – and on this basis condemned female circumcision because it was harmful to the child and violated her integrity as a person. Her argument was trumped by Robert Baker, a self-proclaimed cultural relativist, who criticized her for focusing exclusively on 'female genital mutilation' while ignoring 'male genital mutilation'. He observes that female circumcision may take a variety of forms and male circumcision usually only one, but points out that circumcision (male or female) traditionally "occurs in societies that emphasize the reproductive aspects of sexuality while repressing eroticism" and, further, that "the feature common to both forms of circumcision is that the operation desensitizes responses to sexual stimulation." As Baker aptly concludes, "once one appreciates that cultures that circumcise females typically circumcise males as well, the claim that circumcision is discriminatory, or anti-female, becomes questionable."[103] In her reply, Macklin

[101] See J. Steven Svoboda, "The Limits of the Law: Comparative Analysis of Legal and Extralegal Methods to Control Child Body Mutilation Practices," in *Bodily Integrity and the Politics of Circumcision*, ed. Denniston et al., 297–365.

[102] Richard Shweder, "What About Female Genital Mutilation? and Why Understanding Culture Matters in the First Place," in *Engaging Cultural Differences: The Multicultural Challenge in Liberal Democracies*, ed. Richard A. Shweder, Hazel Rose Markus & Martha Minow (New York: Russell Sage Foundation, 2002): 216–51.

[103] Robert Baker, "Negotiating International Bioethics: A Response to Tom Beauchamp and Ruth Macklin," *Kennedy Institute of Ethics Journal* 8 (1998): 442–43.

tellingly criticizes Baker for misidentifying human rights as pertaining to a culture or society rather than to individuals, but she seems not to have heeded his call for consistency in the application of human-rights principles: Continuing to focus on the harm of female circumcision, she makes no mention of male circumcision at all.[104]

The way forward, in our opinion, is not to abandon the concept of universal human rights, as argued by Baker, but to attempt to apply them consistently, without discrimination on the basis of gender. If surgery to reduce the extent of vulnerable genital mucosa has such great prophylactic value against disease, why should women and girls be denied its benefits? If genital mutilation is as harmful and (when inflicted on minors, or on adults without fully informed consent) as ethically wrong as many claim, why should men and boys be denied protection from it?

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[104] Ruth Macklin, "A Defence of Fundamental Principles and Human Rights: A Reply to Robert Baker," *Kennedy Institute of Ethics Journal* 8 (1998): 403–22.

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Fearful Symmetries

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Table of Contents

Preface and Acknowledgements | vii
Introduction: Why Not the Earlobe? | xi

Section 1: Symmetries

Sami A. Aldeeb Abu-Sahlieh
Male Circumcision/Female Circumcision: Is There Any Difference? | 3

Section 2: Anthropological Wormholes

Michael Singleton
Homo Hierarchicus versus Mulier Aequalis
(Un)acceptable Asymmetry? | 53

Anne-Marie Dauphin-Tinturier
Pleasure and Body Adaptation:
An Approach to Gender in Northern Zambia | 77

Section 3: On Autobiographies

Chantal Zabus
'Beyond Circumspection':
African, Jewish, and Muslim Autobiographies Around Circumcision | 99

Tobe Levin
Nura Abdi and Fadumo Korn:
No to 'Pudendal Desecration' | 129

Robert Darby and Laurence Cox
Objections of a Sentimental Character:
The Subjective Dimensions of Foreskin Loss | 145