SHAPING GENITALS, SHAPING PERCEPTIONS
A Frame Analysis of Male and Female Circumcision

Marjolein van den Brink and Jet Tigchelaar*

Abstract

Human rights claim universal validity, which implies that bias in their applicability as well as in their application should be avoided. From this perspective it is rather remarkable that female circumcision is a major cause for human rights concerns, whereas male circumcision is rarely addressed in the context of human rights. This raises the question whether practices of female circumcision are really that different from forms of male circumcision. There is at least some evidence that there are more similarities between male and female circumcision than commonly perceived. Taking this as a starting point, on the basis of facts, figures and rationales, we distinguish three types of circumcision: the 'African', the 'American' and the 'Abrahamic' type. Whereas male circumcision may fulfil the characteristics of any of these three types, female circumcision seems to fit only the African type. The typology allows for an analysis of the frames used in the debate to justify or delegitimise male and female circumcision. Frames that feature in the debates on male circumcision are a 'medical/health frame' and a 'cultural/religious frame', both with an 'accessory human rights frame'. The debate on female circumcision (mostly referred to as female genital mutilation or FGM), on the other hand, is predominantly a 'women's rights frame'. The differences in normative framing as well as the consequences thereof for the human rights protection of men and women do not seem entirely justified by the differences between the practices of male and female circumcision. We discuss three forms of bias – related to culture, religion and to gender – that may help explain the diverging normative framings. Irrespective of one's normative assessment of the compatibility of circumcision practices with human rights norms, the universality claim of human rights requires the application of the same standards to similar practices, regardless of sex.

Keywords: bodily integrity; circumcision; framing; gender equality; genital mutilation; human rights; universality

* Both authors are assistant professor at the Utrecht Law School, Utrecht University, the Netherlands. The authors like to thank Wibren van den Burg and other participants of the Seminar 'Framing multicultural issues in terms of human rights: solution or problem?' held at Utrecht University, 14 November 2011, as well as the anonymous reviewers for their useful comments on earlier versions of this paper.

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1. INTRODUCTION

Female circumcision became an issue of international (in particular: Western) concern in the 1970s.[1] It has been condemned by the World Health Organisation (WHO), by virtually all human rights bodies, by governments and by NGOs alike. Male circumcision, on the other hand, has for many years remained unnoticed, escaping both normative evaluation and condemnation. It has generally been regarded, and even been promoted, as beneficial for men's health. In the last ten years or so, however, male circumcision has received significantly more attention, both positive and negative. An important proponent of male circumcision is the WHO, which currently strongly advocates male circumcision because it is thought to help prevent the spread of HIV/AIDS.[2] Opposed to male circumcision are men's rights groups, mainly US-based, that try to reduce or even eliminate routine circumcision of newborn boys, invoking arguments of bodily integrity and personal autonomy.[3] Often, these attempts focus on circumcision unrelated to religious practices, thus avoiding discussions related to freedom of religion.[4] However, this seems to be changing, especially in Europe, with the decision of the District Court of Cologne of 7 May 2012 being a case in point.

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1 See Coomaraswamy, R., Special Rapporteur on Violence Against Women, Its Causes and Consequences, Integration of the Human Rights of Women and the Gender Perspective: Violence Against Women, UN Doc. E/CN.4/2002/83 (2002), para 17. According to UN Fact Sheet No. 23, specialised UN agencies and human rights bodies began considering the practice already in the 1950s, but not in a very consistent manner nor at any large scale. See UN Fact Sheet No. 23, Harmful Traditional Practices Affecting the Health of Women and Children, August 1995, p. 2, *available at:* www.ohchr.org/Documents/Publications/Fact Sheet23en.pdf (last accessed 20 September 2012).

2 E.g. WHO, Male Circumcision Information Package: Insert 3 – Health Benefits and Associated Risks; Insert 4 – Male Circumcision as an HIV Prevention Method, 2007, *available at* www.who.int/hiv/pub/malecircumcision/infopack/en/index.html (last accessed 18 October 2012). See also: WHO, Manual for Early Infant Male Circumcision under Local Anaesthesia, 2010, *available at:* www.who.int/hiv/pub/malecircumcision/infopack/en/index.html (last accessed 1 July 2012).

3 Some also argue that the WHO should drop its male circumcision campaign because it allegedly raises false feelings of security, stating that men in Africa in particular are lining up to be circumcised in order to be protected against HIV/AIDS forever after, thus effectively undermining the whole campaign and endangering the health of their sexual partners. See for this and other critiques of the policy of circumcision in Africa in order to prevent the spread of HIV/AIDS: Fox, M. and Thomson, M., 'The New Politics of Male Circumcision: HIV/AIDS, Health Law and Social Justice', *Legal Studies*, Vol. 32, No. 2, 2012, pp. 255–281, at pp. 267–271.

4 This is explicitly stated in the title of the following article: Dekkers, W., 'Routine (Non-religious) Neonatal Circumcision and Bodily Integrity: A Transatlantic Dialogue', *Kennedy Institute of Ethics Journal*, Vol. 19, No. 2, 2009, pp. 125–146. Szasz emphasises that the religious dimension of male circumcision is frequently overlooked: Szasz, T., 'Routine Neonatal Circumcision: Symbol of the Birth of the Therapeutic State', *The Journal of Medicine and Philosophy*, Vol. 21, 1996, pp. 137–148. Androus, however, explains the exclusion of religious circumcision by pointing at the social tradition of circumcision of Americans: Androus, Z., 'Fitting In and Getting Off: Adult Male Circumcision in the United States and Britain,' in: Denniston, G., Hodges, F. and Milos, M.F., (eds.), *Circumcision and Human Rights*, Springer Science and Business Media, Berlin/Heidelberg/Dordrecht/New York City, 2009, pp. 141–147, at p. 143.

The Cologne court found a doctor guilty of causing bodily harm, for performing circumcision on a four year old Muslim boy.[5]

The different conceptions of female and male circumcision underscore common, widespread understandings of these practices as very different, though not to say incomparable;[6] the one extremely harmful, the other benign; the one defined as mutilation and the other as ritual, routine or even preventive medicine.[7] However, some authors – for one reason or another – suggest that the differences between the two are less significant than generally assumed. They argue that these practices should not be considered separately.[8]

DeLaet for example, suggests that the most prevalent forms of both male and female circumcision are very similar in form, referring to the kind of operation performed, the level of invasiveness, and their consequences for health, sexuality and reproduction.[9] Even the most invasive forms seem to be comparable in form and consequence, albeit possibly not in prevalence. Moreover, symmetries in moral and social rationales, like sexual control and enforcement of gender identity, are pointed out. Although this focus on the comparability of male and female circumcision, both in forms and justifications, while not mainstream in international (human rights) policies, seems to be on the rise in academic literature.

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5 Landgericht Köln, 7 May 2012, No. 151 Ns 169/11. In Finland a district court decided in the same line, but this was overruled by the Court of Appeal (in 2007) and the Supreme Court (in 2008). See: Askola, H., 'Cut-Off Point? Regulating Male Circumcision in Finland', *International Journal of Law, Policy and the Family*, Vol. 25, No. 1, 2011, pp. 100–119. See also Dekkers, Hoffer and Wils, who studied religious perspectives on male and female circumcision in the Netherlands: Dekkers, W., Hoffer C. and Wils, J.P., 'Bodily Integrity and Male and Female Circumcision', *Medicine, Health Care and Philosophy*, Vol. 8, No. 2, 2005, pp. 179–191. Compare Gilbert, who discusses the case of Re J about the dispute between his parents regarding his (Islamic) circumcision: Gilbert, H., 'Time to Reconsider the Lawfulness of Ritual Male Circumcision', *European Human Rights Law Review*, Vol. 2007, No. 3, 2007, pp. 279–294.

6 E.g. the Special Rapporteur on Traditional Practices Affecting the Health of Women and Children has stressed the incomparability in her 1997 report as well as in her 2000 report: '…[i]t would seem inappropriate to consider under one head both female circumcision which is harmful to health and male circumcision which has no undesirable effect and is even considered to be beneficial'. Embarek Warzazi, H./UN Commission on Human Rights, 'The Implementation of the Human Rights of Women: Traditional Practices Affecting the Health of Women and Children', UN Doc. E/CN.4/Sub.2/1997/10 (1997) and UN Doc. E/CN.4/Sub.2/2000/17 (2000).

7 Compare Szasz, *loc.cit.,* note 4, at p. 143, who questions the normative effects of language, as follows: 'Why is RNC [Routine Neonatal Circumcision; MvdB & JT] legal? Because it is defined as preventive medicine. Why is it defined as preventive medicine? To avoid having to ban it as male genital mutilation.'

8 For example Johnson, M., 'Male Genital Mutilation: Beyond the Tolerable?', *Ethnicities,* Vol. 10, No. 2, 2010, pp. 181–207; Fox, M. and Thomson, M., 'Foreskin is a Feminist Issue', *Australian Feminist Studies*, Vol. 24, No. 60, 2009, pp. 195–210; Dekkers, Hoffer and Wils, *loc.cit.,* note 5; Davis, D.S., 'Male and Female Genital Alteration: A Collision Course with the Law?', *Health Matrix*, Vol. 11, No. 2, 2001, pp. 487–570.

9 DeLaet, D., 'Framing Male Circumcision as a Human Rights Issue? Contributions to the Debate Over the Universality of Human Rights', *Journal of Human Rights*, Vol. 8, No. 4, 2009, pp. 405–426. See also Smith, J., 'Male Circumcision and the Rights of the Child', in: Bulterman, M., Hendriks, A. and Smith, J. (eds.), *To Baehr in Our Minds: Essays on Human Rights from the Heart of the Netherlands*, SIM, Utrecht, 1998, pp. 465–498.

This issue of comparability of the practices of male and female circumcision is highly relevant from a human rights perspective. To the extent that there is some truth in the alleged similarities, we raise the question whether it is legitimate to frame all forms of female circumcision as intolerable violations of human rights while all forms of male circumcision are – in principle – considered to be unproblematic from a human rights perspective.[10] Is that not withholding from men the protection of human rights they are entitled to or, the reverse, unnecessarily curtailing women in their right to self-determination? If it is true that some forms of male and female circumcision overlap, then such diverging conceptions are problematic in (at least) two respects. First, it undermines the claim of universality of human rights, which demands that similar standards should be applied to similar practices. Second, it seems to contradict the sex/gender equality principle, demanding the equal treatment of men and women, unless there is an objective and reasonable justification not to.

In this paper we will explore how male and female circumcision are framed and to what extent the different perceptions of and approaches to these practices can be considered justified in light of the principles of universality of human rights and gender equality. Of course, it is clear that ideas regarding the roles of women and men underlie most of these practices,[11] and, thus, it is also clear that such gender-based motives behind circumcision practices, affirming the inferiority or superiority of one of either of the sexes, may to some extent justify a different approach to these practices. However, surprisingly, such perceived motives are often simply stated as a matter of fact, not supported by any evidence. This led us to expect to find gender and cultural bias not only in the eye of the practitioner but also in the eye of the beholder. That is, we expect that the unsubstantiated suspicion that circumcision is motivated by gender discrimination may cause equally or even more gender-biased responses to these practices, resulting in gender bias in the protection of peoples' human rights. It is primarily this latter kind of bias that we try to identify here.

By uncovering such bias and suggesting more neutral standards and approaches, we hope to strengthen the universal character of human rights. Biased interpretations and applications of human rights are detrimental to the authority and thus to the effectiveness of human rights and therefore should be avoided. Our intention is not to formulate a position on the (un)acceptability of circumcision (male and female) as such, neither is it to present policy or legal reform proposals to combat successfully those circumcision practices that are problematic from a human rights perspective. We focus on the comparability of female and male circumcision and on the consistency of outsiders' perceptions of circumcision and we suggest some standards that may contribute to a more universal and gender-equal application of human rights to practices of circumcision of both men and boys and women and girls.

10 Male circumcision may become problematic according to actual human rights standards, when it is carried out in a clearly health threatening way or against the will of the more mature minor or one of the parents of a young child.

11 Probably male circumcision for medical reasons such as a too tight foreskin is an exception to this rule.

To uncover the biases, we focus on the frames used in the debates.[12] Frames have been described as 'subconscious filing boxes' that help people to organise and sift information quickly. They help us to come to a value judgment. They are 'oversimplified versions of reality, and therefore do not necessarily reflect reality'.[13] Frames are not *per se* the consequence of active framing by, for example, the media or politicians. Frames can also be the product of long-time exposure to specific ideas or conceptions. Thus, the frames used to assess the (un)acceptability of male and female circumcision may be both the product of living in a specific culture or of active attempts to make us see these practices in a specific, different light. By comparing the differences in the framing of comparable forms of male and female circumcision, the underlying 'versions of reality' of people using or even actively promoting these frames will surface, which in turn will help identify the biases.

So far, we have used the word 'circumcision' as an umbrella term for all interventions regarding genitals. The choice of words is very important, because different words trigger different frames for understanding a particular issue. Kennedy, Fisher and Bailey give an example taken from the field of immigration. The concept of an 'illegal alien' invokes a frame focusing on enforcement and violations of law. 'Undocumented worker' on the other hand suggests an administrative context; solutions have to be found in paperwork. Thus, the mere choice of words already sifts out thinkable and unthinkable solutions, and suggests a positive or negative judgment.[14]

This phenomenon is particularly true when talking about 'circumcision'. Just about any paper, article or policy document on this topic explains and justifies its word choices.[15] However, this word choice primarily concerns female circumcision. The terms mostly used are female genital mutilation, female genital cutting and female circumcision.[16] The latter was the regular term at the start of the debate. These days it is rejected – interestingly, because of the suggested comparability with male

12 There is an extensive body of literature on framing theory. See for example Chong, D. and Druckman, J.N., 'A Theory of Framing and Opinion Formation in Competitive Elite Environments', *Journal of Communication*, Vol. 57, No. 1, 2007, pp. 99–118. For an overview of the field see Chong, D. and Druckman, J.N., 'Framing Theory', *Annual Review of Political Science*, Vol. 10, June 2007, pp. 103–126. However, we do not intend a fully-fledged application of framing theory. We merely use the concept of frames and their effect on people's perceptions.

13 Kennedy, B., Fisher, E. and Bailey, C., 'Frame in Race-Conscious, Antipoverty Advocacy: A Science-Based Guide to Delivering Your Most Persuasive Message', *Journal of Poverty Law and Policy*, Vol. 43, No. 9–10, Jan-Feb 2010, pp. 408–421, at p. 409.

14 *Ibidem* at p. 411.

15 See e.g. Davis, *loc.cit.*, note 8, at pp. 489–491, who prefers 'genital alteration'. See also Tobin, J., 'The International Obligation to Abolish Traditional Practices Harmful to Children's Health: What Does it Mean and Require of States?', *Human Rights Law Review*, Vol. 9, No. 3, 2009, pp. 386–388. Tobin lists UN, African and European bodies that use the term 'female genital mutilation' and mentions authors who use the term circumcision and female genital cutting. Tobin prefers the latter phrase.

16 Sometimes it is referred to as female genital surgeries or genital alteration. Compare: Davis, *loc.cit.*, note 8, at pp. 490–491.

circumcision. The term female circumcision is rejected because any comparison to male circumcision is rejected: the first is regarded as an unacceptable violation of women's human rights, whereas the second remains unproblematic. Circumcision has been replaced by the far more normative phrase 'genital mutilation'. However, at the same time, it is precisely the negative perception of the practice expressed in the word 'mutilation' which sometimes results in the deliberate avoidance of the phrase. This is particularly true in policies and programs targeted at the practicing communities, because it is anticipated that parents and others practicing 'mutilation' will not agree that the practice amounts to mutilation, and thus reject the word 'mutilation' to describe the practice. Accordingly, for strategic reasons, those regarding circumcision as mutilation still do not always refer to it as such, and instead refer to it as cutting, which is considered the more neutral term.[17] Male circumcision is normally just referred to as 'circumcision'. However, increasingly, groups advocating the abandonment of routine circumcision on newborn baby boys in the US do refer to it as male cutting, or even male genital mutilation.[18]

We have thought hard about other, new words, such as 'tinkering' to try and avoid stepping into one or another ready-made frame immediately. However, such terminology entails its own problems. Therefore, we decided to stick to 'circumcision' because it is the oldest word to describe these practices, it seems the least normative and it is applicable to both female and male circumcision.

The following section starts with a description of prevalence, forms, geographical spread and motivations of male and female circumcision, culminating in a typology of circumcisions. This typology gives a first indication of the frames for male and female circumcision used in the discussions. An inventory of these frames will be done in section 3. We continue with an analysis of the frames, with a special focus on differences: are these caused by biased perceptions or are these justified by facts or reasons (section 4)? We conclude that the very different approaches to and perceptions of female and male circumcision are not completely justified by differences between these practices and/or by the differences in position of the men and women, boys and girls subjected to these practices. That is why we identify some standards, in the conclusion (paragraph 5), that could contribute to a human rights frame that is more acceptable in light of the universality of human rights and the gender equality principle.

17 See WHO, Global Strategy to Stop Health-care Providers from Performing Female Genital Mutilation, UNAIDS, UNDP, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, FIGO, ICN, IOM, MWIA, WCPT, WMA, WHO/RHR/10.9 (2010), p. V, *available at*: www.who.int/reproductivehealth/publications/fgm/rhr_10_9/en/index.html (last accessed 20 September 2012).

18 E.g.: Hellsten, S.K., 'Rationalising Circumcision: From Tradition to Fashion, From Public Health to Individual Freedom – Critical Notes on Cultural Persistence of the Practice of Genital Mutilation', *Journal of Medical Ethics*, Vol. 30, No. 3, 2004, pp. 248–253; Johnson, *loc.cit*., note 8, at p. 183, who uses the term male genital mutilation (MGM) to highlight the harmfulness of the act.

2. MALE AND FEMALE CIRCUMCISION: FACTS AND FIGURES

It is estimated that 20–30% of the world's male population is circumcised.[19] About 20 million men and boys are circumcised annually: half of them are Muslim (10 million), followed by nine million Africans 'in traditional settings', one million from Anglo-Saxon, countries, mainly the USA, and about 100.000 Jews.[20] Thus, male circumcision is most prevalent among Muslims and Africans. Nevertheless, non-Muslim Americans, in particular, dominate the discussions on the legitimacy of male circumcision.[21]

In comparison: it is estimated that worldwide 100 – 140 million women and girls have been circumcised and that approximately three million women and girls face circumcision each year.[22] The practice of female circumcision is highly concentrated (over 80 percent) in about 28 African countries and some countries in the Middle East and in South East Asia. Nearly half of all female circumcisions are carried out in just two countries: Egypt and Ethiopia.[23] Moreover, immigrants have brought the practice with them to the Western world (although also in the West circumcision and comparable practices have been known in the past).[24] Thus, there are almost seven times as many boys circumcised annually with a far wider global spread of the practice.

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19 WHO/UNAIDS, Male Circumcision: Global Trends and Determinants of Prevalence, Safety and Acceptability, 2007, *available at*: www.who.int/reproductivehealth/publications/rtis/9789241596169/en/ (last accessed 20 September 2012), mentions on p. 1: 'Approximately 30 percent of males are estimated to be circumcised globally, of whom an estimated two-thirds are Muslims.' See also Shweder, whose estimation is 20–30% of the world's male population. Shweder, R., 'Shouting at the Hebrews: Imperial Liberalism v Liberal Pluralism and the Practice of Male Circumcision', *Law, Culture and Humanities*, Vol. 5, No. 2, 2009, pp. 247–265, at p. 255.

20 Hofvander, Y., 'Circumcision in European Countries: Review of the Possible Annual Numbers of Laws and Regulations and of Economic Aspects', in Denniston, Hodges and Milos, *op. cit*., note 4, at pp. 231–232. The numbers vary. For example: according to the WHO two thirds of the world's circumcised males are Muslim. It could be that the WHO presumes that many of the 9 million circumcised Africans have been circumcised primarily for reasons related to their Islamic religion. It should be noted that Christians in Africa sometimes also practice circumcision for religious reasons. Compare WHO, *op.cit.,* 2007, at p. 4, and DeLaet, *loc.cit.,* note 9, at p. 410.

21 The high numbers of circumcised men in the US are telling. In the US about 65% of the men has been circumcised, most of them as infants. It makes male circumcision in the US the most frequently performed surgical operation. Dekkers, *loc.cit.,* note 4, p. 126.

22 Coomaraswamy, *op.cit,* note 1, at paras. 12–20; RCN, Female Genital Mutilation: A RCN Educational Resource for Nursing and Midwifery Staff, 2006, at p. 5, *available at*: www.rcn.org.uk/__data/assets/pdf_file/0012/78699/003037.pdf (last accessed 20 September 2012); UNICEF, Female Genital Mutilation/Cutting: Child Protection Information Sheet, May 2006, at p. 2, *available at*: www.unicef.org/publications/index_29994.html (last accessed 20 September 2012).

23 WHO, An Update on WHO's work on Female Genital Mutilation (FGM), Progress report, WHO/RHR/11.18, 2011, at p. 2.

24 See Fact Sheet No. 23, *op.cit.,* note 1, at p. 3; Coomaraswamy, *op.cit.,* note 1, DeLaet, *loc.cit*., note 9, at p. 411.

The predominant *form* of male circumcision entails the total or partial removal of the prepuce, the outer skin surrounding the glans (head) of the penis. This form of male circumcision is most comparable to the most common form of female circumcision called 'sunna' which involves the removal of the prepuce of the clitoris.[25] In both of these forms of male and female circumcision 'a part of the genitalia with a dense concentration of neuroreceptors specialised for sexual sensation and expression' is removed.[26]

There are also more invasive forms of both male and female circumcision. An example of very invasive male circumcision is 'peeling the skin of the entire penis, sometimes including the skin of the scrotum and pubis' and male circumcision involving 'a subincision of the urinary tube from the scrotum to the glans'.[27] The most extreme form of female circumcision is infibulation, which entails the 'narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris'.[28] A form of female circumcision that has no male equivalent is the 'partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision)'. This type of circumcision is said to eliminate sexual pleasure, although there are women who still report sexual satisfaction.[29] In contrast to these invasive forms of circumcision, there are also less invasive forms of female circumcision than the most common male variants, like 'ritualistic nicking' or 'cutting of the clitoris'. These are sometimes called 'sunna light' or symbolic circumcision.[30]

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25 Compare Boyle, E.H. and Carbone-López, K., 'Movement Frames and African Women's Explanations for Opposing Female Genital Cutting', *International Journal of Comparative Sociology*, Vol. 47, No. 6, 2006, pp. 435–465, at p. 438. They estimate that 80–85% percent of all female circumcisions are either sunna circumcisions or cliterodectomies, that is the complete removal of the clitoris and labia minora. They do not distinguish between those forms. However in UN Fact Sheet No. 23 (*loc.cit.,* note 1), sunna circumcision is considered comparable to male circumcision. In this Fact Sheet of 1995 excision or cliterodectomy is said to be the most common operation. Apparently this has changed during the last ten years. The UNICEF Report, Female Genital Mutilation/Cutting: A Statistical Exploration, November 2005, 53 pp., indicates on p. 15 that the first type of the WHO levels (sunna) is most common. This report is available at www.unicef.org/publications/index_29994.html (last accessed 24 October 2012).

26 DeLaet, *loc.cit.,* note 9, at p. 413.

27 *Ibidem*, at pp. 411–412: the former is assumed to be practiced still by some tribes in South Arabia; the latter is practiced by Australian aborigines.

28 This form is practiced mainly in Sudan and Eritrea. *Ibidem*, at p. 413, UNICEF Report of 2005, *op.cit.,* note 25, p. 15.

29 This form corresponds with the second type in the classification of the WHO, UNICEF Report of 2005, *op.cit.,* note 25, at p. 1. See for a reflection on the comparability of the different forms of male and female circumcision: Johnson, *loc.cit*., note 8, at pp. 184–185. See for the view that women still enjoy sexual pleasure and experience orgasms: Shweder, R.A., 'Disputing the Myth of the Sexual Dysfunction of Circumcised Women', *Anthropology Today*, Vol. 25, No. 6, 2009, pp. 14–17; Obiora, A. L. 'Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision', *Case Western Reserve Law Review*, Vol. 47, No. 2, 1997, pp. 275–378, at p. 298; Dustin, M., 'Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies', *European Journal of Women's Studies*, Vol. 17, No. 1, 2010, pp. 7–23, at p. 10.

30 This form belongs to the fourth classification type of the WHO: 'All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping

Circumcision can have serious health complications, irrespective of the sex of the person subjected to it. However, the more invasive the form of circumcision is, the higher the risks of serious complications. Complications following male circumcision seem dependent primarily on the level of hygiene and professionalism of the practitioner. For female circumcision, however, research shows more mixed results. Female circumcisions that have been carried out by medical professionals still entail health risks and other consequences, presumably linked to the level of invasiveness. It has to be noted though that the figures found for female circumcision generally are not segregated to the level of invasiveness.[31]

Most men are circumcised in their childhood. In the US and in some African tribes, boys are circumcised immediately after being born. In Judaism, boys are circumcised on the eighth day after birth. Boys belonging to the amaXhosa in South Africa and some other indigenous minorities are circumcised in late puberty or even as young adults.[32] The age of circumcision for women also varies, from infants a few days old to adult women, the latter for instance at the occasion of their marriage.[33] According to UNICEF, the most common age range to circumcise girls is between 4 and 14.[34]

The purposes of circumcision vary from group to group. Female circumcision is often part of the rites of passage, marking the coming of age of children, but it also serves to control female sexuality, by reducing sexual desire, and to help girls to remain virgin or chaste.[35] In Britain, Canada and the US, it was practiced in the 18–19th century to prevent masturbation and cure hysteria and some psychiatric conditions.[36] Male circumcision is also related to sexuality, but in varying and even

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and cauterization'. See for the WHO classification: WHO, Eliminating Female Genital Mutilation: An Interagency Statement – UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, 2008, p. 4, *available at*: www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf (last accessed 20 September 2012).

31 Dustin, *loc.cit.,* note 29, at p. 9. Dustin also argues that the depicted health consequences are not inevitable but 'usually a worst-case scenario'. Johnsdotter and Essén contend that the health consequences are often exaggerated and miss scientific evidence. Johnsdotter, S. and Essén, B., 'Genitals and Gender: The Politics of Genital Modifications', *Reproductive Health Matters*, Vol. 18, No. 35, 2010, pp. 29–37, at p. 33.

32 The age of male circumcision among amaXhosa ranges from 15 to 25. See: Vincent, L., 'Cutting Tradition: The Political Regulation of Traditional Circumcision Rites in South Africa's Liberal Democratic Order', *Journal of South African Studies*, Vol. 34, No. 1, 2008, pp. 77–91, at p. 80. See for variations in age: Zampieri, N., 'Male Circumcision Through the Ages', *Acta Peadiatrica*, Vol. 97, No. 7, 2008, pp. 1305–1307, at p. 1306. On the age of South Korean males see: Shweder, *loc.cit*., note 19, at p. 257. See for more facts about the age of circumcision in different ethnic groups: WHO/UNAIDS, *op.cit.,* note 19, at pp. 4–5.

33 See Fact Sheet No. 23, *op.cit.,* note 1, at p. 3.

34 UNICEF Report of 2005, *op.cit.,* note 25, at p. 1.

35 See for instance Fact Sheet No. 23, *op.cit.,* note 1., at p. 3; Coomaraswamy, *op.cit.,* note 1, at p. 10; Obiora, *loc.cit.,* note 29, at pp. 293–298.

36 See RCN, *op.cit.,* note 22, at p. 3, referring to Ng, F., 'Female Genital Mutilation: Its Implications for Reproductive Health – An Overview', *British Journal of Family Planning*, Vol. 26, No. 1, 2000, pp. 47–51. See also Obiora, *loc. cit*., note 29, at pp. 298–299.

contradictory ways. On the one hand, it is promoted for chastity reasons and to reduce sexual pleasure, but, on the other hand, (male) circumcision is sometimes said to prolong sexual interaction.[37] Circumcision also serves as an identity marker of a social or religious group. This can entail a combination of a tribal, adult and gender identity (as is often the case with male and female circumcision in Africa), as well as a combination of religious and gender identity, as is the case with male circumcision in Judaism and Islam. These identity markers serve to confirm the in-group identity.[38]

> The rationales for male circumcision (that may overlap) generally fall into three categories: The *first* category is of a cultural ritualistic nature. It confirms gender roles in adulthood and includes control of sexuality.
> The *second* category points at perceived health benefits, such as the prevention of HIV/AIDS infections. Adapting to what is 'normal' may come under this heading as well.
> The *third* category refers to religious reasons, which are more or less ritualistic. There is no question for Muslims and Jews as to the religious background of the practice. However, there is some debate on whether the obligation to circumcise a child constitutes a core obligation, or is more of a secondary obligation.[39]

Female circumcision is equally based on these rationales. The first rationale seems to be dominant, although the other motives seem to be present and intertwined as well. Female circumcision is usually referred to as a 'social convention' that can only be discontinued by persuading the entire community to abandon the practice (rationale 1 and 2). The lack of a religious source (rationale 3) for the practice is often emphasised in campaigns seeking to eradicate female circumcision. And although female circumcision may be part of a ritual (rationale 1), male circumcision, and in particular its very invasive forms, may also be a test of masculinity. In these cases, there is a rejection of medical interventions or assistance – which seems to be absent in female circumcision (maybe not really surprising). This might explain the ready adoption by practicing communities of the – now internationally rejected – medical frame for women, which refers to the second rationale and was originally introduced to prevent the more severe health complications.

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37 Fox and Thomson, 2009, *loc.cit.,* note 8, at p. 200, refer to both views.

38 See Pollack, M., 'Circumcision: If It Isn't Ethical, Can It Be Spiritual?', in Denniston, Hodges and Milos, *op.cit.,* note 4, pp. 189–194, at p. 91; Shweder, *loc.cit.,* note 19, at p. 247; Davis, *loc.cit.,* note 8, esp. Chapter IV, 'The Meaning of Genital Alteration'. An example of the reverse situation, namely circumcision as identity marker towards an outgroup, is the forced circumcision of male adult supporters of the equally uncircumcised candidate for the presidency, Raila Odinga, in the post-election crisis in Kenya in 2007–2008. See IRIN, Press Release 'Kenya: Plea to ICC over Forced Male Circumcision', *available at*: www.irinnews.org/printreport.aspx?reportid=92564 (last accessed 2 March 2012).

39 See Chapter II, paragraph I of: Aldeeb Abu-Sahlieh, S.A., 'To Mutilate in the Name of Jehovah or Allah: Legitimization of Male and Female Circumcision', *Medicine and Law*, Vol. 13, No. 7–8, 1994, pp. 575–622.

2.1. TYPES OF CIRCUMCISION

On the basis of these types of rationales combined with the forms of circumcision, a typology of three of the most common types can be made.[40] As far as comparability is concerned, obviously the first type entails both female and male circumcision.

1. Cultural, ritualistic, with emphasis on gender roles in adulthood, including control of sexuality: carried out by traditional circumcisers, without anaesthesia as a rite of passage from infant to adult men or women with a high risk for health and even life; practiced by some ethnic groups in Africa. We will call this the *African* type.
2. Cultural, non-ritualistic, with emphasis on health/hygiene and social and sexual normality: carried out (routinely) by medical staff, most commonly on newborn boys, without therapeutic indication, and with a highly debated risk of mental and physical harm.[41] The medical motive is also present in Africa, firstly to curb the serious physical consequences of type 1 on men and women and secondly to prevent the spread of HIV/AIDS, but is not routinely carried out on newborn males. We will take the routinely carried out neonatal circumcision (RNC) as paradigmatic for this type and as this is mostly performed in the US, we will call this the *American* type.[42]
3. Religious, more or less ritualistic, predominantly in Judaism and Islam, but also among Christians, particularly in Africa. In Judaism, male circumcision is considered to be a commandment of God to the father to have it carried out at a very young age on his son (on the eighth day after birth). Muslim boys are sometimes circumcised when a bit older and the Islamic obligation to circumcise is less strict than within Judaism. In general, female circumcision is not considered to be a compulsory religious practice. Some consider it at the most recommendable, but the religious nature of this recommendation is again contested; cultural influences seem to be at play.[43] In both Judaism and Islam male circumcision is carried out

40 Dekkers, Hoffer and Wils, *loc.cit.,* note 5, at p. 180, have a different typology. They distinguish between '(1) medical-therapeutic, (2) preventive-hygienic, (3) religious and (4) cultural reasons'. We use a broader conception of culture that includes culture-specific perceptions of health.

41 As stated above, female circumcision practices in the Anglo-Saxon world in the 19th century, would have fallen in the second category.

42 It would be interesting to discover the extent of American influence on the circumcision promotion policy in Africa of the WHO/UNAIDS. Fox and Thomson, *loc.cit*., note 3, at p. 259 refer to several authors who have argued that a successful promotion of circumcision in Africa could be transported back to the USA in order to reverse the declining rate of circumcisions there. See for the history of RNC in the US: Darby, R., 'The Masturbation Taboo and the Rise of Routine Male Circumcision: A Review of the Historiography', *Journal of Social History*, Vol. 36, No. 3, 2003, pp. 737–757.

43 Compare Aldeeb Abu-Sahlieh, *loc.cit.,* note 39. Of course culture and religion are not always easily distinguishable. In the African type, which we labelled as cultural, spiritual/religious aspects may play a role as well. See e.g. Shweder, R., 'What About "Female Genital Mutilation"? And Why Understanding Culture Matters in the First Place', in: Shweder, R., Minow, M. and Markus, H. (eds.), *Engaging Cultural Differences: The Multicultural Challenge in Liberal Democracies*, Russell Sage Foundation, New York, 2002, pp. 216–51, at p. 218.

by religious or medical circumcisers, although Jews generally seem to attach more weight to the ritual being carried out by a religious circumciser (*mohel*). Many Christians do not regard male circumcision as a religious obligation. Baptism is considered to have replaced male circumcision. Still, some Christian groups do regard male circumcision as a religious practice, especially in Africa. We will call this the *Abrahamic* type.

This typology is interesting as it not only puts into perspective the comparability of male and female circumcision, but also gives a first indication of how both male and female circumcision are framed.

3. FRAMES

3.1. INTRODUCTION

Three different frames dominate the discussion on circumcision: a medical/health frame, a cultural and/or religious frame and a human rights frame. With regard to *male circumcision*, the medical/health frame serves primarily to oppose or defend circumcision for bodily reasons. Cultural and religious frames refer to non-bodily reasons to attack or defend circumcision. The human rights frame is a kind of accessory frame: it is used to strengthen (one or both of) the other frames in the discussion whether (a certain form of) male circumcision is legitimate or not and can be found in both areas.

With regard to *female circumcision*, the same frames are used, but with different accents and gaps. The medical/health frame is never used to support female circumcision, except maybe by those of the in-group who practise female circumcision. As these groups are largely absent in the discussion, the medical/health frame is rather used to oppose female circumcision. In the past it was also used to promote safer conditions, but this was dropped when the frame turned out to be 'too successful', resulting in continued practice instead of a gradual decline. Furthermore, the religious frame for female circumcision is only marginal, while a cultural frame seems to represent an anti-position, again taking into account that proponents of the practice are almost absent from the discussion. Most importantly, contrary to male circumcision, a human rights frame is not an accessory frame, but the most dominant frame for (condemning) female circumcision. Let us consider each of these frames.

3.2. THE BODY: THE MEDICAL/HEALTH FRAME

Dominant in the arguments concerning the body is the medical/health frame, which touches on notions of (preventive) health benefits, including issues of hygiene, on the one hand, and risks or harm, including psychological harm, on the other hand. The

positive or negative influence on the functioning of sexual parts of the body is also covered by this medical/health frame.

Proponents of *male circumcision* use the medical/health frame as follows: because male circumcision has health benefits (and hygiene and sexual benefits), male circumcision is legitimate. Opponents use the frame by stressing the health risks and even the harm that can be inflicted. In this area, medical professionals dominate the discussion with an appeal to scientific medical knowledge.[44] Health and avoidance of harm is the shared frame. The discussion is concentrated on the question whether health benefits or suffers from male circumcision. This discussion takes place especially in the US with regard to the *American* type of routine neonatal circumcision on boys.[45] A similar debate is conducted on the scientific proof of claimed health consequences. The discussion with regard to the promotion of male circumcision in Sub-Saharan Africa in response to HIV/AIDS includes contextual factors, such as the (low/high) costs of male circumcision compared to anti-AIDS medicines or condoms and sexual behavioural practices that may undermine the perceived protection against HIV/AIDS.[46] In the European context, in contrast, the health frame is used to oppose the most prevalent practice of male circumcision, that is the *Abrahamic* type.[47]

The health frame is also an important frame in the *African* type of male circumcision. If we take the conflict between the amaXhosa and the government of South Africa as paradigmatic it is the State that uses the health frame to delegitimise the male circumcision as carried out by ritual circumcisers, as far as they do not follow the hygienic procedures as required by the State in order to diminish the high rates of health complications and morbidity among circumcised teenage boys. Traditional leaders and ritual circumcisers often do not share this frame: health risks and harm are celebrated as symbolic death in the rite of passage and actual death is accepted.[48] In the religious, *Abrahamic*, type of male circumcision the health frame is less dominant. Religious reasons are in the forefront and when the health frame is used, it is often presented in (or in combination with) a religious frame, as we will see below.

Although definitely perceived as a human rights violation, *female circumcision* was in the initial stages framed by the Western dominated international community as a medical issue, presumably to avoid accusations of neo-colonialist practices. Those who

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44 Medical professionals may be either proponents or opponents of male circumcision, using scientifically, but apparently also culture specific medical/health arguments. Compare Dekkers, *loc.cit.,* note 4, p. 131, and Johnson, *loc.cit.,* note 8, p. 183. Still, it is repeatedly reported in literature that there are probably minimal health advantages of (routine) male circumcision, but that these are not sufficient to counterbalance the disadvantages or risks of health complications.

45 Szasz however rejects this frame, arguing that it hides the ritual origin and the moral (and legal) character of the practice. Szasz, *loc.cit.*, note 4.

46 See e.g. Fox and Thomson, *loc.cit.,* note 3, at pp. 263–266.

47 See e.g. Askola, *loc.cit.*, note 5, at p. 110.

48 Compare Vincent, *loc.cit.*, note 32, at pp. 80–82; Kepe, T., '"Secrets" That Kill: Crisis, Custodianship and Responsibility in Ritual Male Circumcision in the Eastern Cape Province, South Africa', *Social Science and Medicine*, Vol. 70, No. 5, 2010, pp. 729–735.

used this medical frame, urged people to have the circumcision of girls and women done by health care professionals to reduce health complications. However, as pointed out above, the medical framing was so successful, that now international collective action is taken so as to actively stop health-care providers from performing female circumcisions.[49] Often the health frame is also used to stress the radical difference with male circumcision: female circumcision has no health benefits at all. To the contrary, it is said to cause extremely serious (long lasting) health consequences, while the health benefits of male circumcision are at least equivocal.[50] It is interesting to note that there has been a deliberate separation of male circumcision from female circumcision for bodily reasons as 'the fight against female genital mutilation would be more difficult if male circumcision were also to be challenged'.[51]

So, while there is a lively discussion on the medical/health benefits of male circumcision, the dominant claim of the devastating bodily effects of female circumcision is very rarely contested. Nonetheless, it has also been pointed out that at least in the past, the consequences of female circumcision have been exaggerated somewhat and that many of the consequences attributed to female circumcision seem related to poor medical conditions surrounding pregnancy and giving birth, and thus are suffered equally by uncircumcised women.[52]

However, the WHO's *Global strategy report* mentions that 'in certain countries some health-care providers consider FGM to be medically indicated for most women, while others see the practice as harmless'.[53] In particular, members of practicing communities opposing female circumcision still prefer the medical frame because it is regarded as more neutral, less normative than other frames such as the human rights frame. Moreover, the frame is much narrower, and does not necessitate an evaluation of the values underlying the practice, including an assessment of gender relations.[54]

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49 WHO 2008, Female Genital Mutilation, WHA61.16, 24 May 2008, at p. 12, *available at*: www.who.int/reproductivehealth/topics/fgm/fgm_resolution_61.16.pdf (last accessed 20 September 2012); WHO 2010, *op.cit.,* note 2. See also: Boyle and Carbone-López, *loc.cit*., note 25, at p. 443.

50 E.g. the Special Rapporteur on Traditional Practices Affecting the Health of Women and Children firmly states the incomparability in her reports of 1997 and 2000 because of the absence of health benefits of female circumcision. *Op.cit*., note 6.

51 The Report of the UN Seminar related to Traditional Practices affecting the Health of Women and Children in 1991 states: 'As regards the strategy for combating female circumcision, it was recommended that efforts should be made to separate, in people's minds, male circumcision, which has a hygienic function, and female circumcision, which is a grave attack on the physical integrity of women', compare: UN Doc. E/CN.4/Sub.2/1991/48/ (1991), at p. 6 and p. 9. Quoted in Smith, *op.cit.,* note 9, at p. 476.

52 An exception is Obermeyer, a medical anthropologist and epidemiologist, who concluded after reviewing the existing medical literature on female circumcision in Africa, that the evidence for the devastating effects was highly exaggerated. See Shweder, *op.cit.,* note 43, at p. 219. In the same vein: Johnsdotter and Essén, *loc.cit.,* note 31, at p. 33.

53 WHO, *op.cit.,* note 17, at p. 7.

54 See Boyle and Carbone-López, *loc.cit.,* note 25, at p. 451. This narrow approach is considered to be both an advantage, in that it depoliticises the practice, and a disadvantage, because it dismisses

3.3. THE BODY: THE HUMAN RIGHTS FRAME

The human rights frame that is used to strengthen the medical/health frame includes the right to life, when the practice results in death,[55] the prohibition of torture or cruel, inhuman or degrading treatment or punishment,[56] the right to health and the related obligation of States to abolish traditional practices prejudicial to the health of children.[57] Most of these human and children's rights presuppose health risks or bodily harm and as such are used by opponents of *male circumcision*. However the right to enjoy the highest standards of physical health can be used as well by proponents who are convinced of health benefits.[58]

The opponents of *female circumcision* have an easier job to claim that the practice is harmful for the health of girls as both the CEDAW Committee and the Committee on the Rights of the Child have identified female circumcision explicitly as such a practice.[59] Along the same line, Article 5 of the Protocol to the African Charter on Human and Peoples' Rights on the rights of women in Africa, mentions female circumcision as a harmful practice that should be eradicated. Furthermore, the CEDAW Committee and the Human Rights Committee have denounced female circumcision as violence against women.[60] In addition, the Committee Against Torture has qualified female circumcision as a form of torture with regard to which States must exercise due diligence.[61]

The dominant human rights frame in the discussion on *male circumcision* is the right to bodily integrity. This right is not as such formulated in a binding human rights instrument for European countries,[62] but is considered connected with several

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the local or cultural background as 'politically unreasonable' and as a 'narrow Western centric assessment'. See Tobin, *loc.cit.,* note 15, at pp. 388–389.

55 Art. 2 ECHR and Art. 6 ICCPR.

56 Art. 3 ECHR and Art. 7 ICCPR.

57 Art. 12 ESCR and Art. 24(1) and 24(3) CRC.

58 Compare for example Gilliam, F. D. et al., 'Framing Male Circumcision to Promote its Adoption in Different Settings', *AIDS & Behavior*, Vol. 14, No. 5, 2010, pp. 1207–1211.

59 CEDAW Committee, General Recommendation No. 14 on the Eradication of Female Circumcision, ninth session (1990), A/45/38 and Corrigendum; CEDAW Committee, General Recommendation No. 24 on Article 12: Women and Health, twentieth session (1999), Doc. A/54/38 at 5 (1999); Committee on the Rights of the Child, General Comment on the Right of the Child to Freedom from all Forms of Violence, UN Doc. CRC/C/GC/13 (2011), at para. 29.

60 CEDAW Committee, General Recommendation No. 19 on Violence Against Women, eleventh session (1992), UN Doc. A/47/38 (1993); Human Rights Committee, General Comment No. 28 on the Equality of Rights between Men and Women, UN Doc. CCPR/C/21/Rev.1/Add.10, (2000), at para. 11.

61 Committee Against Torture, General Comment on the Implementation of Article 2 by States Parties UN Doc. CAT/C/GC/2 (2007), at para. 18. See for female circumcision as a violation of Article 3 ECHR in relation to refugee law: ECtHR, *Collins and Akaziebie v. Sweden*, 8 March 2007 (Appl.no. 23944/05).

62 It is formulated in Art. 3 UDHR and in the American and African regional human rights charters. To date, there has not been a case regarding male circumcision decided by the ECtHR.

specific human rights, of which the right to privacy is the most obvious.[63] The notion of bodily integrity is a complex (ethical) notion. It entails protection against external interference of the body and the right of self-determination over the body. Both elements are of relevance with regard to male circumcision. The external protection part is used to criticise unnecessary or violent interventions by circumcisers (especially in relation to the *African* and *American* types). Some use the term child abuse in this regard.[64] The self-determination approach in the discussion on male circumcision goes beyond the medical/health frame: it states clearly that whatever the medical/health aspects – positive, neutral or negative – it should be the decision of the child himself at an older age or as an adult to have his body altered. This clearly refers to the *American* and *Abrahamic*, and more specifically the Jewish, types of male circumcision, in which children are circumcised at a young age. It also opposes the quite broadly accepted position that parents can decide for their minor son, in case of presumed positive health effects as well as in case of the (assumed) absence of a clear indication of positive and negative health effects.

One difference between the human rights frames on male and female circumcision stands out: the virtually unquestioned acceptance of *all* forms of *female circumcisions* as harmful, violent and tortuous, that should be outlawed even for consenting adults. In terms of bodily integrity, female circumcision is apparently considered primarily as an external interference of the body, which seems to imply that the other aspect of bodily integrity, namely the right of self-determination over the own body is not taken into consideration. Protection of girls and women against an outside intrusion is what counts first and foremost.

3.4. NON-BODILY REASONS: CULTURAL AND RELIGIOUS FRAMES

In the debate on circumcision there are *defenders* of the practice, irrespective of medical or health reasons. They argue that although male and female circumcision is about the body, it is legitimate for non-bodily, immaterial reasons. The arguments in favour of male circumcision can be identified as cultural and religious frames. The arguments in favour of female circumcision seem to be restricted to a cultural frame.

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63 Art. 8 ECHR, Art. 17 ICCPR. See for a discussion on the relevance of Articles 8 and 3 ECHR for female circumcision: Kool, R. 'The Dutch Approach to Female Genital Mutilation in View of the ECHR: The Time for Change Has Come', *Utrecht Law Review*, Vol. 6, No. 1, 2010, pp. 51–61. The right to bodily integrity is sometimes formulated as a constitutional right. See e.g. Askola, *loc.cit.*, note 5, at p. 101 for the Finnish situation. Art. 11 Dutch Constitution was referred to by the Royal Dutch Medical association (KNMG) in their study of male circumcision. KNMG, *Viewpoint Non-Therapeutic Circumcision of Male Minors*, p. 15, *available at*: www.knmg.artsennet.nl/Over-KNMG/English.htm (last accessed 20 September 2012).

64 Fox and Thomson oppose the 'labelling of this practice [as] a form of child abuse'. Fox, M. and Thomson, M, 'Reconsidering "Best Interests", Male Circumcision and the Rights of the Child' in: Denniston, Hodges and Milos, *op.cit.*, note 4, pp. 15–31, at p. 16.

The cultural frame that legitimises both male and female circumcision corresponds to the *African* type. Male and female circumcision is considered necessary with regard to the gender and age identity. It signifies the status of the adult gendered person within the cultural group. The accessory human rights frame that is used to strengthen the cultural frame, is the right to culture. Arguments against female circumcision are also coached in a cultural frame. Such a cultural practice is denounced as 'bad tradition'[65] or as a harmful 'traditional' practice.[66] The accessory human rights frame focuses on the perceived underlying gendered rationale of female circumcision as based on the inferiority of women and/or stereotyped roles for men and women.[67]

In the *American* type, the legitimacy of male circumcision is based on notions of beauty, sexual appeal and normality. This cultural frame is put forward by male and female adults, but also by parents who are allowed to decide about the surgery of their boys. An appeal to the human rights frame in the latter case is done by subsuming the decision of parents as the right to family life and qualifying it as in 'the best interests of the child'.[68] The argument of the best interests of the child seems to gain ground as a result of dwindling scientific conviction that male circumcision has beneficial health effects. It runs as follows: in so far as there are no clear indications of positive or negative health effects of male circumcision, parents may decide for their child because they are in the best position to know what is in the best interests of the child. The notion of the best interests of the child encompasses cultural non-bodily reasons.[69]

Those who oppose the *American* type because of the human rights notion of bodily integrity and especially the self-determination of the child, are critical of the parental choice model. They point out that the irreversibility and health risks of male circumcision imply that the choice for male circumcision should not be made by the parents, but by their child. But as the boy is not yet capable of an autonomous choice at an early age, it is in the best interest of the child to postpone the moment for deciding on circumcision until he is able to make an informed and free decision himself. The cultural value of individual autonomy requires this. The human rights framework that strengthens this liberal culture of individual rights includes the right to bodily integrity and the best interests of the child.[70]

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65 See Boyle and Carbone-López, *loc.cit.,* note 25, at p. 447.

66 See General Recommendation No. 14 of the CEDAW Committee. It is noteworthy that female circumcision is mentioned in the recommendation as a *traditional* practice harmful to the health of women, while in Article 5 of the Maputo Protocol female circumcision (genital mutilation) is merely called a harmful practice.

67 Art. 5 CEDAW and Art. 2(2) Maputo Protocol.

68 Art. 8 ECHR, Art. 17 ICCPR, and Art. 3 CRC.

69 Dekkers, *loc.cit.,* note 4, at p. 132. See for a critique: Fox and Thomson, in Denniston, Hodges and Milos, *op.cit.,* note 64.

70 Dekkers, *loc.cit.,* note 4, at pp. 132–134; Fox and Thomson, in Denniston, Hodges and Milos, *op.cit.,* note 64, at pp. 27–28.

However, this line of reasoning does not seem to extend to female circumcision. For instance, adult women who would ask to be circumcised on the occasion of their marriage should, arguably, not be facilitated but receive 'information and consultation' (although the outcome of the consultation is not debatable apparently). Likewise, requests of women who have just given birth and demand to be reinfibulated should be refused.[71] This contrasts not only with the still rather unsuccessful attempts to get male physical integrity on the human rights agenda, but also with the emphasis of the advocates of the ending of male circumcision on newborn boys, on the fact that practices of male circumcision are unacceptable because these infants cannot consent. Male circumcision on consenting adults as such is not targeted by these groups.

Interestingly, in the American literature the human rights notion of bodily integrity as an argument against male circumcision of children is used almost exclusively as an argument against the *American* type. Because this notion of bodily integrity can be considered in a secular and individualist way, it can of course be used as well against the *Abrahamic* type, a development that seems to become more noticeable in Europe.[72] However, so far, the debate on the *Abrahamic* type has been framed mainly in religious terms among proponents and opponents within Judaism and Islam. One issue for debate is whether male circumcision is a strong religious obligation or a recommendable practice, as it is not mentioned in the Koran. Other issues are whether alteration of the body is allowed, considering the belief that man is created in the image of God, and whether he is allowed to inflict pain or even create health risks.[73] Also the gendered aspect of male circumcision is debated.[74]

In discussions between in-groups and out-groups or about practicing groups, the human rights frames used center primarily on the meaning and scope of the freedom of religion, including the right of parents to ensure the religious and moral education of their children in accordance with their own convictions. Other fundamental rights issues that feature in the debate are the right to family life and the question of whether the 'best interest of the child' is limited to the individual interests of children, or encompasses collective family, cultural and religious interests.[75]

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71 WHO, 2010, *op.cit.,* note 2; Dustin points out the inconsistency in the UK between the illegal reinfibulation of consenting adult women and the legally provided hymen repair and other genital cosmetic surgery of adult women. Dustin, *loc.cit.,* note 29, at p. 13.

72 KNMG, *op.cit.*, note 63; Hofvander, *op.cit.*, note 20; Gilbert, *loc.cit.,* note 5.

73 Dekkers, Hoffer and Wils, *loc.cit.,* note 5, at pp. 183–187, who discuss religious perspectives of bodily integrity in terms of wholeness, and Aldeeb Abu-Sahlieh, *loc.cit.,* note 39, Chapter II on religious arguments.

74 See for Judaism: Pollack, *loc.cit.,* note 38, at pp. 192–193. See for Islam: Aldeeb Abu-Sahlieh, *loc.cit.,* note 39, at p. 10.

75 Fox and Thomson, in: Denniston, Hodges, and Milos, *op.cit.,* note 3, p. 21; De Blois, M., 'Besnijdenis en godsdienstvrijheid' [Circumcision and Freedom of Religion], *Pro vita humana*, No. 3, 2010, pp. 80–85.

In the above frame analysis of the discussion on male circumcision we have discussed proponents and opponents. Of course this is too simple. The debate covers a whole range of positions including in-between positions that take into account the form of the circumcision and the dimension of health benefits, the seriousness of health risks or other harm. Thus, the practice may be accepted when it is carried out in a medical, professional or safe way. Some have a different interpretation of bodily integrity or include both contextual and individual interests of children when trying to decide on their best interests.[76] However, these in-between positions are virtually absent as regards female circumcision.

3.5. NON-BODILY REASONS: THE HUMAN RIGHTS FRAME AS THE DOMINANT FRAME FOR FEMALE CIRCUMCISION

Female circumcision was initially framed as a cultural and health issue. This changed at the end of the 1970s when female circumcision was tabled by American writer and feminist activist Fran Hosken, who may be regarded as the 'founding mother' of a world-wide crusade against the practice.[77] Since then, the practice was framed as a human rights violation, although the drafters of the CEDAW Convention more or less deliberately avoided the topic and refrained from including a provision on physical integrity in the Convention.[78] As already mentioned elsewhere, the Convention's monitoring body nonetheless adopted several General Recommendations referring to the reprehensibility of the practice. The Human Rights Committee and the Committee on the Rights of the Child have likewise denounced female circumcision.[79] This happened as well in the so-called Maputo Protocol of 2003 on the rights of women in Africa. Outside the area of human rights, female circumcision has been condemned in the strongest wording by the WHO,

[76] De Blois stresses parental liberty as an aspect of the freedom of religion as laid down in Art. 18(4) ICCPR and Art. 14(2) 2 CRC. De Blois, M., 'Jongensbesnijdenis en het Recht' [Circumcision of Boys and the Law], *Nederlands Tijdschrift voor Kerk en Recht*, Vol. 6, 2012, pp. 51–71, at pp. 58–59. See also Shweder, *loc.cit.,* note 19, who focuses on religious interests, and Dekkers, Hoffer and Wils, *loc. cit.,* note 5, who give a different perspective on bodily integrity. Compare also the Committee of the Rights of the Child, which recommends to the South African Government to ensure safe medical conditions during the practice of male circumcision, thus not condemning male circumcision as such. Committee of the Rights of the Child, Concluding Observation: South Africa, CRC/C/15 Add 122 (2000), at para. 33.

[77] See Hosken, F.P., *The Hosken Report: Genital/Sexual Mutilation of Females,* Women's International Network News, University of California, 1979.

[78] Van den Brink, M., *Aan Den Lijve; Over het Vrouwenverdrag en Lichamelijke Integriteit*' [Bodily Experiences; On the Women's Convention and Bodily Integrity], Utrecht University – ISEP-papers, 1993, pp. 30–31.

[79] See for references section 3.3 of this contribution.

by the World Health Assembly[80] and by many other both governmental and non-governmental international bodies.[81]

The human rights frame that is directly related to the body, such as the right to health, life, freedom from harmful practices, torture or physical violence are mentioned above. Besides these 'bodily human rights', female circumcision is framed in non-bodily human rights terms, especially as a reflection of 'deep-rooted inequality between the sexes' and 'an extreme form of discrimination against women', and as a (cultural) practice that is based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.[82] As such, the gendered character of female circumcision is the focal point. This is confirmed in the often stated 'fact' that female circumcision is a violation of the human rights of girls and women. There seem to be no organisations that advocate the practice, although the condemnation of the least invasive form of female circumcision, 'pricking', has been questioned and is regarded by some, among them doctors and even state officials, as an acceptable alternative for practicing communities.[83]

The complete separation of male and female circumcision is not a coincidence, but the result of conscious efforts 'to separate, in people's minds, male circumcision, which has a hygienic function, and female circumcision, which is a grave attack on the physical integrity of women'.[84] The qualification of circumcision as a form of sex-discrimination is absent in discussions on male circumcision, although the fact that male circumcision has so far been ignored by the international human rights agenda has been characterised by some as a form of gender bias in itself.[85] This, however, is a different notion. The idea that male circumcision, in itself, is somehow a form of discrimination of men is never raised.

Thus far, we have identified the frames for both male and female circumcision. The most obvious results for male circumcision are that the medical/health, cultural and religious frames are still quite strong, so long as the actual circumcision is carried

80 WHO, *op.cit.,* note 49.

81 See e.g. WHO, 2008, *op.cit.,* note 49.

82 See Art. 5 CEDAW and Art. 2(2) Maputo Protocol, WHO 2010, *op.cit.,* note 2, at p. 6; WHO, Fact Sheet No. 241, February 2012; Lewnes, A. (ed.) *Changing a Harmful Social Convention: Female Genital Mutilation/Cutting*, UNICEF Innocenti Digest, 2005, at pp. 15–21, *available at*: www.unicef-irc.org/publications/pdf/fgm_eng.pdf (last accessed 20 September 2012).

83 Obiora, *loc.cit.,* note 29, at p. 287; Johnsdotter and Essén, *loc.cit.,* note 31, at p. 29. Both mention the protest that arose when the Ministry of Health and Culture of the Netherlands in 1992 proposed to allow ritual pricking. Limborgh and a medical doctor faced similar opposition in 2008 when both of them proposed to make sunna light or symbolic pricking lawful in the Netherlands. Limborgh, W.M., *Culturele Vrijheid en het Strafrecht* [Cultural Freedom and Criminal Law], Wolf Legal Publishers, Nijmegen, 2011, at p. 169.

84 Report of the UN seminar related to Traditional Practices affecting the Health of Women and Children, Ouagadougou, Burkina Faso, 29 April – 3 May 1991, UN Doc. E/CN.4/Sub.2/1991/48, para. 27; Smith, *op.cit.,* note 9, at p. 476.

85 E.g. Johnson, *loc.cit,.* note 8, at p. 183; DeLaet, *loc.cit.,* note 9, at p. 422.

out in a safe way. Nevertheless, this in-between position with an accessory human rights frame towards male circumcision is increasingly criticised by the human rights notion of bodily integrity of the child/man. In contrast, the dominant frame in the discourse on female circumcision is the human rights frame of women's and girls' rights that denounces any in-between position, extends beyond the medical/health frame and disqualifies the (African) cultural frame.

4. ANALYSIS AND EXPLANATIONS

4.1. INTRODUCTION

After this inventory of the contrasting frames for male and female circumcision, we return to the question whether this (partly) different framing is justified from the viewpoint of universality of human rights. Universal validity requires that similar standards should be applied to similar practices. Likewise, the sex/gender equality principle demands the equal treatment of men and women, unless there is an objective and reasonable justification not to do so. The dominant position regarding male and female circumcision is that they are in no way comparable. Still, one would expect arguments to be consistent, regardless of comparability and regardless of one's ideas about the practice. Therefore, first the consistency of the arguments of proponents and opponents will be explored.

We have not come across arguments in the literature against male circumcision and in favour of female circumcision,[86] so this position will not be discussed. A more recently evolved position opposes both male and female circumcision because of medical/health risks or harm. Some hold that, even if there are no health risks, the notion of bodily integrity requires outlawing circumcision of children, as long as there are no clear health benefits.

Opponents of male circumcision who are confronted with the actual situation in which male circumcision is allowed, while female circumcision is prohibited, use an additional human rights frame: discrimination of boys. So far there is consistency. Interestingly, however, the idea that adult women might choose to be circumcised or (re)infibulated does not figure in the debate.[87] Until recently, everyone has been silent about adult women, who according to the accessory human rights notion of self-determination would be allowed to have female circumcision carried out on their own body, while male circumcision does not meet any opposition as far as adult men

86 However, Limborgh, *op.cit.,* note 83, at pp. 164–177, attacks the form of male circumcision called *periah* and defends one form of female circumcision, namely sunna light or symbolic pricking.

87 On the issue of reinfibulation see e.g. Allotey, P., Manderson, L. and Grover, S., 'The Politics of Female Genital Surgery in Displaced Communities', *Critical Public Health*, Vol. 11, No. 3, 2011, pp. 189–201; see also Dustin, *loc.cit.,* note 29, at p. 13.

are concerned.[88] The only consistent reason to prohibit adult female circumcision and allow male circumcision is the far more serious health risks or bodily harm in case of some of the forms of female circumcision. In that case, the violent intervention aspect of bodily integrity by those who carry out the circumcision could override the self-determination aspect of bodily integrity. Not every intervention on the human body is justified just because it is requested by the person concerned.

The approach of proponents of male circumcision towards female circumcision is more diverse. There are proponents of both male and female circumcision, but they are not directly involved in the academic discussion. Proponents of circumcision of both men and women can be found within some Islamic cultures and presumably in some African cultures which practice both male and female circumcision.[89] In so far as this position is taken on the basis of a specific perception of gender roles, it would be interesting to explore the dominant perception that female circumcision is sex discrimination whereas male circumcision is not. However, far more often proponents of male circumcision are critical of female circumcision. How can this be explained? What is apparently not comparable?

4.2. EXPLANATIONS FOR ENDORSING MALE BUT REJECTING FEMALE CIRCUMCISION

There are several explanations for this apparent inconsistency. First, it is possible that health benefits of female circumcision are absent. This undermines a sufficient bodily justification. Second, the health risks or bodily harms may be too serious to render female circumcision legitimate for non-bodily reasons. A third possible explanation is that the non-bodily reasons in the sphere of religion and culture are not considered important enough to outweigh health risks or bodily harm.

Indeed, literature shows that while some health benefits are ascribed to male circumcision (especially in some contexts), these are absent with regard to female circumcision. But this cannot be decisive. The second argument requires a closer look at the different forms/methods of male and female circumcision. Some types of male and female circumcision are quite similar, while others differ significantly. There are very invasive forms of male circumcision and very light forms of female

88 KNMG pays attention to this aspect, indicating however that the permission of the patient does not offer sufficient justification for others (like doctors) to perform the intervention. Therefore an additional reason is required, such as medical interest. KNMG, *op.cit.,* note 63, at p. 14. See also CEDAW Committee/Committee on the Rights of the Child, Joint CEDAW-CRC General Recommendation/Comment on Harmful Practices: Call for papers, that explicitly mentions harmful practices detrimental to the well-being of boys, *available at* www2.ohchr.org/english/bodies/cedaw/JointCEDAW-CRC-GeneralRecommendation.htm (last accessed 1 October 2012).

89 Aldeeb Abu-Sahlieh, *loc.cit.,* note 39, at pp. 6–7, mentions religious arguments in favour of female and male circumcision within the Islam; it has to be said that the proponents of both male circumcision and female circumcision within the Islam do not have the same arguments for both types.

circumcision and the other way around, as described in section 2. Thus, one cannot consistently uphold the health risks/bodily harm arguments in favour of all forms of male circumcision and against all forms of female circumcision.

The third explanation is the most normative, with expected variations between internal and external standpoints. It is here that the external standpoints tend to focus on kinds of cultural harms regardless of the form of female circumcision, while ignoring male circumcision. Female circumcision is consistently looked at from the perspective of women's subordinate position in practicing cultures. Women are required to remain chaste, which is easier when the possibility to experience sexual pleasure is diminished. It may be difficult for uncircumcised women to find a suitable husband. However, continuing the practice for that purpose merely strengthens the status quo. Also, male circumcision may be perceived as the stronger religious obligation in comparison with female circumcision. However, some of these disadvantages or harms, such as diminished sexual pleasure and the need to belong to the group, can be attributed to male circumcision as well. Thus, in so far as male and female circumcisions are comparable, this seems an indication that criteria are not consistently applied, when the same criteria lead to different outcomes in similar cases.

4.3. INCONSISTENCIES: THREE BIASES AT WORK

The second and third explanations seem to lay bare the inconsistency as regards proponents of male circumcision who – at the same time – are opponents of female circumcision. It is this position that we question. However, a remark should be made: the most dominant position seems to be that male circumcision is neglected, while female circumcision is condemned, without a serious comparison being made. Proponents of male circumcision stress the (contested) positive health effects of male circumcision and may acknowledge minor health risks or harm, but see an overall benefit in religious or cultural reasons. At the same time, female circumcision is regarded as genital mutilation; thus, as degrading violence against women that is not a religious obligation but grounded in discriminatory cultural practices. We assume that there are at least three biases at work.

The *first explanation* relates to gender: we suspect that women are quickly perceived as victims of their culture or religion, while men are not. An indication of gender bias is the 'framing' of female circumcision as an expression of women's subordinate and disempowered role, which is completely absent from any discussion on male circumcision. However, even though female circumcision definitely seems to be grounded in gendered expectations regarding women's role in life, it is also true that the practice is continued by women mostly, and there are indications that if all women in a community would decide to discontinue the practice, it might not

lead to much male resistance.[90] Thus, the perception of women in the practicing communities as (just) victims seems to be gendered. It appears to be not only gender biased but also partly Western biased in that the West is unable to see the agency of these women. Similarities with contemporary practices of cosmetic plastic surgery are overlooked or ignored. Therefore, although gender norms are criticised by those opposing female circumcision, they are confirmed at the same time by accepting male circumcision. This is arguably reinforced by conceptualising female circumcision as female genital mutilation that is a serious interference of women's rights. This view can lead to the neglect of men's human rights, and is only redressed now through the notion of children's rights.[91]

This gendered perception of circumcision is probably enforced as far as female circumcision is considered to be a harmful practice of an 'other' or 'exotic' or 'traditional' culture, located in some parts of Africa. In other words, a *second explanation* for the inconsistencies identified, may be that practices in another culture are more easily considered unjust and senseless than practices of one's own or a familiar culture.[92] This may occur in the West, but of course it also occurs in other parts of the world, including Africa.[93] Yakin Ertürk, the special rapporteur on violence against women, has noted how the 'harmful traditional practices agenda' has 'contributed to essentialising certain cultures as the source of the problem'.[94]

Interestingly, this cultural frame was initially a reason to ignore female circumcision: the sensitive intercultural relations after decolonisation rendered female circumcision too touchy a topic for an intercultural discussion. Female circumcision was considered an issue of culture (or religion) that should be considered 'private' and an area of non-intervention. This position has changed though into a warlike framing by opponents of all forms of female circumcision, called female genital mutilation (FGM), as women's human rights that can be addressed regardless of the cultural or

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90 As to the practice in Guinea, see for instance Human Rights Committee, Communication No. 1465/2006, *Diene Kaba, on her own behalf and on behalf of her daughter, Fatoumata Kaba v. Canada*, views of 25 March 2010, esp. para. 4.10.

91 See Art. 24(1) CRC that recognises the right of the child to the enjoyment of the highest attainable standard of health. However, Art. 19 CRC on freedom from violence and Art. 24(3) CRC about harmful practices, include only FGM, and remain silent on circumcision of boys. CRC, General Comment on the Right of the Child to Freedom from all Forms of Violence, UN Doc. CRC/C/GC/13 (2011), at para. 29.

92 Androus, Z., 'Cultural Relativism at Home and Abroad: An American Anthropologist Confronts the Genital Modification of Children', in: Denniston, Hodges, and Milos, *op.cit.,* note 4, pp. 33–41.

93 See the interesting research of Boyle and Carbone-López, *loc.cit.,* note 25, into the frames used by African women to oppose female circumcision. The reference to female circumcision as a bad tradition or 'against my religion' is quite often put forward as a reason to oppose female circumcision, although use of the medical frame increases in a region that supports female circumcision, while the women's rights frame is not used very much to oppose female circumcision.

94 Ertürk, Y., Report of the Special Rapporteur on Violence Against Women, Its Causes and Consequences: Intersections Between Culture and Violence Against Women, UN Doc. A/HRC/4/34 (2007), at para. 33.

'private' character.[95] The definitions used for female circumcision are broad, so as to make sure that all practices fall within its scope. The WHO definition reads 'The term "female genital mutilation" refers to all procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons'.[96] Presumably, this definition is adopted at least partly for strategic reasons and reasons of effectiveness, to avoid confusion in the communities involved as to which practices are and which are not acceptable; prohibiting all forms will give the best guarantee that all harmful practices are properly understood as unacceptable. The WHO definition does encompass 'Western' contemporary practices such as vaginoplasty. This is not *per se* problematic, if indeed one wishes to end all such practices. However, it is not at all clear that these practices are acknowledged at all by anti-female circumcision advocates, and if so, that they are likewise rejected as unacceptable.[97]

In the same line of Western and gender bias, is the rejection of the idea of consent if not by all, at least by most anti-female circumcision campaigners. This seems to be in clear opposition to the Western approach to cosmetic surgery, which is grounded in the presumption of consenting adults, and by some even more or less celebrated as an example of women's agency, empowerment and an expression of their own free will.[98] This bias of culture can also explain how a dangerous or even harmful practice of male circumcision in one's own (or especially the American) culture is downplayed or overlooked.[99]

A *third explanation* is a variation of the second one. It is easier to downplay the value of a rule or practice of 'another' or a 'strange' *religion* or to consider it even illegitimate than to one's own religion or a familiar religion. This can explain why it is easier for Westerners to condemn female circumcision that is carried out (as a ritual) in the name of Islam or of African traditional religions than to criticise male circumcision that is essential as a ritual in Judaism and as an Abrahamic religion familiar to Islam and Christianity. It explains that the dominant discussion in America is about routine neonatal circumcision, leaving aside 'ritual' male circumcision. The fear of being accused of anti-Semitism could be an important reason for separating the medical and human rights frame of bodily integrity from the religious and human rights frame of freedom of religion.[100] At the same time, Islamophobia might explain

95 Arts. 2(f) and 5(a) CEDAW.

96 WHO, 2010, *op.cit.,* note 2, at para. 2.

97 Gender reassignment arguably falls outside the scope of the WHO definition, because of the international classification of trans people as suffering from a 'gender identity disorder'; see WHO's International Classification of Diseases (ICD), *available at*: www.who.int/classifications/icd/en/ (last accessed 24 October 2012).

98 See Davis, S.W., 'Loose Lips Sink Ships', *Feminist Studies*, Vol. 28, No. 1, 2002, pp. 7–35, at p. 25, quoting a surgeon who declares that he will not operate on women who do it to please their partners, but only on women who 'do it for themselves'.

99 Johnson, *loc.cit.,* note 8, at p. 202.; Askola, *loc.cit.,* note 5, at p. 110.

100 Aldeeb Abu-Sahlieh, *loc.cit.,* note 39, at p. 35.

a growing opposition towards male circumcision, or at least a growing acceptance of measures to curtail male circumcision practices in Europe.

5. CONCLUSION

We have noticed a different normative approach of male and female circumcision, mainly neglecting or respecting the former and condemning the latter. First, we asked whether differences in the practices of male and female circumcision could justify this different normative assessment. We found that the most common forms of male and female circumcision are comparable, but that there are also more as well as less invasive forms of female circumcision than the most common male variants, just as there are extremely intrusive forms of male circumcision. It seems, however, that female circumcision overall entails more serious health complications, especially as a result of more invasive forms of female circumcision. This implies that the general condemnation of female circumcision and almost total acceptance of male circumcision should be nuanced.

Second, we asked whether differences in rationales could justify the different normative evaluation. The rationales are quite similar, although the importance of these rationales for male and female circumcision differs. Male circumcision is based on a variety of rationales including culturally defined gender roles, perceived health benefits and religious obligation. In contrast, the most important reason for female circumcision originates in culturally defined gender roles. The religious rationale for female circumcision is considered to be weak and health benefits are absent. Outsiders seem biased in their assessment of male and female circumcision. Gender and cultural bias play a role in condemning female circumcision in 'alien' cultures, while overlooking female genital operations in Western culture and respecting male circumcision in culturally familiar religion(s). This is reflected in the way male and female circumcision is framed as a human rights issue.

As far as male circumcision is concerned, the ongoing debate on perceived health risks or health benefits is supplemented by an accessory human rights frame that tries to strengthen cultural and religious arguments. The attack on the legitimacy of male circumcision is based on the cultural notion of privacy and individual autonomy or bodily integrity of the child/adult, while the defense of the legitimacy of the practice is argued with the (more collective) right to culture, to family life and the freedom of religion, especially the right of parents to provide direction and guidance to the child in the exercise of his right to freedom of religion.

The discussion, thus, seems to center on who may legitimately decide what is in the best interest of the boy/man: he himself as a child (depending on age), his parents, he himself as an adult or the State. In the human rights frame of male circumcision, respect for and protection of individual bodily integrity, on the one hand, and respect for private or religious group life, on the other hand, dominates.

As far as female circumcision is concerned, the human rights frame is not about who may legitimately decide about what is in the best interests of the girl/woman: the international community has already decided that it is in the best interests of the girl/woman to condemn female circumcision as mutilation, harmful tradition and sex discrimination. In the human rights frame of female circumcision, protection against infringements of bodily integrity by cultural groups dominates.

In order to evaluate male and female circumcision in a more universal and gender equal way, and thus in a more truly human rights way, we propose to start with the observation that circumcision is an intervention of the right to bodily integrity of every human being, irrespective of sex or age. As such, our proposal is to leave – at least initially – the frames of female and male circumcision behind and focus on the intervention itself. The intervention of the body is easily justified in case of clear health benefits and is easily condemned in case of highly serious physical harm or health risks. This implies, on the one hand, that circumcision that is obviously medically indicated is justified. On the other hand, clear long-lasting or irreversible serious health issues undermining interventions and the ways in which they are carried out are not justified. Arguably, this implies that the most invasive form of female circumcision – infibulation – is unacceptable just as the most extreme forms of male circumcision, as practiced by Aboriginals and by traditional circumcisers in South-Africa, are equally unacceptable.

As most circumcisions should be positioned somewhere in between these extremes, the first consideration should be the level of harm inflicted by the interventions. This consideration should include the immediate pain inflicted by the intervention itself, health consequences, including effects on sexuality, in the short and long term, the (ir)reversibility of the bodily alterations and whether and to what extent health risks or harm can be reduced by the way it is carried out. It may be clear that circumcisions with minor health risks, carried out in a hygienic and professional way, possibly using anaesthesia to prevent pain, are quite unproblematic. The symbolic pricking could be an example of this. However, these aspects of seriousness of the intervention only offer a *first indication* as to whether and which additional considerations may play a role in deciding whether the circumcision is or is not a justified violation of bodily integrity.

A *second aspect* is the consent of the person to be circumcised. As self-determination is an important aspect of bodily integrity, the starting point would be to take requests of adults seriously and to normally honour them. Circumcision of children should be postponed until they are capable of choice and have a real context of choice. This latter issue is especially relevant when the bodily intervention is irreversible.

This second aspect will make irreversible and painful circumcisions more acceptable. This approach could render several types of circumcision in Africa less problematic, as long as they concern less extreme forms, carried out in a relatively safe way on girls and boys, or young men and women, who are capable of making informed choices and are in a position to refuse. Professionally carried out male circumcision on Muslim boys of an older age might fall within this scope. However, according to

this second consideration, circumcision on newborn Jewish babies is problematic, as are the routinely carried out circumcisions of the American type. Parents should not be allowed to decide for their young child, and thus forego their consent, unless there are very weighty reasons.

This brings us to the *third consideration*: the weight of the rationale of the bodily intervention and whether there are other less intrusive ways to serve that rationale. For example, the rationale of health because of hygiene, or for the prevention of HIV/AIDS might not be sufficient to justify circumcision as there are other, less invasive ways to achieve this purpose. The notions of beauty and normality as rationales of the American type of routinely carried out circumcision on just born boys do not seem very weighty. In contrast, the obligation for Jews to circumcise new born boys seems to be a rather strong obligation that cannot easily be replaced by something else. Compared to the Jewish religious obligation, the Islamic obligation seems weaker, and at least offers the possibility to postpone the decision to circumcise until the child is able to make an informed decision. The cultural rationale in the African type of male and female circumcision, on the other hand, can be quite strong as regards the aim to be achieved (becoming a fully-fledged member of the group), but might prove to be less strict regarding the form of the initiation rite. This could render some more health endangering types of circumcision (like clitoredectomy and excision) problematic.

A *fourth* aspect is the legitimacy of the rationale. The most legitimate rationale as regards circumcision is of course health benefits, leaving aside the discussion whether they are as clear as often presented. Furthermore, cultural and religious rationales are not *per se* legitimate. This leaves us with the question whether circumcision lacks legitimacy as far as the rationale aims at or perpetuates gender inequality. It seems to us that all circumcision practices, except maybe the American type, confirm more or less to stereotyped roles of men and women. This seems to be more on the forefront in the *African* type, but is also discernable in the *Abrahamic* type, more specifically the Jewish circumcision, that serves (among others) the patriarchic confirmation of the membership of the boy in a dominant male community.

Therefore, we propose to consider the legitimacy of the rationale increasingly problematic when the circumcision is more directly aimed at the confirmation of the inferiority or superiority of one of the sexes, thereby taking into account the perceptions of those who request circumcision for themselves and the social effects of (not) being circumcised in social reality. This could imply that in some contexts some forms of female circumcision are not at all legitimate, like infibulations that are meant to confirm the property status of a married woman. Other forms could be more legitimate in other contexts, for example in case circumcision has primarily a symbolic meaning of a rite of passage from childhood to adulthood with less gendered impact on social opportunities. Furthermore, occasionally male circumcision could be less legitimate than generally conceived.

These four aspects could be considered as a first attempt to develop a list of relevant criteria that may serve as standards to judge forms and types of circumcision,

irrespective of where and to whom it is done. The health and harm risks, consent and motives for the violation of bodily integrity can and should play a role in balancing the interests involved. Arguably, such an approach makes the outcome of a global policy less straightforward, but it contributes to the use of the human rights frame in a more universalist and less gender and culture biased way. In the end, it is not about comparing male and female circumcision, but about comparing which practices can be justified by standards of human rights.