

Genital Cutting and Western Discourses on Sexuality

This article explores dominant discourses surrounding male and female genital cutting. Over a similar period of time, these genital operations have separately been subjected to scrutiny and criticism. However, although critiques of female circumcision have been widely taken up, general public opinion toward male circumcision remains indifferent. This difference cannot merely be explained by the natural attributes and effects of these practices. Rather, attitudes toward genital cutting reflect historically and culturally specific understandings of the human body. In particular, I suggest that certain problematic understandings of male and female sexuality are deeply implicated in the dominant Western discourses on genital surgery. [genital surgery, genital mutilation, male circumcision, female circumcision, sexuality]

Introduction

The topic of genital cutting first captured my interest while I was teaching a gender course at a regional university in the United States. During the semester, we explored female circumcision as part of a broader examination of the ways in which gender becomes physically inscribed on human bodies. My goal was to provide students with a more culturally relative perspective on female circumcision and to encourage them to consider similar practices in their own society. To this end, I drew comparisons to male circumcision: the most common surgical procedure in the United States today. Each semester, the reaction of the students was both immediate and hostile. How dare I mention these two entirely different operations in the same breath! How dare I compare the innocuous and beneficial removal of the foreskin with the extreme mutilations enacted against females in other societies! As far as my students were concerned, there was no basis for comparison.¹

In an effort to move beyond the intellectual impasse I seemed to have reached with my students, I discussed the tendency among policy makers to homogenize female genital surgeries and to equate operations diverse in form and function with their most severe manifestations, while simultaneously reducing their meaning to patriarchy. I also pointed out that just as there is a common inclination to consider

all female operations under the rubric of "mutilation," there is a parallel tendency to collapse the widely variable forms of male genital cutting into a single operation involving the removal of the prepuce of the penis (see Caldwell, Orubuloye, and Caldwell 1997:1184).

I tried to convey that an enormous degree of variation exists between operations. For example, in parts of East Africa not all of the foreskin is removed, while in other regions the foreskin is left largely intact but cut into strips (Caldwell, Orubuloye, and Caldwell 1997:1184). Such ritual circumcisions also take place in Aboriginal Australia, the Philippines, Eastern Indonesia, and Melanesia, with wide variation in procedures.² Similar variation exists in the religious circumcisions conducted among Islamic and Jewish populations. Even the clinical circumcisions familiar to many of my students vary widely, as judgments regarding the amount of skin to be removed from the penis are left to the skill and aesthetic preferences of the individual doctor.³ Indeed, while the majority of circumcisions are performed on newborns, a minority undergo the operation after infancy, and some men choose to be recircumcised in later years due to dissatisfaction with the original result (see Altschul 1990).

Moreover, other forms of male genital cutting such as superincision and subincision are also practiced. Superincision, where a dorsal slit is made in the foreskin, is performed in several Pacific island societies (see Firth 1963; Kempf 2002).⁴ Subincision, a far more invasive procedure, involves

slitting open the whole or part of the penile urethra along the ventral or under surface of the penis. The initial cut is generally about an inch long, but this may subsequently be enlarged so that the incision extends from the glans to the root of the scrotum, in this way the whole of the under part of the penile urethra is laid open. [Montagu 1974:312]

This operation was historically widespread among Aboriginal groups in Australia's Central Desert (see Berndt and Berndt 1982; Montagu 1974; Roheim 1949),⁵ and variations existed in Melanesia (e.g., Hogbin 1970) and Polynesia (e.g., Martin 1981).

Although many of these genital surgeries are less common than the removal of the foreskin, they begin to approach the tenor of female operations such as infibulation in both their degree of physical invasiveness and their potentially damaging health outcomes. Indeed, there are reports of subincision necessitating the adoption of a squatting position to urinate, as males lose the ability to control the direction of their urine flow (Bettelheim 1962:101). Bettelheim (1962:100) also speculates that subincision "probably alters the sensations during coitus."

Despite my efforts to reveal the heterogeneity of the practices glossed as "male circumcision," the relative equanimity of my students when they learned of these male surgeries was a striking contrast to their sense of outrage and indignation at the female operations. Although it is true that several of the students did perceive that operations such as subincision constitute a form of mutilation, there was little sense that it was of a sexual nature. Indeed, what was striking was how willing students were to relegate such practices to the realm of "culture," and how unwilling they were to place female surgeries in the same realm. Importantly, the lack of equivalence many of my students perceived between male and female

genital surgeries extended well beyond male circumcision and included an unwillingness to consider *any* form of male genital surgery in conjunction with the female operations. For the majority of students in the class, the only procedure that they considered at all equivalent to female circumcision was castration, or more than that, full frontal castration—a penectomy.

Over the course of our discussions on this topic, one thing became clear: students did not think that carving up male genitalia had any damaging effects on male sexuality as long as the penis remained largely intact. My students reasoned that as long as the man retained the ability to ejaculate, his sexuality was unimpaired.⁶ They were so ready to assert that female sexuality has been totally annihilated by genital surgery of any kind and so reluctant to proclaim that anything short of full frontal castration will affect a man's sexuality in the same way, it seemed clear that something very interesting was being revealed. Importantly, their insistence seemed to have less to do with these practices themselves and more to do with underlying assumptions about the nature of female and male sexuality, assumptions echoed in the dominant discourses on genital cutting.

It is these assumptions that I am interested in exploring in the remainder of this article. Although I look at two very large bodies of literature in this article (that on female and male circumcision), I focus my discussion of male circumcision on the United States where secular, medical circumcision is most pervasive. However, I believe that much of the argument that follows also applies to other countries where secular male circumcision is still relatively common, such as Canada, Australia, New Zealand, and the United Kingdom.

The Literature

In the past few years, a number of books have explored the debates surrounding female circumcision as well as the practices themselves (e.g., Boyle 2002; Gruenbaum 2001; James and Robertson 2002; Shell-Duncan and Hernlund 2000). These works signal a welcome shift toward a wholesale critical reflection on the meanings placed on female genital surgery and seek to problematize Western responses to these operations.⁷ However, although passing reference is made to male circumcision, the attention of the authors of these books is directed toward female genital operations. This is true of the majority of studies on female surgeries, where a comparison between male and female circumcisions is generally dismissed altogether, with the qualifier that *sunna* circumcision bears some equivalence to male circumcision, but that the comparison ends there.⁸

The key activist to make some effort to explore the similarities between female and male genital surgeries is Hanny Lightfoot-Klein (see 1989:183–195, 1994). However, most writers who take up the comparison between male and female genital surgeries are *activists opposing male circumcision*. Like Lightfoot-Klein (and often drawing explicitly on her work), these writers emphasize that the cultural explanations and justifications for male and female surgeries are similar (see Boyd 1998; Denniston and Milos 1997; Romberg 1985). They also point to the hypocrisy in decrying only those surgeries that are performed in non-Western contexts (see Boyd 1998; Gollaher 2000). This point has also been made by scholars such as Nancy Scheper-Hughes (1991:28), who writes, “Where are the passionate voices of our Western, male medical anthropologists—some of them circumcised, some

of them not—speaking out on the practice of male genital surgery in the United States? Why isn't male circumcision also one of the places . . . 'where we ought to draw the line?'"

There have also been important moves to consider male and female genital cutting *together* in an African context (e.g., Caldwell, Orubuloye, and Caldwell 1997; Orubuloye, Caldwell, and Caldwell 2000). As Caldwell, Orubuloye, and Caldwell (1997:1181) convincingly demonstrate, the conceptual separation underlying Western treatments of male and female circumcision is alien to many Africans, who consider these operations to be fundamentally related in both their functions and effects. However, little attempt has been made to explore precisely *why* international opinion remains largely hostile to female genital cutting and indifferent to the male operations.

Female and Male Genital Operations: "And Never the Twain Shall Meet"

Although female genital cutting entered the consciousness of colonial administrations in Africa in the 1930s, the practices did not come to larger attention in the West until the 1970s—in large part due to the work of activists such as Fran Hosken and feminists such as Gloria Steinem, Robin Morgan, and Mary Daly. Although these Western perspectives have subsequently been given a certain degree of legitimacy by the writings of Africans such as Dirie (and Miller 1999), Dorkenoo (1994), El Sadaawi (1980), Koso-Thomas (1987), and Toubia (1995), opinions on female circumcision remain firmly divided—both within Africa and the international arena.

Few topics have polarized opinion as much as female circumcision, and during the past few decades it has generated an onslaught of discussion and debate (Shell-Duncan and Hernlund 2000:1). The 1990s especially saw an unprecedented level of interest in this issue. Events such as Alice Walker's appearance on *Oprah* (subsequent to the publication of her 1992 novel, *Possessing the Secret of Joy*) and the publication of excerpts from Waris Dirie's *Desert Flower* in *Reader's Digest* in 1999 helped in no small way to dramatically increase public awareness of "female genital mutilation" (FGM). Female circumcision became such a hot topic it was discussed in women's magazines, the U.S. radio program *All Things Considered*, and was even featured on a 1997 episode of *Law and Order*. The 1990s also saw an intensification of eradication efforts, with international health and aid organizations placing political and economic pressure on African governments to legislate against the practices (see Shell-Duncan and Hernlund 2000:32–34).

Over this same period, a parallel body of literature on male circumcision also developed. In 1971, the American Academy of Pediatrics stopped endorsing the routine circumcision of males, concluding that there was "no absolute medical indication" for routine circumcision. In 1989, they modified their position slightly, stating that neonatal circumcision has potential medical benefits and advantages as well as disadvantages and risks. They have since revisited the issue (AAP 1999) in light of more recent studies—particularly those linking circumcision with lower HIV infection rates⁹ and continue to maintain that although male circumcision may have potential benefits, the available studies are inconclusive and insufficient to justify recommending routine male circumcision.

In conjunction with the growing medical debate over male circumcision, the antircircumcision movement began to gain ground in the 1980s, with the publication of Edward Wallerstein's (1980) respected *Circumcision: An American Health Fallacy*.¹⁰ Since this period, there has been a subtle groundswell of literature opposing male circumcision. A number of antircircumcision organizations have also been formed over the years such as NOHARRM: the National Organization to Halt the Abuse and Routine Mutilation of Males, NOCIRC: the National Organization of Circumcision Information Resource Centers, BUFF: Brothers United for Future Foreskin, RECAP: Recovery of a Penis, and DOC: Doctors Opposing Circumcision. Many of these organizations have created websites and there is also a journal, *Foreskin Quarterly*, devoted to similar activist activities.

Despite the proliferation of antircircumcision materials on the Internet, for the most part the profiles of these preservationist¹¹ organizations are reasonably low. Thus, while the anti-FGM position has enormous public currency, the male preservationist position is not well known, nor is it taken very seriously. The biomedical debates about male circumcision in the United States do not seem to have infiltrated public attitudes toward the practice to any significant degree.¹² According to a recent article published in *USA Today*, in many parts of the United States, neonatal circumcision rates have remained steady, and in areas such as the Midwest, they have actually increased (Rubin 2001).

The only region that has seen a reduction in circumcision rates is the West, and this decline seems largely attributable to increasing levels of migration from noncircumcising countries and the increase in Hispanic births in this region—an ethnic group in which circumcision rates are comparatively low. Thus, the claims of sexual mutilation made by opponents of male circumcision are more likely to be met by the public (and the press) with snorts of derision than nods of recognition. Indeed, activists working to eradicate male circumcision tend to be depicted in the press as a small, misguided group of “extremists” (e.g., Epstein 1997).

Ultimately, the evidence regarding the benefits of male circumcision remains extremely controversial.¹³ Yet, while there has certainly been a great deal of hyperbole on both sides of the male circumcision debate, some scholars and activists have argued compellingly about the disputable value of studies claiming health benefits for male circumcision and the tendency to unthinkingly reproduce accepted wisdom regarding these benefits¹⁴ (see Boyle et al. 2002; Gollaher 2000; Wallerstein 1980).

Carla Obermeyer (1999, 2003) makes a similar point in relation to the anti-FGM literature.¹⁵ She argues that a number of the reports on the health effects of female genital cutting rely on sources that have numerous shortcomings, such as a lack of information about where the data were from and how they were collected, high percentages of nonresponses to questionnaires, inconsistencies in calculations, and biased estimates due to small sample sizes. Recent attempts to link HIV transmission with female circumcision,¹⁶ despite the poorly documented and epidemiologically improbable health risks (see Taverne 1994), seem to support Obermeyer's claim (2003:81) that “despite their deficiencies, some of the published reports have come to acquire an aura of dependability through repeated and uncritical citations.”

The tendency to minimize the health effects of male circumcision and maximize the damage caused by female circumcision, particularly in popular

representations of the operations, seems to require little justification. The so-called commonsense explanation for the differing reception of male and female genital cutting relates to the specific nature of the female operations, which are seen to be fundamentally more damaging to health (unlike the male operations, which are often seen to be actively health promoting). Thus, the World Health Organization (1997:1) states that “female genital mutilation is universally unacceptable because it is an infringement on the physical and psychosexual integrity of women and girls and is a form of violence against them.”

Implicit within the WHO position is the assumption that such operations destroy female sexuality. This focus on sexual health becomes even more explicit in labels such as “sexual castration” (Badawi 1989; Hosken 1994:38) and “sexual blinding” (Walker 1992) that several writers have used to describe the procedures. Thus, although these organizations claim to be concerned about health generally, they are really concerned specifically with sexual health. This is because the detrimental long-term health consequences seem limited largely to infibulation (see Obermeyer 1999, 2003; Shell-Duncan and Hernlund 2000:14–18; Shweder 2000), which accounts for around only 15 percent of cases. Moreover, the short-term health effects can be minimized through the use of trained surgeons, sterile equipment, and anesthetics (i.e., the transfer of surgery to a medical setting). Yet, as Shell-Duncan, Obiero, and Muruli (2000:110) point out, “paradoxically, those who emphasize female ‘circumcision’ as a public health issue at the same time oppose any medical intervention designed to minimize health risks and pain for women being cut.” Thus, the opposition of the World Health Organization (1997) and many other international agencies to the medicalization of female operations would reinforce the idea that their key opposition to female genital cutting relates specifically to its impact on female sexual health.

The other key argument against female genital cutting relates to the issue of informed consent. According to Fran Hosken (in Abusharaf 2000:151), “Any violation of the physical nature of the human person, for any reason whatsoever, without the informed consent of the person involved, is a violation of human rights.” Gerry Mackie (2003:136) similarly states that “in general there is an absence of meaningful consent to the irreversible act of FGC [female genital cutting],” echoing Nussbaum’s (1999:123) position that, “female genital mutilation is usually performed on children far too young to consent even were consent solicited.” In a slightly different vein, Rahman and Toubia (2000:3) take the position that “the act of cutting itself—the cutting of healthy genital organs for non-medical reasons—is at its essence a basic violation of girls’ and women’s right to physical integrity. *This is true regardless of the degree of cutting or of the extent of the complications that may or may not ensue*” (emphasis added).

Yet, even the most superficial examination of these positions reveals that the particular arguments being produced here to condemn female genital cutting can be used equally to condemn male circumcision.¹⁷ Each operation involves an unnecessary bodily violation that entails the removal of healthy tissue without the informed consent of the person involved (see Price 1999; Winkel 2003; Zavales 1996). That a general lack of recognition prevails¹⁸ reveals just how conceptually distant the male and female operations are. Indeed, attacks against male circumcision by agencies and health workers in Africa tend to condemn only the

conditions under which the operations are performed, rather than the actual procedures themselves.¹⁹

This has led to some rather contradictory policies on the part of international health organizations, which seek to medicalize male circumcision on the one hand, oppose the medicalization of female circumcision on the other, while simultaneously basing their opposition to the female operations on grounds that could legitimately be used to condemn the male operations. Ultimately, the message is clear: genital mutilation is gendered. These male and female genital operations are not merely seen to differ in *degree*, they are seen to differ in *kind*. Thus, despite the heterogeneous voices speaking out against female circumcision, a common thread unites many: all forms of female genital cutting are seen to constitute a sexual mutilation and violation of bodily integrity, and male genital operations are dismissed as benign.

Medical Circumcision: “An Operation in Search of a Disease?”

As numerous scholars have documented, the origins of secular male circumcision are surprisingly recent, dating merely to the late Victorian era, when a number of U.S. and British doctors began to regularly endorse circumcision to cure all manner of physical ailments. Especially interesting are the connections made between male circumcision and hygiene. Although proponents of male circumcision still commonly promote the hygienic benefits of the operation, there is little recognition of the fact that the hygiene of the Victorian imagination conflated physical and moral sanitation much more overtly than the contemporary meaning of the word would suggest.

The best example of this conflation was the attitude toward masturbation, which was considered to be not only morally unclean, but also, by implication, the cause of physical health problems such as asthma, insanity, epilepsy, gout, headaches, rheumatism, curvature of the spine, hip disease, and kidney failure (Boyd 1998:52). Moreover, a number of people have argued that it is precisely such beliefs that go a great way toward explaining the Victorian embrace of medical male circumcision. (See Darby 2003 for an extensive review and discussion of the literature; see also Boyd 1998; Gollaher 1994, 2000.²⁰) Circumcision, it seemed, helped cure the tendency to masturbate, and its hygienic and health benefits stemmed largely from this correlation. Thus, according to American doctor J. M. McGree, writing in 1882, male circumcision “is acknowledged to be useful as a preventative to masturbation” (in Gollaher 2000:85).

The popular 1896 U.S. parenting manual, *All about Baby*, also advised that male circumcision was to be preferred in most cases and recommended it largely for preventing the “vile” habit of masturbation (in Gollaher 2000:104). John Kellogg, cocreator of Kellogg’s corn flakes and health reformer obsessed with both regular bowel movements and masturbation, saw similar value in circumcision. In 1888 he writes,

Tying the hands [to overcome masturbatory tendencies] is also successful in some cases. . . . Covering the organs with a cage has been practiced with entire success. A remedy which is almost always successful in small boys is circumcision. The operation should be performed by a surgeon without administering an anesthetic,

as the brief pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment. [in Boyd 1998:51]

Although the justifications for male circumcision have changed, the **continuation of the practice should not merely be understood to reflect more “neutral” medical appraisals of the operation’s benefits.** As David Gollaher (2000:205) cautions, “much as we believe ourselves to be enlightened citizens of the age of science, not superstition, the continuing circumcision of newborn American boys betrays lingering illusions about health and reveals the power of culture in shaping medical practice.”

The history of female circumcision in the West sheds light on the way that changing cultural attitudes (as opposed to “enlightened” medical opinion) may lead to the continuation or cessation of medical practices. As many scholars have noted, during the Victorian era male circumcision was not the lone prophylactic in shielding children from the dangers of **masturbation; female circumcision was also practiced during this period for very similar reasons** (Darby 2003:738; Gollaher 2000:201; Wallerstein 1980).

Perhaps the most public endorsement of female circumcision was provided by Isaac Baker Brown, an eminent obstetrical surgeon who ran a practice in London during the latter half of the 19th century. He worked mainly on diseases of women, and in 1866 he published a book entitled, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy, and Hysteria in Females*, which advocated clitoridectomy as treatment for the aforementioned medical weaknesses in women (Sheehan 1997). As Elizabeth Sheehan (1997) points out, although Baker Brown was publicly vilified following the publication of this book, the medical reasoning behind clitoridectomy was not discredited. Indeed, in 1936, Holt’s medical reference text, *Diseases of Infancy and Childhood*, recommended cauterization or **removal of the clitoris for girls as a cure for masturbation** (in Lightfoot-Klein 1989:180).

Clitoridectomies were occasionally endorsed in Australia and the United States well into the 1960s as a cure for excessive masturbation. For example, in the popular Christian coming-of-age manual, *On Becoming a Woman*, first published in 1951 and reprinted in 1968, Dr. Harold Shryock writes,

There are teenage girls who, impelled by an unwholesome curiosity or by the example of unscrupulous girl friends, have fallen into the habit of manipulating these sensitive tissues as a means of excitement. This habit is spoken of as masturbation. . . . There is an anatomical factor that sometimes causes irritation about the clitoris and thus encourages a manipulation of the delicate reproductive organs. . . . Oftentimes the remedy for this situation consists of a minor surgical operation spoken of as circumcision. This operation is not hazardous and is much to be preferred to allowing the condition of irritation to continue. [1968:38]

That secular male circumcision was taken up while female circumcision never really caught on, except in a limited way, reveals a great deal about the attitudes toward female and male sexuality that were crystallizing over this period.

Sexuality and the Rise and Fall (and Rise) of the Clitoris

As Thomas Laqueur (1999) has shown, **before the 18th century, the existence of female sexual pleasure, and its necessity for the successful reproduction of**

humankind, was taken for granted. Male and female bodies were understood to be fundamentally similar, although a lack of heat caused female genitalia to be inverted (see also Martin 1987). In this period, male and female sexual excitement was seen to be critical to reproduction: the combined orgasmic heat generated by sexual intercourse concocted and commingled the seed of life. Thus, during the Renaissance, the clitoris was routinely described as the organ “which makes women lustful and take delight in copulation” (Laqueur 1999:220). Seventeenth-century writers insisted that male and female pleasure were located in essentially the same kind of organ: the end of the clitoris was likened to the glans of the penis and was defined as the seat of sexual pleasure in women (Laqueur 1999:220).

However, in 18th-century Europe, a radical reconstitution of female sexuality took place, which Laqueur insists cannot be explained by scientific progress alone. At this time, a new model of human biology emerged, which emphasized both fundamental and immutable differences between the sexes. The female body was no longer understood to be an inversion of the male body with similar organs, functions, and characteristics. It was now of a different order altogether, and in this reconfiguration of the female body sexuality was pushed to the periphery (Laqueur 1999:219). Theodor Bischoff’s discovery in 1843 that ovulation in dogs occurs independent of sexual intercourse was taken as proof that the female orgasm serves no reproductive purpose and was therefore unnecessary to the perpetuation of life (Laqueur 1999:233, 239). Thus, the idea that woman was inherently passionate was sacrificed in the effort to assert a fundamental underlying difference in male and female biology.

These assumptions about passive female sexuality were maintained for much of the 20th century. Early support arrived in the form of Sigmund Freud’s 1905 essay entitled *Three Contributions to the Theory of Sex* (1905/1962). According to Freud, mature female sexuality resided in the vagina, and immature female sexuality resided in the clitoris. As he explains it, puberty in females brings with it the transference of “erogenous excitability” from the clitoris to the vagina (pp. 78–79). Indeed, it was precisely this focus on the vagina as the source of sexual satisfaction and reproductive action that allowed the clitoris to be desexualized to the extent that Victorian doctors routinely performed clitoral massages on hysterical females as a form of medical treatment. In this conceptual framework, the pretense could be maintained that the resulting orgasms, or “hysterical paroxysms,” were of a nonsexual nature (see Maines 1999).

And so it was that in the 19th and early 20th centuries, the clitoris, so venerated in previous centuries as the organ most closely resembling the penis, was denigrated to the status of irrelevant anatomical appendage. Nevertheless, it is possible to detect certain contradictory elements in the early 20th-century testimonies on female anatomy. Moore and Clarke (1995) point out that the homology between the penis and the clitoris did not disappear completely at the turn of the 20th century, although the latter was deemed a “rudimentary” imitation of the former. Furthermore, Freud (1905/1962:77–78) also emphasizes the homology between the clitoris and penis, even though he ultimately dismisses its role in mature female sexuality. Indeed, I would speculate that the disfavor attending the publication of Baker Brown’s theories on the value of clitoridectomy occurred because he was publicly creating a link between the clitoris and female sexuality that contradicted the prevailing theories of the day, even if it was privately accepted by many

physicians. As Sheehan (1997:328) notes, “it would appear that the medical profession wanted it both ways: the clitoris was so unimportant to a normal woman as not to be missed if removed, yet lurking in its tissue was the greatest threat to female welfare ever known.”

The tendency to **downplay the clitoris** became even more entrenched over the course of the 20th century, and by the late 1940s it was common practice to omit the clitoris from anatomy textbooks altogether (Moore and Clarke 1995:274). However, in the 1970s, **the clitoris was taken up once again**, this time by feminists intent on sexual liberation. In the mid-1970s, with the publication of *The Hite Report* (Hite 1976), the clitoris was restored to its former seat of glory. *The Hite Report* indicated that almost all women achieve orgasm through clitoral, as opposed to vaginal, stimulation.²¹ It therefore raised the question of why clitoral stimulation was not seen to be a normal part of sex, when it is so fundamental to a woman’s sexuality. At the time of its publication, *The Hite Report* obviously provided an important rebuttal to Freudian theories about immature clitoral sexuality and mature vaginal sexuality.

The findings of *The Hite Report* were quickly taken up by feminists and helped support the earlier claims made by Anne Koedt in her article, *The Myth of the Vaginal Orgasm* (1970 [1991]). In language that echoes eerily the Renaissance midwifery texts, Koedt argues, “It is the clitoris which is the centre of sexual sensitivity and which is the female equivalent of the penis” (1991:326). She continues, “Its erection is similar to the male erection, and the head of the clitoris has the same type of structure and function as the head of the penis” (p. 329). In Koedt’s framework, there is no room for females who do not fit this clitoral model. She accuses women who claim the capacity for vaginal orgasms of ignorance and false consciousness. According to Koedt, these women are confused, because they either fail to locate **the real center of their orgasm (the clitoris)** or they desire to fit their experience into the male-defined idea of sexual normalcy.

The Boston Women’s Health Book Collective (1971/1978) made similar assertions regarding the clitoris in *Our Bodies Ourselves*, as did the 1981 book, *A New View of a Woman’s Body* (cited in Moore and Clarke 1995). As Moore and Clarke (1995) note, in these works the clitoris is transformed from minor homologue into the *raison d’être* of other organs. Susann Gage, the illustrator of *A New View of a Woman’s Body*, later noted, “I think that we were revealing the truth. And how can you argue with anatomy? It is all the same. The erectile tissue of the clitoris functions the same as the penis” (in Moore and Clarke 1995:280). Similarly, *Our Bodies Ourselves* (Boston Women’s Health Book Collective 1971/1978:20) describes the “shaft” and “glans” of the clitoris, appropriating the anatomical terminology of male genitalia to portray the female organ.

The collective influence of these feminist writings and the findings of *The Hite Report* were influential, and Koedt’s (re) **equation between the clitoris and the penis is commonplace today**. Indeed, it is in the arena of female circumcision that this connection is most explicitly asserted. Thus, the World Health Organization states that “almost all types of female genital mutilation involve the removal of part or all of the clitoris, which is the main female sexual organ, equivalent in its anatomy and physiology to the male penis” (WHO 1997:8). For Fran Hosken (1994:25), “The excision of the penis which is the equivalent of the excision of the clitoris is instantly recognized as a severe physical genital mutilation with

permanent consequences and is a criminal offence.” Similarly, Rahman and Toubia (2000:4) note that, “The male equivalent of clitoridectomy, in which all or part of the clitoris is removed, would be amputation of most of the penis.” Finally, according to Nussbaum (1999:119),²² “the male equivalent of the clitoridectomy would be amputation of most of the penis. The male equivalent of infibulation would be ‘removal of the entire penis, its roots of soft tissue, and part of the scrotal skin.’”

Clearly, the argument being put forward echoes precisely the position of my undergraduate students: because the clitoris is the equivalent of the penis, only removal of the penis can parallel the effects of female circumcision. Koedt declares as much in her article, arguing that men fear the clitoris because they recognize that it is almost identical to the penis. Thus, she argues that men either ignore the clitoris or they excise it altogether. As Obermeyer (1999:96) and Shell-Duncan and Hernlund (2000:21–22) point out, in this conceptual framework, clitoridectomy became the symbol par excellence of patriarchal oppression.

However, although the genital equation between clitoris and penis has now become central to the dominant discourses surrounding both male and female genital cutting, how valid are equations of this kind? Although it is important to recognize that second-wave feminists deployed the homology argument to subvert the original biomedical intent to diminish the clitoris (Moore and Clarke 1995:995), the ongoing tendency to define the clitoris as the female penis merely reinvents androcentric notions of female sexuality first described centuries ago (see Laqueur 1999; Martin 1987). Male physiology is *still* taken as the norm, and female physiology is *still* understood in relation to it. Indeed, by defining the clitoris as the female penis, contemporary activist discourses merely *phallicize* female sexuality instead of attempting to understand it on its own terms. Although the clitoris may play an important role in female sexual response, does it necessarily follow that female anatomy, so radically different in form and function to male anatomy, can be understood through the latter? Yet, in the dominant discourses on genital cutting, male anatomy continues to be the yardstick against which female structures are compared.

Nevertheless, the tendency to condemn female genital operations while remaining indifferent toward their male counterparts cannot simply be understood in terms of the genital equation between clitoris and penis that I have outlined above. There are other dimensions at work here, stemming from the 19th-century disconnection of orgasm from female reproduction. It seems that despite the genital equation between the penis and the clitoris, a difference is also maintained—a difference that feminist revisions were never entirely successful in challenging. As Moore and Clarke (1995:284) note, “although narratives centered on discussing female sexual experiences are now acceptable, these sexual experiences are depicted as limited.” Thus, although an equivalence is asserted between the clitoris and the penis, a difference is ultimately maintained, largely because of the anatomical structure of the genitals and the perceived relationship between the male and female orgasm.

As previously stated, male genital surgeries are deemed *unharmful to the male*, because as long as the penis is left structurally intact, the man can still have an orgasm, signaled by the ejaculation of semen. However, female orgasm is signaled by no such recognizable emission.²³ In this framework, a man’s orgasm

is both essential to reproduction and accompanied by an objective sign: ejaculation. A woman's orgasm, on the other hand, is entirely incidental to reproduction and accompanied by no objective signal. Thus, the homology between penis and clitoris only takes us so far, because this deeper, more fundamental difference is simultaneously recognized and plays an important role in the construction of both female and male sexuality.

Active Men and Passive Women: Contemporary Constructions of Male and Female Sexuality

Lenore Tiefer (1992) has noted a number of sexual beliefs to which many American men subscribe,²⁴ including the perception that men's sexual apparatus and needs are simple and straightforward (unlike women's); that men are ready, willing, and eager for as much sex as they can get; and that sexual prowess is central to masculinity. Implicit within this discourse is a parallel discourse on female sexuality. Because of the seemingly less straightforward nature of female physiology and sexual response, women's sexual needs are presumed to be more complicated and limited than men's.

Susan Bordo (1999) writes at length about the prominence of the "hot man" thesis, reenergized by popular science, which "[has been] busy re-establishing that men are testosterone-driven, promiscuous brutes whom nature won't permit to keep their peckers in their pants" (p. 232). This image of the sexually rapacious male pervades popular representations of masculinity, from media advertisements to relationship manuals, such as the immensely successful works of psychologist John Gray. As Bordo (1999:232) notes, for Gray, "women need to *talk* in order to raise their sexual temperature . . . , because unlike men, we get warmed up not by physical but by mental chemistry. . . . In contrast, man's blowtorch is ignited by 'mindless' physical attraction to body parts."

The ongoing currency of these ideas is also evident in Smith and Doe's²⁵ 1998 bestseller, *What Men Don't Want Women to Know: The Secrets, the Lies, the Unspoken Truth*. The central premise of their book is that man is a "sexual animal" (p. 11) who "spends his life in one of two basic states: loaded or unloaded" (p. 26).²⁶ In this discursive framework, genital surgery is far less likely to impair a man's sexuality than a woman's because of his highly developed, instinctive, and powerful sexual drive. A woman's sexual instincts, being fundamentally more delicate, will be crippled by any form of genital surgery.

This connection between circumcision and male sexuality is most evident in popular perceptions that circumcised men "last" longer during sexual intercourse.²⁷ Procircumcision websites provide a fascinating source of information regarding this aspect of male circumcision. Unsurprisingly, many of these websites originate in countries where male circumcision is less common (such as the United Kingdom and Australia), just as the bulk of anticircumcision websites come out of the United States.²⁸ Nevertheless, I would argue that these sites provide an important source of information regarding the cultural meanings that male circumcision has—meanings that are often only explicitly articulated in contexts where male circumcision is less normalized.

Several procircumcision websites (notably <http://www.circlist.com> and <http://www.circinfo.com>)²⁹ actively configure male circumcision as a sort of

positive sexual restraint stopping the man from “jumping the gun” during sexual intercourse. According to circlist.com, although an uncircumcised penis may be more sensitive, this same sensitivity can lead to premature ejaculation. Such “benefits” of male circumcision are a regular focus of discussion, as the following selection of quotes demonstrate:

My husband had a very long, thick foreskin which did not retract automatically when erect. . . . This provided very little stimulation for me. Consequently, after discussing this for several months (during which time he did not provide me with one orgasm), I convinced him to be circumcised. . . . My husband and I are very happy with the results. He now has a very tight circumcision with no frenulum remaining. . . . Sex is much better for both of us.—Karen, U.S.A. [Circlist 1999]

I would like to write and express the joy and liberation I too feel about being circumcised. It is a beautifying operation, cosmetic surgery at its best. It's also more comfortable, sex is better and it is so much nicer for your partner. It beats me how any woman consents to sex with a man who still has his foreskin. So it follows that you would expect women to have their male offspring circumcised for the sake of the next generation of females, but then you hit a problem. These males will never have the chance of experiencing the joy of getting circumcised, though hopefully they will be content with their circumcised status once their mothers tell them about what was done to them and why.—Anonymous, UK [Circlist 1999]

My girlfriend told me that she preferred the appearance of a circumcised penis, and asked me if I would consider it. At first I gave her only evasive answers, but after thinking it over for a few weeks I decided to go ahead and tell her that I would indeed consider it. . . . Thoughts and memories of this experience have since enriched our sexlife [*sic*] beyond description, and although I wouldn't want to go through that again, I am glad that I did and would recommend such an experience for anyone.—George, USA [Circlist 1999]

My first circumcision was at the age of 17 being done by a general practitioner [*sic*]. On my own I requested the surgery without parental knowledge. . . . The circ was done under local anesthetic in the doctors [*sic*] office. Unfortunately no stitches were taken which resulted in a 3/16" wide uneven scar. I was recircumcised at the age of 23 to remove the excessive scar tissue. I have no regrets about being circumcised. The somewhat reduced sensitivity of the head is made up for by prolongation of sexual intercourse. My wife approves of the circumcision. I find sex much more prolonged and enjoyable.—Rob. [Circinfo 1999]

I was circumcised as a newborn so my perspective is from the point of always being circumcised. . . . Quite a few of my hundred plus partners (not bragging) have made unsolicited [*sic*] comments about their preference for circumcised partners and that they were pleased to see my penis had been neatly done. . . . Another advantage to my being circumcised is apparently lasting longer during sex; again commented upon by the ladies. This may come at the expense of some sensitivity [*sic*]. But again I cannot speak to that, since I have always been circumcised.—Bob. [Circinfo 1999]

Although these commentaries are mostly from men circumcised at a later age, I believe that they articulate constructions of male sexuality that are entrenched and pervasive. Importantly, these anecdotes speak to the role that sexual competence

plays in constructions of contemporary masculinity, as many men clearly believe that any loss of sensitivity that accompanies circumcision is compensated by their enhanced sexual performance.³⁰ Indeed, what is interesting here is how irrelevant the issue of reduced sensation is for both the men who have this operation and their sexual partners. This poses a striking contrast to the dominant discourses surrounding female genital cutting, where the idea of a woman undergoing genital surgery to enhance her partner's sexual pleasure (while concomitantly reducing her own level of sensation) strikes most observers as "barbaric" and misogynistic. The differing reaction these operations evoke is hardly surprising in light of the assumptions regarding instinctive, active male sexuality and fragile, passive female sexuality that I have detailed above. Thus, as Bordo points out, when it comes to sex, "mostly, men's bodies are presented like action-hero toys—wind them up and watch them perform" (1999:191).

Genital Surgeries and the "Natural" Body

It is clear that popular discourses on genital cutting are infused with cultural assumptions about male and female sexuality. Yet, these same discourses display a tendency to essentialize and universalize human sexuality in rather disturbing ways. As Fuambai Ahmadu (2000:284) notes,

The aversion of some writers to the practice of female circumcision has more to do with deeply embedded Western cultural assumptions regarding women's bodies and their sexuality than with disputable health effects of genital operations on African women. . . . One universalized assumption is that human bodies are "complete" and that sex is "given" at birth. A second assumption is that the clitoris represents an integral aspect of femininity and has a central erotic function in women's sexuality.

Ahmadu argues that many women (herself included) who had sexual experiences prior to excision perceive either no difference or increased sexual satisfaction. She also points out that many Western women who have clitorises are unable to achieve orgasms. Similarly, Rogaia Abusharaf (2000:152) points out that Western women overemphasize the effects of female circumcision on sexual pleasure and that the specificity of African women's experience is overlooked.

Ellen Gruenbaum (2001:133–157) also questions the generalization that female sexual response is destroyed in circumcised women, pointing out that these perspectives are, in part, the result of *ethnocentrism*. Discussing her Sudanese experiences, she documents the changes in her own perceptions of female sexuality, as they were challenged over the course of her fieldwork. Gruenbaum (2001:140–141) writes,

I knew that men have orgasms ("finish") in sex, but do women also? Yes, I was told, women "finish." I wanted to ascertain that what they were talking about was a true orgasm and not some vague conceptualization by women who had never personally experienced them. I pressed for a clearer description. Somewhat exasperated that I didn't seem to understand plain Arabic, a visiting midwife named Miriam grabbed by hand, squeezed by fingers, and said, "Look, Ellen, some of us do 'finish.' It feels like electricity, like this," and she flicked her finger

sharply and rhythmically against my constricted fingers. I was convinced we were talking about the same thing.³¹

Vicki Kirby (1987:44), in an early article on female circumcision, cuts to the heart of the problem with applying Western understandings of sexuality to other cultural contexts. She writes,

Although a whole battery of disciplinary practices (medical, pedagogical, familial, architectural, etc.) have *produced* what we take to be this essence of our personhood, we have reclaimed this cultural effect as a biological fact. Consequently, what has come to secure the “truth” of Western bodies becomes problematic when it is used as a universal, explanatory grid: the pleasures and desires of a body situated in other histories and other cultures, may not be so readily comprehended.

Obermeyer (1999:95) concurs, pointing out that while studies that systematically investigate the effects of genital cutting on female sexuality are rare, the available evidence raises important questions about whether the link between an intact clitoris and orgasm represents an indisputable physiological reality. Although scholars such as Mackie (2003:151–153) are critical of approaches that question the causal connection between anatomy and orgasmic sexual response, a wealth of literature from disciplines as diverse as anthropology, cultural studies, literary studies, and feminist philosophy support such attempts to denaturalize the human body and sexuality.

It is worth noting that questions can also be raised about the parallel tendency to reduce human sexuality to physiology in the literature opposing male circumcision,³² where a great deal of attention is paid to the structure and sensitivity of the foreskin and its role in determining sexual response. Many activists tend to equate the reduced sensation accompanying the removal of the foreskin with a corresponding reduction in sexual pleasure. According to this logic, the more of the penile skin removed, the greater the decline in sexual satisfaction. However, as discussed, for many men, reduced sensation cannot be unproblematically linked with reduced sexual pleasure—hardly surprising when pleasure and performance are so inextricably linked in the minds of most men (and women). Once again, this demonstrates the fundamental problems in attempting to separate the physiological from the cultural dimensions of sexuality or, worse still, ignoring the cultural elements altogether.

Let me be clear that I am *not* suggesting that sexuality bears no relation to physiology; however, it certainly cannot be reduced to it. My point is that sexual pleasure and desire are impossible to quantify and measure, and they are certainly not reducible to observable biological response.³³ Clearly, many circumcised women feel that the operation constitutes a sexual mutilation that has greatly diminished their capacity to experience sexual pleasure (e.g., Dirie and Miller 1999). And a growing number of men similarly feel that they have been sexually impaired by a medically unnecessary operation. However, some circumcised African women do not feel that their sexual capacities have been reduced through the operation, and countless men make similar claims. Thus, attempts to condemn genital cutting on these grounds alone (whether they be operations performed on females or males) seem doomed to failure, because the resulting discourse of sexual mutilation and incapacitation can be so far removed from people’s personal

experiences and daily lives. Ultimately, I do not endorse an extreme cultural relativism that denies the possibility of questioning the efficacy and value of female genital cutting; my key concern is with the *asymmetry in discussions of genital cutting and the problematic assumptions they perpetuate*.

Conclusions

Given the wide range of literature on genital cutting and the fact that research on this topic spans a variety of disciplines, including the medical sciences, anthropology, history, women's studies, psychology, social work, political science, law, literature, and the humanities (Obermeyer 2003: 81; Shell-Duncan and Hernlund 2000:1), I recognize the problems in attempting to discuss "dominant" discourses, when a plurality of opinions clearly exists. However, despite the heterogeneous voices speaking on this topic, I believe that many of these perspectives share common reductionist tendencies. Therefore, I think that policy makers err in assuming that their readiness to condemn female circumcision and condone male circumcision stems merely from the natural attributes and effects of these practices. *Medical and commonsense constructions of the human body are not divorced from cultural beliefs and values*, and such assumptions about the nature of the male and female body need to be critically interrogated in all of their complexity.

It is my view that *genital operations become tied into much larger discourses about the nature of sexuality*. As I have shown, in the context of genital cutting, assumptions are regularly invoked that are readily challenged elsewhere. These assumptions include the idea that the male body provides the basis for understanding the female body; that men are ruled by their penises and that females are sexually passive; and that human sexuality is reducible to anatomy and physiology.

Unsurprisingly, this framework results in a widespread inability to conceptualize male circumcision as anything other than beneficial and a similar inability to conceptualize female circumcision as anything other than a form of sexual mutilation tied directly to patriarchal domination. However, I suggest that the terms under which female circumcision is presently condemned by international agencies such as the World Health Organization deserve close scrutiny. *This scrutiny must be accompanied by a similar willingness to scrutinize male circumcision and a recognition that perceptions of one are fundamentally implicated in understandings of the other*. Ultimately, it is only by examining *why* people react to male and female genital cutting in the way that they do that consideration of these issues can start to move beyond this limiting conceptual framework.

NOTES

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1. Perhaps the comments of my students may seem anomalous in light of Nussbaum's (1999) discussion of her own undergraduate students' reaction to female circumcision, where they were inclined to be "ethical relativists." However, I would be interested to know how her students would have reacted had they been asked to consider the relationship between male and female circumcision. In my experience, students (often well versed

in the writings of Naomi Wolf) are able to think far more critically about dieting and cosmetic surgery than male circumcision, given the fundamentally normalized status of the operation. As Gollaher (2000:205) points out, "most Americans, even those who consider male circumcision unnecessary, cannot help but think of the circumcised penis as normal and the foreskin as a piece of excess skin."

2. See Hull and Budiharsana (2001) on Asia and Melanesia, and Peterson (2000) on Australia.

3. In some cases, the skin removal is apparently so excessive that men are "cut back to the balls." This is common enough that the expression "proud cut" has developed to describe the effects (see the "Personal Experiences" section at <http://www.circinfo.com>).

4. It seems that some circumcisions in East Africa also fall into this category.

5. Reports indicate that it was still being conducted as late as 1983 (see Pounder 1983), although the operation seems to have been largely replaced by circumcision in recent years (see Peterson 2000).

6. Interestingly, female students tended to be the strongest advocates of this position.

7. Individual critiques along these lines have obviously existed for a number of years (e.g., Kirby 1987). However, the fact that four books devoted to this topic appeared in two years indicates that a more widespread and sustained critique has emerged.

8. Some scholars have even questioned this comparison, arguing that an operation removing merely the hood of the clitoris (a common definition of sunna circumcision) does not actually exist (see Shell-Duncan and Hernlund 2000:4).

9. Although several well-regarded studies have pointed to a connection between circumcision and lower HIV transmission rates, it is important to note that legitimate questions have been raised regarding the findings of these studies (see Gollaher 2000:149–152). Interestingly, despite the publicity surrounding these studies, few organizations have made active moves to instigate male circumcision as a public health measure. For example, although some organizations such as USAID (2003) seem to support the idea of mandating male circumcision as a tool in the fight against HIV/AIDS, their support is qualified, contingent on further research and clinical trials. Organizations such as the Population Council, the International Planned Parenthood Federation (IPPF), and the United Nations Family Planning Agency (UNFPA) are even more cautious, pointing to the ethical ramifications of promoting male circumcision (Population Council 2000:2) and the fact that male circumcision may be contraindicated by an increase in risk-taking behavior (UNFPA 2001). In light of these factors and many others, IPPF (2000) points out that it is impossible to predict whether the promotion of circumcision will ultimately reduce the prevalence of HIV. I should also point out that as female circumcision takes place in societies where male circumcision is simultaneously performed and the so-called AIDS belt corresponds largely with regions where circumcision (either male or female) is *not* practiced, a correlation also exists between female circumcision and lower HIV transmission rates. Yet, it is hard to imagine any health organization endorsing female circumcision on the basis of this correlation.

10. However, it is important to point out that opponents of male circumcision had existed in the United States well before the 1970s (e.g., Lewis 1949).

11. This seems to be the preferred term for activists opposing male circumcision (see Boyd 1998:12–13).

12. However, countries such as Australia, New Zealand, and the United Kingdom have witnessed substantial declines in neonatal circumcision rates over the past two decades.

13. Mackie (2003) also makes the point that evidence on male circumcision is not ideal, although his intent appears to be to show that evidence regarding the health complications of FGC is "not peculiarly wanting" (p. 146).

14. For example, it has been commonly asserted that male circumcision guards against cervical cancer in women, which seems to stem largely from flawed studies produced in the 1940s and 1950s on Jews and gentiles (see Gollaher 2000:140–142 for a discussion). Two

former members of the American Cancer Society have also strongly rejected attempts to link male circumcision with reduced cervical cancer in women, stating "Research suggesting a pattern in the circumcision status of partners of women with cervical cancer is methodologically flawed, outdated and has not been taken seriously in the medical community for decades" (Shingleton and Heath 1996). Yet reputable papers such as the *Sydney Morning Herald* (see Skatsoon and Jacobsen 2003) continue to uncritically cite the circumcision and cervical cancer equation in discussions on the medical benefits of male circumcision.

15. See Mackie (2003) for a refutation of Obermeyer's arguments, and Obermeyer (2003) for her response.

16. The WHO (2004) discusses this possible link in the "FGM" section of their website (<http://www.who.int>). Although they mention that this link has not been the subject of detailed research, the fact that they discuss it at all provides covert legitimacy to this proposed "health risk."

17. The same is also true of operations on intersexed infants. See Cheryl Chase (2002) on medical double standards in relation to intersexed infants in the United States, who are routinely subjected to surgery to modify and "normalize" the appearance of their genitals.

18. While some of these authors may find male circumcision entails a similar lack of consent, this is not stated, although many of the authors cited (e.g., Nussbaum 1999; Rahman and Toubia 2000) *actively* dismiss any connection between the two.

19. A good example of this sort of attention is the focus on Xhosa circumcision ceremonies in South Africa during the mid-1990s (e.g., Taylor 1995).

20. Virtually all of the preservationist websites make similar statements about the connection between secular male circumcision and attempts to cure masturbation but seem to rely on the research of scholars such as those cited.

21. The earlier Kinsey report made similar observations but did not receive the same widespread attention.

22. It appears that Nussbaum is relying in part on Toubia's definition.

23. This is true from a biomedical perspective at least. There are certainly cultural contexts where a female emission analogous to semen is recognized (e.g., India).

24. Her comments seem equally relevant to social constructions of masculinity in other Western countries such as Australia, Canada, and the United Kingdom.

25. These names are pseudonyms as the authors hid their real identities.

26. The gun metaphor is used quite explicitly throughout the book—according to the authors, "It's shaped like a gun. It shoots. And, like a gun, a penis is definitely more dangerous when it's loaded than when it's unloaded" (p. 27).

27. Such ideas are common in Australia, although perhaps less consciously articulated in the United States, where the majority of men are circumcised.

28. Clearly, being "procircumcision" only becomes a meaningful label in contexts where the practice is not fundamentally normalized, and, conversely, being "anticircumcision" becomes similarly charged in contexts where it is more taken for granted.

29. Although *circclist.com* seems to focus on the erotic and aesthetic dimensions of male circumcision far more explicitly than other procircumcision websites (many of the commentaries are accompanied by pornographic images), nevertheless, sites that focus on "education" such as *circinfo.com* contain similar commentaries, as the quotes show.

30. Of course, the opponents of male circumcision argue that it is precisely such loss of sensitivity that makes the operation a form of sexual mutilation.

31. Given my arguments regarding the role of culture in sexuality, I'm not sure that it is possible to talk about orgasms cross-culturally as the "same thing."

32. The proponents of circumcision occasionally demonstrate similar tendencies, as they focus on the fact that removal of the foreskin permanently exposes the sensitive penis glans. The anticircumcision websites counteract these claims by pointing to the fact that the

exposure of the glans to everyday friction eventually results in a reduction in the sensitivity of the glans itself.

33. I certainly recognize the value of Masters and Johnston's interesting and important research, but I do not think that their clinical studies represent the final word on human sexuality.

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