

Policy in the Pants: Peeling Back the Layers in Political Discourse on Male Circumcision and its
Creation of the Masculine Body

by

Zachary Rintoul
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Abstract:

Male circumcision is surgical procedure that amputates the male foreskin from the penis, and its merits have been debated for millennia. The surgery is highly contested as it represents a collision of ideas surrounding gender, infant vs adult bodies, human rights, religion, and understandings of health, to name a few. To justify its continued existence, rooted in differing ideological frameworks, claims that are regionally specific for the arrest or continuation of the practice are made around the world. This research examines through a critical discourse analysis the cultural differences between the Canadian Paediatric Society and the American Academy of Pediatrics policy recommendation statements that were constructed for both health practitioners and the public. Beginning in 1975 both Canada and the United States began in 1975 to release policy recommendation statements after having been spurred into action from a small statement in an American text for physicians titled “Standards and Recommendation of Hospital Care of Newborn Infants.” Circumcision policies are not simply theoretical imperatives but claims that enact physical changes to bodies and their lived experiences of the universe. Therefore, I utilize the three bodies of Lock and Scheper-Hughes (1987) to ground my linguistic findings to bodies – with first and third body most present. Ultimately, I discuss how scientific framing of data in both countries policies create two different individual bodies, with the Canadian holding more holistic views of individual bodies than Americans. The body politic differed whereby, Americans emphasized efficacy of procedure, Canadians expressed the need for regulating and controlling pain and who can perform the procedure.

Keywords:

circumcision, male, foreskin, intact, three bodies, critical discourse analysis, policies, United States, Canada

In late February 2015 a young 31-year-old single mother would go on the run from United States government authorities with her 4-year-old son in the attempt to save him from having his foreskin amputated from his body (Kaplan 2015, Lupkin 2015, Sedensky 2015). For nearly three months she and her son would lodge in a domestic violence shelter away from the boy's father and law enforcement until mid-May she was found, separated from her son and placed in jail. There the judge would explain to the mother she would remain there indefinitely until she agreed to sign the consent form for her son's foreskin to be removed from his body; as per the pre-agreed upon parental agreement she had made with the father years before (Kaplan 2015, Lupkin 2015, Sedensky 2015). Tearfully, she signed the consent form, objecting all the while that the procedure would harm the child; whilst the father continued to maintain his position, stating its removal as simply "a normal thing to do" (Kaplan 2015). Nowhere in this news story debate, other than in passing mention, was boy's own opinion of not wanting to undergo the procedure (Lupkin 2015).

Introduction

The surgical removal of the male foreskin from the penis, also known as circumcision, is a technology that serves to inscribe the will of one body upon that of another. The procedure dates back several millennia with the earliest inscriptions dating back to the ancient Egypt 3000 BCE (Gollaher 2000). While often associated with religious and spiritual beliefs, a more recent development within the past couple of centuries is the secular argument for its continued practice (Gollaher 2000). The argument is that of "risk management," with "risk" constituting diseases that put an individual or society's physical health in jeopardy. Circumcision can be seen under the umbrella ideological notion of "risk management" and the conceptual framework of standard views of technology (Pfaffenberger 1992), as a rational, technological solution that efficaciously

controls the problem of sexual health “risk” – mitigating the possible spread or contraction of diseases such as urinary tract infections (UTIs), cancer, phimosis, and or sexually transmitted infections (STIs) (American Academy of Pediatrics 1989; Canada 2015).

The contemporary example at the beginning, with what became an international debate, demonstrated how various actors all over the world contested over who had the right, and thus power, in the choice of whether to excise the foreskin from the boy’s penis. The story serves to elucidate a couple of points, first is that the foreskin is not just an anatomical structure that can be removed without contestation. The practice of circumcision is not only a technology, but it is a political and cultural practice that is subject to multiple meanings, perceptions and ideologies (Gollaher, 2000). As such it is important for anthropological research, especially as the procedure lies at the collision of ideas surrounding juvenile vs adult bodies (Gollaher 2000; Prazak 2016); gender (Gosselin 2000; Prazak 2016; Thomson 2008; Walley 1997); agency (Thomson 2008); genitalia vs rest of the body (Prazak 2016; Thomson 2008); consumption practices of the individual and state (Gollaher 2000); ethnicity (Glick 2005); aesthetics (Thomson 2008); fertility (Gollaher 2000; Gosselin 2000); spirituality and religion (Gollaher 2000; Glick 2005; Prazak 2016); morality (Darby 2005; Gollaher 2000); human rights (Gosselin 2000; Walley 1997); tradition (Darby 2005; Glick 2005; Prazak 2016; Thomson 2008); ideas of cleanliness (Darby 2005; Gollaher 2000); ideas and practices of health (Gollaher 2000).

The second point the story brings to light, is that the judge’s ruling in favour of recognizing the parental agreement rather than the mother’s position against the surgery came from the underlying current national health organization’s position in favour of circumcising because of perceived medical benefits (Kaplan 2015, Lupkin 2015, Sedensky 2015). Medical policies, as this case illuminates, are much more than simple linguistic discourses making claims

to ‘truth,’ their use in social practice also makes them an exercise of power that not only shape but enable reality (Jäger and Maier 2009, 36). Thus, the focus of my paper is a cultural and linguistic analysis of two national health organization policies, the Canadian Paediatric Society (CPS) and the American Academy of Pediatrics (AAP). These two nations were chosen to limit my discussion of what is a global practice, because both Canada and the United States of America remain the highest secular circumcising nations in the world (WHO UNAIDS 2010). A historical prevue of circumcision and its relation to Canada and the United States functions to explain how such a phenomenon came to be, as well as hint at how the formation and sustained creation of policies during this time serve as the perpetuation of the surgery.

In the North American context, circumcision arose in popularity in late 19th century through a combination of two factors. First, circumcision was believed to cure the “problem of masturbation” (Darby 2005; Gollaher 2000) because such sexual expression was against religious dogma that sex was strictly for procreation (Darby 2005). The foreskin was believed in Euro-American societies as the source of pleasure (Darby 2005). Its removal, then, would assure that the individual in question would not be swayed to sexual “perversion” (Darby 2005). Second, with understandings of the natural sciences on the rise, yet still largely incomplete, circumcision was seen as a method of dealing with a wide variety of diseases (Darby 2005; Gollaher 2000). Although circumcision began to be prescribed with medicinal properties, it was not until 1971 that America released a simple statement in their “Standards and Recommendation for Hospital Care of Newborn Infants” that: “There are no valid medical indications for circumcision in neonatal period” (110).

This statement spurred the release of Canada’s first political health statement on the practice of circumcision in 1975. Similarly, within that same year, the United States of America

returned to the topic with an ad hoc “task force” to more fully investigate the possible medicinal benefits to circumcision. In the years following up to the year 2015, both countries saw the release of three more official policy statements from both the CPS (in 1982, 1996, and 2015) and AAP (in 1989, 1999, and 2015).

Although a historical view, and linguistic consideration of policies on circumcision is important. There has been little investigation in anthropological research to the practice of male circumcision in anthropological research in the North American context. Therefore, I address this dearth in research by viewing the policies that emerge are also technologies with political and cultural implications that prescribe and shape reality upon bodies. With conceptual understandings of bodies being central to a critical discourse analysis on policies, Lock and Scheper-Hughes (1987) provide an excellent theoretical framework for any anthropological work on bodies. Specifically Lock and Scheper-Hughes (1987) define three major bodies in their paper. The first body they define is ‘individual body’, which is understood not in terms of embodiment but the relationship between concepts of body and concepts of self (7). The second body from their work is the ‘social body’, defined as the representational uses of the body as a natural symbol to think about nature, society, and culture (7). Finally, the third body as the ‘body politic’, explicated as being the regulation, surveillance and control of individual and collective bodies (7-8).

Ultimately, the aim of this paper will be to utilize a critical discourse analysis, following the dispositive analytical framework of Jäger and Maier (2009), to demonstrate how the CPS and AAP articulated their positions on male circumcision in their four major policy statements from 1975 to present. The policies I examined lacked a sociocultural and economic dimension to their analyses and overall recommendation. The lack of these dimension in the policies create

constructed truths – ultimately validity – about bodies. In this way, the body politic, as articulated by Scheper-Hughes and Lock (1987), is present through the policies' claims about the regulation, surveillance and control of bodies. It is through this political discourse, I argue that the individual body – concepts of body and self – become illuminated, and only through overall sense does the social body appear.

Self-Location:

In all policies there lacks a decisive statement in how researchers and policy makers are approaching this highly contended topic (American Academy of Pediatrics 1975, 1989, 1999, 2012; Canadian Paediatric Society 1975, 1982, 1996, 2015). At best, they state there were “conflict[s] of interest,” (American Academy of Pediatrics 2012, 585) yet this still fails to explain what the “conflicts” were, or how they were addressed. Research, even ‘scientific’ research, is grounded in the researcher’s background and preconceived ideas on the issue. This statement is born from the fact that despite looking at largely the same data sets two national institutions come up with differing policy recommendations for the public to follow. Thus, I will outright state that my position as that which is coming from a circumcised, cis-gendered, gay male. I was born prematurely in the United States to an American Baptist father and Canadian agnostic mother. My father supporting the practice from a traditional mindset as “just the normal thing to do,” while my mother also claimed the surgery is medically necessary to maintain optimal health. I grew up believing that circumcision was normal, and it was not until I moved to Canada when I was eleven that this perspective was challenged. Suddenly, in the locker rooms I was the minority – sometimes the only – circumcised individual. At this point, I began to wonder: if it was normal and so medically important for the wellbeing of a male to have his

foreskin removed, why then was I the minority in British Columbia, while back in the United States I had never even seen an intact male?

The psychological effect of suddenly feeling like my own body had not been fully my own and having someone else's will inscribed upon my own body, leaving not only a scar but removing a portion of my penis, led me to the current topic of circumcision. This unpleasant experience, led me to my current beliefs that the surgery is medically unnecessary in all but the most extreme cases when all medical alternatives have been exhausted. Furthermore, I uphold an individualistic perspective believing, unless all alternatives have been exhausted, the surgery should be up to the individual because it is their body the surgery ultimately effects.

Anatomy of the Penis

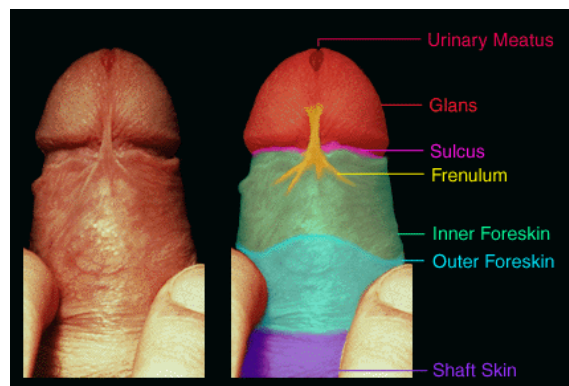


Figure 1. Medical diagram of the ventral side of an intact male (NoHarmm 2018)

A critical discourse analysis of circumcision policies and these policies' articulation of bodies necessitates a better knowledge of what exactly the foreskin is. I argue that the foreskin is a complicated physiological structure composing a significant portion of the penile skin of the adult male penis, operating like an organ involving the concerted working of several tissues. To briefly summarize then, the foreskin is a double-layered fold of skin that, when the penis is in its flaccid state, wraps and hangs over the glans, or head of the penis (see Figure 2). The double-layered fold possesses two different types of skin tissue – inner and outer, with the inner being

what wraps around the glans. Between these two layers is a sheath of smooth muscle tissue called the dartos fascia acting to permit the excretion of urine while keeping contaminants out of the body (WHO UNAIDS 2007). The foreskin, is connected to the glans, just below the meatus, on the underside of the penis, through another fold of skin called the frenulum (see Figure 1) (WHO UNAIDS 2007). In normal physiological response to sexual excitation the foreskin retracts back until the entire head of the penis is exposed for stimulation (see Figure 2). The frenulum then that acts as a tension retainer, pulling the foreskin to cover the glans when the penis returns to flaccid state, as well as the nerve center of the penis housing the densest collection of nerves in the penis (WHO UNAIDS 2007)



Figure 2. The erection process of an intact male (OrlandoDL 2008)

Circumcision, as largely practiced in Canada and United States, is a technological sophisticated surgical procedure that is most often performed in the infant stage and involves significant removal of described penile tissues (Gollaher 2000) – particularly most of the inner foreskin and to a great extent, the frenulum. Less obvious, though no less important, are internal structures the loss of the dartos fascia muscle and the specialized nerve cells.

Anthropology of Bodies

A discussion on circumcision necessitates a discussion about bodies. However, first it is important to define what a body is before explaining how policies impact bodies. To begin, since circumcision is necessarily a dialectical relationship between an individual being altered by another, I start with a broad definition provided by Lock and Farquahar that allows one to include both physical individual bodies and nonphysical social bodies. They define a body as “contingent formations of space, time, and materiality... assemblages of practices, discourses, images, institutional arrangements and specific places and projects” (2007: 1). Such an open description of bodies allows one to begin to account for the many different ways that bodies are experienced and understood. For instance, the works of Adams (1998) and Taylor (1988) serve as illuminating examples that contrast with Western Cartesian ideological notions of bodies being separate and separable from the mind. Adams’ (1998) discussion of the Tibetan ideological conception of bodies brought to light an expansion upon idea of somatization: the expression of psychological or social distress through the body. Adams furthered that such a concept lacked enough acknowledgment to the social world as experienced through the Tibetan body whereby “the social disruptions... drawn on their bodies, making their bodies physical maps of the social universes in which they existed” (Adams 1998, 87). Adams expressed how Tibetan ideological frameworks of lived body experiences comes from winds flowing through the body and imbalances to wind flow were what caused illnesses, bad moods or even material reward. Continuing this thread how bodies and various ideologies can lead to similar though different views of bodies and lived experiences, is Taylor’s (1988) discussion of Rwandan bodies. In this example, liquid and its flow were central to how bodies were made, lived and experienced, and not wind as in the Tibetan body.

Understanding that there are different conceptual frameworks for viewing the body is important as these frameworks ultimately attempt to explain the observed and lived universe. Whether through the humoral or Cartesian framework, the current body “may not be the best one – bodies are imperfect, variable and in a state of constant degeneration and need[ing] repair” (Hogle 2005, 696). In this light, circumcision policies function as an “enhancement technology” whose “aim [is] to improve human characteristics, including appearance and mental or physical functioning, often beyond what is ‘normal’ or necessary for life and well-being” (Hogle 2005, 695). As will be noted later, the scientific discourse that is used to articulate policy recommendations, no matter the position, attempt to address the questions of not only is it “necessary” for health but does performing the procedure actually “improve” well-being? In this way, policies are an expression of the ‘body politic’ (Lock and Scheper-Hughes 1987, 7-8) and through this body discourse come to regulate individuals. Thus, circumcision posed originally as an enhancement technology, also becomes a technology of the self whereby modifying and maintaining one’s body is a constant effort of processes that fall in line with authoritative discourses about health, beauty, and normalcy (Foucault from Hogle 2005, 701).

Circumcision policies construct the human body as needing repair as no matter the stance, the omnipresent concept of ‘risk management’ prevalent suggests that circumcision takes away the need for constant management or scrutiny of ones’ own body. Policies are enacted because they are believed to reflect a truth about ‘body image’ (Kaplan-Myrth 2000). This image is not just in ones’ own head or other’s heads but very much lived through the body. A poignant example of this is Greenhalgh’s (2012) work on obesity in America. Her analysis of the biopolitics and anatomopolitics of obesity discourse by the governmental state, media and individuals expressed how ‘sense of self’ is intimately and inexorably tied to governmentality in

how nation states produce the kinds of bodies needed by society through a power that is not necessarily violent or coercive but a power that we do to ourselves – collectively and individually.

Although enacted upon these preceding ideas, policies are not universally applied; evident by the fact that circumcision possesses high regional variability, across nations and within nation-states (WHO 2010). In a discussion of dental hygiene and social inequalities with access to health care Horton and Barker (2009) articulate how health professionals and policy makers enacted geographies of blame to express why health disparities were seen and remained in undocumented Mexican migrants. They showed differing ideas of who or what was to blame varied by region but, on the whole, health practitioners ignored the lived social realities of the migrants themselves. Health officials utilized concepts such as bad parenting, their foreignness, lack of morals, or general ignorance of scientific facts to explain dental health problems among the migrants. They contrasted this view with how the migrants themselves saw their predicament. For most while they knew dental hygiene was important and could articulate the basic scientific facts surrounding dental care, they expressed that it was their lack of economic status that inhibited their abilities to properly maintain health. Additionally, they also articulated high social moral values to dental care, seeing that because they were not achieving the ‘American Dream’ they were bad parents, bad citizens, and lacking general self-worth.

Finally, it must not be forgotten that while policies articulate various forms of control over different bodies, there is a material messiness to bodies. Wacquant’s germinal (1995) work with boxers demonstrated that the informal policy framework boxers’ constructed about how to play the game at their best would percolated into every aspect of their lived existence. While outside the scope of my paper, the examples I have brought forward in this section, while further

explaining bodies in the theoretical sense, were used in the attempt to branch away from simply viewing bodies as theoretical vessels. I discussed several of them to demonstrate that bodies, ultimately, are lived realities encompassing many different concepts, ideologies and experiences that vary according to culture, region and interactions with other bodies. I turn attention to this issue so one remembers that circumcision does not affect just a man's conception, agency and views of the world upon whom the surgery is performed, but rather also represents and affects the entire social network's own conception, agency and views of the world (Watson and Wilson 2014).

Linguistic Anthropology

Critical discourse analysis (CDA) is a linguistic problem-solving, interdisciplinary approach that attempts to describe how discourse operates in the social world. The 'critical' component of CDA aims to 'demystify' how discourse in the social world works upon underlying power and ideological frameworks. Furthermore, the 'discourse' component of CDA comes from seeing language as a 'social practice' in which 'discourse' presents 'structured forms of knowledge,' whereby 'context of language use' emerges as the fundamental basis the analysis builds from (Wodak and Meyer 2009, 5-6). The difficulty of CDA emerges when one tries to examine because the concepts such as ideology – defined as “a coherent and relatively stable set of beliefs or values” (Wodak and Meyer 2009, 8) – and power - loosely defined as one entit(ies) capacity to achieve a particular goal against the resistance of other entit(ies) (Wodak and Meyer 2009, 9) – inherently mean that there is no 'outside position' from which one can operate, as all positions are situated within 'social fields' (Wodak and Meyer 2009, 7).

The primary issue that emerges from the fact that in discourse with all positions being situational, such that there being no objective viewpoint one can adopt in analyzing discourse, is

the problem of operationalization of theoretical concepts in power and ideologies (Wodak and Meyer 2009, 23). This ‘problem’ can be partially rectified through the implementation of a specific CDA method that approaches the analysis of a discourse through either a deductive or more inductive perspective (Wodak and Meyer 2009, 19). The approach chosen will have its inherent strengths in viewing certain aspects of a social and weaknesses in viewing other aspects, yet two major features to CDA approaches remain its common basis. First, CDA approaches are problem-oriented and with a linguistic bent, requiring enough linguistic expertise for selection of relevant specific items for research. Second, CDA is flexible in its combination of theory and method permitting researchers to better encapsulate and understand social problems under study (Wodak and Meyer 2009, 31). Ultimately, CDA “analyz[es the] opaque as well as transparent structural relationships of dominance, discrimination, power and control ... as it is expressed, constituted, legitimized, and so on, by language use” (Wodak and Meyer 2009, 10).

My project on male circumcision focuses upon the political discourse present in CPS and AAP – national health organizations – policies regarding the issue. My goal is to illuminate how Lock and Scheper-Hughes (1987) notion of the three bodies are differently presented and applied by the two countries. To achieve such a goal I found the critical methodological framework of dispositive analysis as used by Jäger and Maier (2009) to be particularly elucidative. This methodological framework aims to firmly connect power relations to knowledge within dispositives and discourses. Dispositives are the “synthesis” of how knowledge practices are discussed, acted upon and materialize. However, in relation to my project, I will limit my discussion to the discourse portion of how knowledge practices are discussed. I will allude to how circumcision is acted upon based on this knowledge which produces the material product – the circumcised penis – as its result.

Since my discussion is limited to policy discourse, a more thorough understanding of discourse and its connection to reality is needed. Therefore, I start out with a simple definition of discourse as ‘an institutionalized way of talking that regulates and reinforces action and thereby exerts power’ (Link 1983, 60, author’s own translation). Branching from this definition of discourse, I agree with Jäger and Maier (2009) statement that “discourses do not merely reflect reality. Rather, discourses not only shape but enable (social) reality” (Jäger and Maier 2009, 36). To ground this theoretical dialogue on discourse to the more material plane dispositive analysis affords, my project examines the both “power of discourse” (Jäger and Maier 2009, 37) and “power over discourse” (Jäger and Maier 2009, 38) and how these two elements shape each other over time. To state another way, “power of discourse” is created by those with “power over discourse” leading to a material social practice of circumcision to be performed or not performed. As time passes the previous subjects to the “power of discourse” – that is were circumcised or left intact – become the new agents with “power over discourse”. This example does not lead to a never-ending spiraling loop, whereby a specific ‘power of discourse’ grows stronger with each passing decade. Human subjects of a particular discourse live in a networked field of social discourses that, once the subjects become the new agents with ‘power over discourse’ there is chance that a new discourse will emerge. In the end, dispositive analysis permits me to see the fluid social template by which policy recommendations can change or remain the same, but even if they remain the same – variations in how similar discursive themes articulate a change in “power of discourse” by those with “power over discourse”.

Policies Against the Recommendation of Male Circumcision

United States of America: AAP 1975, 1999

The American Academy of Pediatrics Task Force on Circumcision have with two policy recommendation statements in 1975 and again in 1999 that do not condone the practice of male circumcision. Despite their overall positioning, the authors would fashion linguistic phrases that put leaving the child intact as a greater hassle than performing the surgery. Take the following segment from AAP 1975 statement: “Circumcision, properly performed, eliminates much of the need for careful penile hygiene. If circumcision is not elected, the necessity for lifelong penile hygiene should be discussed with the parents, preferably before birth of the infant...” (610).

The idea of leaving the infant intact creates a necessity for “lifelong penile hygiene,” yet if one were to surgically remove the foreskin, one would also remove the need for proper hygienic care. At its core, the statement subsumes a position that frames circumcision as a benefit. It articulates that the regulation and control of the body, requiring the expenditure of energy would no longer have to be enacted or by others – such as the parents during infant years. Furthermore, subsumed under this quote is the pronouncement that the individual body that is separable from physical and psychosocial lived experiences. It also voices through implication a social body of the physical body as a machine – that the removal of an unnecessary, even more energy-costing part, leads to better overall functioning in life.

However, this being said, circumcision is not expressed as being a simple ‘snip’ at the end of one’s penis; as expressed in the following quote: “Circumcision is a surgical procedure that requires careful aseptic technique, systematized postoperative observation, and evaluation after discharge from hospital” (1975:611). Instead, circumcision is expressed in the preceding quote as being a highly sophisticated technology. Use of the term ‘careful aseptic technique’

expresses there is a procedural set of enacted actions that must happen for its proper administration. The next part of the sentence, describes that the surgery can't simply happen in an uncontrolled and specifically constructed environment as 'systematized postoperative observation.' Finally, circumcision is a technology that requires a high level of monitoring, regulation and control over the infant well after the surgery – indicated within the phrase “evaluation after discharge from hospital.”

Across all policies four major health concerns appeared: phimosis, urinary tract infections, cancer and sexually transmitted infections. The following quote addresses one of these health concerns: “Cancer of the penis is a rare disease; the annual age-adjusted incidence of penile cancer is 0.9 to 1.0 per 100 000 males in the United States. In countries where the overwhelming majority of men are uncircumcised, the rate of penile cancer varies from 0.82 per 100 000 in Denmark... to 2.0 to 10.5 per 100 000 in India” (1999: 690).

I draw attention to while authors of the policy state ‘cancer of the penis is a rare disease.’ I find it striking that they do not articulate more about the disease itself. For instance, the Canadian 1975, 1999, 2015 policies explain that cancer of the penis does not even happen in the foreskin, and while higher prevalence in intact men – it is most associated with those of a previous medical condition: phimosis. These policies were written for both medical and public communities, however, the lack of a more detailed explanation would lead the general reader to be unsure to the true nature of cancer of the penis. Furthermore, cancer of the penis as explained in Canadian policies, happens in the elderly – well after many other lifestyle choices, such as work, diet, number of sexual partners, and substance use have an effect on cancer rates.

However, the policy does hint that education and penile hygienic care are perhaps more important with its inclusion of statistics of cancer rates in other countries. Denmark only has a

minority of men who are circumcised (WHO UNAIDS 2010), as such the country possesses a culture that properly educates men – perhaps not formally – how to properly and consistently take care of their penises. India by contrast, possesses lower access to health care systems and access to basic health care needs – thus penile hygiene would be more difficult to maintain.

Following are two linguistic patterns demonstrated below were noticed throughout all American policies. This linguistic patterning established a privileging of the circumcised penis:

“There is evidence that carcinoma of the penis can be prevented by neonatal circumcision. There is also evidence that optimal hygiene confers as much, or nearly as much, protection” (1975: 610).

“Existing scientific evidence demonstrates potential medical benefits of newborn male circumcision; however, these data are not sufficient to recommend routine neonatal circumcision” (1999: 686).

The underlined portions in both quotes establish where circumcision is framed as being a benefit or potential benefit. AAP policies, not just those that took a position against its recommendation, would consistently establish in the first clause a proposed positive then in the next clause, sometimes the part of the same sentence (1999 statement above), introduce ambiguity to the claims made. There is no mixing up in the order, such that proposed positives or solutions circumcision solves come after a statement that the following statement only shows possible effect.

Canada: CPS 1975, 1996, 2015

“The cultural and religious ritual of male circumcision has been practiced for thousands of years. Circumcision as a medical procedure arose in Britain and the United States in the late 19th century... However, the rate of neonatal circumcision has declined over time

to the current Canadian average of 32%, with significant regional variability” (2015: 311).

The CPS, in contrast to AAP, consistently frames circumcision as a cultural practice with deep historical roots, whereby social practices have a stronger influence over its continued practice. The quote taken from the first sentence of the introduction, immediately starts to de-medicalize the practice. By explaining how the practice was born and how it is fading out of popular medical practice – it sets the tone for readers to question why one should do it in the first place. Importantly, it implicitly conveys the idea that if the practice were necessary for optimal health, it would not be declining over time. Furthermore, besides being the only country to consistently emphasize “significant regional variability”, Canada also points out an answer to readers that may make the claim that they have only known men of a particular status. By adding in the concept of geography, the authors point out that some geographic regions can have higher or lower percentage of men with a certain status than the national average.

Canada was also the only one to consider social practices, such as adoption, into its policy statements. Take the following quote from CPS 1975 statement:

“Because a decision to circumcise in the newborn period must be ascribed to social rather than medical reasons, it would be even more inappropriate in an infant who is destined for adoption... A natural parent giving up a child for such placement should not be empowered to authorize circumcision... such an agency would be overstepping any mandate provided by its Provincial Protection of Children Act.”

While discussion of ethics of circumcision with regards to adoption was unique to the 1975 statement, overall Canadian policy discourse possessed a level of conscious contestation over whose agency could exercise control in the choice of circumcision. Sometimes, as this case

above shows an explicit demonstration that natural parents and political adoption agencies are not allowed to exercise control over the decision to circumcise infants.

Finally, beyond what was previously discussed, Canada was the only country to consistently put circumcision under the critical light – going further than simply listing complications from performing the procedure with names or even just stating them as ranging from “minor” to “major” (AAP 2012). An example from CPS 1996: “The exact incidence of postoperative complications is unknown... However, published rates range as widely as 0.06% to 55%. Williams and Kapila have suggested that a realistic rate is between 2-10%” (1996: 774). Here the CPS articulated relatively high rates of complications – especially when compared to listed complications from remaining intact such as cancer demonstrated earlier.

Policies For the Recommendation of Male Circumcision

United States of America: AAP 2012

“All authors have filed conflict of interest statements with the American Academy of Pediatrics. Any conflicts have been resolved through a process approved by the Board of Directors” (585).

It is interesting to note that AAP’s most recent statement had ‘all authors’ filing ‘conflict of interest statements’ that were resolved through a process ‘approved by the Board of Directors’. This paraphrase, however, fails to encapsulate the complexities within these two sentences. First, when thinking of the third body from Lock and Scheper-Hughes (1987), it raises the questions how were these “resolved;” what was the “process;” what were the natures of the conflicts and how could the ‘Board of Directors’ enact such resolution? Second, the linguistic pattern creates ambiguity as to whether and whoever claimed there was “conflict of interest.” The first clause states definitively that all authors in the report had a conflict. Therefore, the

ensuing clause should have stated “Conflicts have been resolved through a process approved by the Board of Directors.” Questions I have raised in my previous first point would still apply, but through the addition of the adjective “any” to the beginning of the second clause, the claim made in the first clause is mitigated. For now, readers also must wonder: was there any conflict actually reported to the Board of Directors?

The second and final point I want to point out how of all policies examined this policy remains the only one released specifically for the general public, while in the same year producing a “Technical Report” for professionals or educated readers to examine the scientific reasoning supporting their statement that “... preventative health benefits of elective circumcision of male newborns outweigh the risks of the procedure” (585).

Canada: CPS 1982

Canada only released one policy statement that supported the practice of circumcision. It was written in a completely different style from policies before and after. It contained many bullet points in its various sections that acted as summarized goalposts saving the reader from having to read the paragraphs and instead read the ‘scoreboard’ highlights. Following, I have extracted one to analyze how they frame the concept of risk and circumcision: “Hemorrhage, infection and other immediate complications of circumcision have been reported. Most are easily treated; those that are not are very rare” (975). Here the complications of circumcision are minimized in importance through ‘most are easily treated’ with those that are not ‘are very rare’. However, the first clause lists some serious sounding complications, yet the bullet point does not expand upon rates or treatability of these complications. Thus, the goalpost highlights that these bullet points create within the policies obfuscates more than it explains.

Additionally, this was the first and only policy released by the CPS that expressed monetary expense by the state: “In comparison with therapeutic circumcision at a later age, neonatal circumcision saves time and money and carries less risk of complications or death even though it involves a larger number of operations” (976). This strong statement found in the policy’s conclusion serves to burn the importance of circumcision into reader’s memory as infant circumcision saves one ‘time, money’ and risk of ‘complications and death’. Lost in this recommendation statement is the strong sense of self that is more holistic.

Policy Providing No Recommendation for Male Circumcision

United States of America: AAP 1989

“Newborn circumcision has potential medical benefits and advantages as well as disadvantages and risks. When circumcision is being considered, the benefits and risks should be explained to the parents and informed consent obtained” (390). Ironically, by not taking a certain stance, AAP approached a more similar conception of the three bodies to many of the Canadian policies. The individual was seen less as a machine and more as a holistic web where connections to the physical and social world emerge as important. Indeed, even its presentation of evidence was more conciliatory and less firm than policies before or after as seen in the following quote: “... in the absence of well-designed prospective studies, conclusions regarding the relationship of urinary tract infection to circumcision are tentative” (390). Although this particular statement is for UTIs, this rhetorical device was consistently used for all four major health concerns circumcision is believed to address.

Discussion

The CPS and the AAP make claims in their policies from a scientific medical perspective, that separates the ‘mind’ – and all its incumbent ‘subjective’ experiences the

concept entails – from the ‘body.’ Taking such a perspective attempts to absolve the organizations from notions of “bias” in the claims to “truth” they create. In spite of these organizations’ efforts, all claims are biased because these claims are constructed to specific sociocultural locales, and political in their usage – even if only implicitly. Take note, that I am not claiming that there are no legitimate medical reasons for circumcision. My usage of bias is strictly in the sense that doctors with biased understandings, prescribe circumcision as solution to perceived problems that might not be as medically necessary as believed.

Bias, however, can come in greater forms than simply prescribing or not prescribing circumcision. For instance, an implicit demonstration of their bias is, no matter the position the policies take on circumcision: for, against, or no recommendation, there is an implicit linguistic privileging and naturalizing of the surgically altered penis, or as stated in policies “circumcised penis”. The naturalization happens through the constant use of “circumcised” or “uncircumcised” to describe the two physiological forms a penis can take on a man, which linguistically approaches “natural” and “unnatural” – the prefix “un-” serves to destabilize the natural form the male sex is born with at birth and normalize the surgical-altered “circumcised” form. Words that connote an implicit naturalness to the unaltered body, such as “intact” or “whole” are never seen in reference to the male penis.

Contrary to what I thought I would find there was only a general sense of national identity present in policies. Neither nation maintained a specific position over time, and while Canada maintained the most consistent in its condemnation for circumcision, the reasons for the stance taken varied. For instance, the Canadian 1975 policy brought up before circumcision is considered the social factors such as adoption needs to be accounted for, yet this idea does not come up again in any of the later policies. Similarly, CPS’s 1999 policy, in its discussion of

urinary tract infections, mentions that maternal contact and transfer of bacterium to infant could offer as an effective prophylactic alternative to circumcision as these beneficial bacteria cultures could prevent the ‘bad’ bacteria from populating the foreskin causing infection.

Despite variability across policies, all policies attempted to answer the question - is circumcision medically necessary – in a consistent format. First, all policies discussed what medical ‘problems’ the technology of circumcision addresses. Here many policies would elaborate out four major health concerns: phimosis (the inability to retract the foreskin behind the glans), urinary tract infections, sexually transmitted infections and cancer. Subsequently, policy makers would expose the risks of circumcision – yet, in many cases the severity of the risk would be obfuscated. Some policies would claim there were “minor risks” as well as “major risks” (American Academy of Pediatrics 2012) yet fail to elaborate as to which medical conditions would classify under this dichotomy. Other policies would explicate the various medical conditions with little or no summary as to their prevalence when circumcision is performed (American Academy of Pediatrics 1975, 1989; Canadian Paediatric Society 1975, 1999, 2015). Furthermore, these other policies would in many cases not provide an explanation for the lay reader as to what these medically specific and advanced terminology meant to the person suffering such an affliction. In later policies beginning in 1982 with CPS and 1999 with AAP, a third section began to appear to provide more information outside what to surgery attempts to address and possible risks. Topics that began to be included were discussion of penile anatomy with relation to the foreskin, penile care and hygiene with a foreskin, types of surgical procedures and economic cost/benefit analyses both in terms of economic cost to the individual or state as well as life expectancy.

All policies expressed the body politic of their national organization through scientific claims of whether circumcision is medically ‘necessary’ as an effective form of ‘risk management’. Science, however, is a *methodology* that employs a specific way of viewing the world. It is the *application* of science that science becomes imbued with moral and social values. Here, the discourse in application and explication of scientific results, are what policies articulate. Similar to Greenhalgh’s (2012) study of political, popular and individual discourse on obesity, governmentality and biopower within the policies enunciated particular views of Lock and Scheper-Hughes conception of the three bodies that was split upon national identities.

AAP, no matter the stance taken, policies would consistently apply a linguistic pattern to give an undercurrent of validity to the continued practice of circumcision. First, they would posit possible positives that circumcision can or could address. The following clause, sometimes in the same sentence, ambiguity about the previously made claim would be expressed. The linguistic pattern that frames circumcision positively, rather than prefacing or acknowledging that evidence presented specific to certain studies looked at, was not the only similarity among American policies. American policies articulated concepts of the body and concepts of the self in a Cartesian ego-centric perspective. This type of individual body (Lock and Scheper-Hughes 1987) sees autonomous individuals as separate and distinct from others and society, while at the same time seeing a separation of the mind and body. In this manner the foreskin is simply a body part that can be excised without any consequences to the individuals psychological or social experiences in the world.

Policies that promoted circumcision take the strongest stance, yet even policies that were against circumcision articulated this individual body. In this way AAP policies against circumcision viewed the foreskin as a body part that could serve the individual from a

physiological functional perspective and thus its removal might not be the most beneficial course of action. Lock and Scheper-Hughes' (1987) 'social body' was less prevalent in policy discourse and could only be gained through implication. Overall, AAP policies construct the male social body as a machine made of parts; that is, they disconnect the psycho-social lived realities from the physical body. The amputation of the foreskin was a removal of a part to make the machine run better. Finally, the body politic, the largest of the bodies noticed in policies, emerged through the many different claims to the regulation, surveillance and control of bodies: who could perform the surgery, where to perform the surgery, when to or when not to perform the procedure, and how to perform the surgery. Yet, as the largest body, it was the one that fluctuated the most over the decades, however two major themes emerged despite changing stance was that circumcision needed to be performed in sterile ('aseptic') environment by professional.

The CPS, by contrast, voiced an entirely different set of individual, social, and political bodies. The individual body revealed from all policies was a blend between egocentric and sociocentric self. Ultimately, the self was constructed as being an autonomous individual, distinct from others and society but on that is built up through relationships between other individuals and objects. In this way, the physical body was never separated from lived experiences, and so excising the foreskin would lead to a change in lived experience. This could be evidenced with the 1975 section claiming it would be "more inappropriate" for a child destined for adoption to be circumcised "before the transition into the new family setting has been completed." The heavier recognition of sociocultural and psychological factors in Canadian circumcision policies described a social body that saw the body not as a machine but a web with many interconnections whereby individual and collective identities were not easily separable,

removing the foreskin would irreparably change the web of connections that the individual who is circumcised makes in life. Even CPS' only policy that recommended circumcision in 1982, the positive recommendation came more tentatively because of the recognition of social realities. Finally, like the AAP, the body politic was the most voiced body in Canadian policies – yet differed in that throughout policies the two major themes. First, if the surgery is to be performed pain from the procedure and afterwards must be properly controlled. Second, the procedure needs to be performed by an *accomplished* professional – thus to mitigate any long-term impacts that a botched surgery would mean for the individual's life.

Thinking back to my previous discussion of Horton and Barker's (2009) work with Mexican migrants and dental health, I would like to bring up the concept of “geographies of blame.” Circumcision policies, like dental health discourses, are a technology that is enacted differentially depending on the region and physician's perspective. However, I would like to expand this concept from Horton and Barker's (2009) usage to include the more theoretical realm by demonstrating how the health care system through subtle manipulations in linguistic framing, that the political institutions of CPS and the AAP divorce the health predicaments from social inequalities in access to health care and proper sexual education to the health care predicaments experienced by individuals.

The shift of blame in poor management of “risk” from the structural health inequalities to families' choice to elect or not elect for the surgery. AAP and CPS policies present the statements to the public and professionals through prescribing actions through “recommendation” backed with “informed” ideas. However, if people later want to challenge the stance health care systems articulate that it was the choice of the family. Thus, if a man suffers from more complications because of the surgery, it was not the health care system who

circumcised them, but rather their parents, as all policy statements voiced that the choice to circumcise should rest with the parents alone. Therefore, blame for hardships endured, while prescribed by political systems, it is the individual social groups – the parents, that sufferers should blame. The only responsibility of the health care system came though with the guidance of professionals who would present the pros and cons to the surgery.

A point I have mentioned a couple times previously and outside of my research methodology to prove that similar to Horton and Barker (2009), structural health inequalities could compose a significant portion of health problems observed between circumcised and intact men. For instance, mentioned in CPS 1996 a possible preventative measure against UTI is maternal contact, rather than standard hospital procedures that sanitize and keep infants away from the mother while she recuperates. Through physical contact with the mother after birth, the infant male is colonized with healthy bacteria, rather than more problematic strains of *E. coli* commonly found in hospital environments, which then colonize the foreskin and lead to higher UTI prevalence than in circumcised infants (Canadian Paediatric Society 1996, 771-72). This research lines up with other research that have demonstrated maternal breastfeeding leads to the successful colonization of bacteria that further aid in the development of the infant (Kurki 2017).

Continuing with the concept of blame, it is a concept whereby one holds another responsible for their misfortune. Blame is deeply nested in ideologies of power, therefore “geographies of blame,” as I have used it, necessitates a clear audience because *who* or *what* is to blame is the central question the concept focuses upon. However, I argue that the policies were created for shifting notions of who the intended readers of the document will be. The result from having unclear ideas as to who the audience is created ambiguity in the overall message policies

tried to convey. Outside of the CPS 1975 and AAP 2012 policy statements, the intended readers were for both professionals and public.

For many readers of the public, namely prospective parents, the medical language and scientific methodologies explained and employed to make truth claims would lend an air of legitimacy to only the broadest of claims concepts. Scientific analytical such as ‘odds ratio’ or ‘relative risk’ used to explicate particular claims whether remaining intact or not was a benefit or hindrance, would be lost to the general audience as each of these methodologies means specific things within a scientific framework but are not commonly used. I also argue that while heavily scientific for the general public, the brevity of analysis to health problems circumcision addresses and health risks to performing the surgery coupled with broad claims stated, make the policies of limited use for professionals. At worst, for the uncritical health professional, these policies can serve as a ‘quick brush up’ on current discourse around circumcision. However, the bodies, as discussed previously, then become the principle method by which professionals shape their opinions on the practice.

The CPS 1975 policy differed in that each claim of medical conditions and risks were explained such that even a person unknowledgeable of scientific terms would understand. The lack of references to scientific studies or quantitative empirical data suggested that the audience was specific to the general reader. The only other policy that was not created for both professionals and public was AAP 2012. In a similar fashion the claims were kept simple and broad with no empirical data presented. However, this policy differed from CPS 1975 and all other policies because the authors explicitly stated who their audience was – the public. Additionally, the AAP 2012 policy elaborates that if someone with greater knowledge, or a medical professional would like to see the scientific reasoning and validity behind their

statement, they should read an accompanying document entitled “Technical Report: Male Circumcision” by the AAP in the same year as the policy statement was released.

The nature of the data presented is empirical in nature and thus from this perspective there should be no blank spaces. However, there are several points to be made about data and its presentation in policies. First, CPS and AAP policies question the medical ‘need’ for circumcision, yet they largely do not discuss international discourse and practices. Looking from a broader cultural perspective raises some interesting questions. An example is that despite sexually transmitted infections becoming a larger portion and reason to promote the practice of circumcision in North American policy discourse – such reasons are not utilized by international countries’ views on circumcision. Indeed, many European countries have lower rates of STI transmission than the United States and Canada. The concept of education as effective preventative measure has been key in demonstrating the link between the STI transmission and these countries (WHO UNAIDS 2010).

Secondly, even from an empirical perspective, metadata analyses are constructed by the author’s own perspective as to what data is more important. In compiling multiple studies into shorter statements, the author must make decisions as to what to include and what to leave out. Policies make claims but rarely state the structural problems in studies used to present facts – such as how many participants, length of time of study, methods used to collect and enumerate data. For instance, policies no matter their stance on circumcision, further validate concerns for the extremely rare forms of diseases. One of the diseases discussed in most of the policies, as pointed out earlier, is the risk of contracting penile cancer and its correlation to the circumcision status of these men. Policies largely acknowledge penile cancer is not found in the foreskin, and generally found in elderly patients (Canadian Paediatric Society 1975, 1996, 2015; American

Pediatric Society 1989). Furthermore, the rate of penile cancer is extremely low and not expressed in these studies are the details of the studies. It is this lack of standardized explanations and hierarchy of data that leads to some policies to construct circumcision as the cure for cancer [or other various illnesses] (American Academy of Pediatrics 2012) while in others there is simply a correlation between circumcision status and cancer rates [or other illness rates] (Canadian Paediatric Society 2015).

'Fore-' Future Research

The United Nations Convention on the Rights of the Child (n.d.) is an internationally recognized document outlining inalienable rights granted to all peoples upon birth. This paper has tackled one aspect of human rights, namely how policies on male circumcision articulate the concept of 'risk management' to led to some bodies being subjected to a surgery they might have themselves not elected for had the men themselves had a voice. Similarly, female genital modification/mutilation has been condemned as a violated of basic human rights to bodily integrity such that its practice has been made illegal all over the world. However, its male counterpart continues to be widely practiced. In the North American context, genital modification has been differentially constructed according to the sex of the child (Gollaher 2000; Walley 1997). This differential allows one sex (female) to be afforded protection by national and international laws from their bodies being modified (Gosselin 2000; Walley 1997; WHO 2018), whilst arguments made for this sex are not conveyed to the other sex (male). One avenue for research would could more fully expand upon this through would be another critical discourse analysis of policies surrounding both female and male genital modification.

My research only examined policies on male circumcision from Canada and the United States, to continue along this vein how would policies of the World Health Organization

compare? How would policies from other nations from nations with less circumcised men compare? Since Canada and United States are secular nations, how would religious nation-states articulate circumcision policies and practices? Furthermore, my analysis did not go into deep into questioning the political and economic situation of the nations themselves during their formation of policies, for instance: what caused both nations to change from strictly against the practice in the 1970 to the 1980s policies voicing a position that was ambivalent or supported the practice?

Finally, to move away from policy discourse, since policies are describing control over bodies – how do men feel about having no choice and having the procedure done? How do men feel in general about the surgery? Policies began to express concern for how pleasure would be affected later in life from such a surgery to the penis. How do men themselves say circumcision affects their phenomenological experience of sex? Indeed, the underappreciated work of Watson and Wilson (2014) are starting to fill in the missing blank with men’s own voices, yet more critical research is needed to fully expand out the concepts presented.

Conclusion

Male circumcision is surgical procedure that amputates the male foreskin from the penis, and its merits have been debated for millennia. The surgery is highly contested as it represents a collision of ideas surrounding gender, infant vs adult bodies, human rights, religion, and understandings of health, to name a few. My research does not contribute to the debate of whether the practice of circumcision should or should not happen to infant males, despite my previously stated position on the matter as being firmly against it being performed unless absolutely necessary. Instead, my research aims through a critical discourse analysis to demonstrate the cultural differences between the Canadian Paediatric Society and the American Academy of Pediatrics policy recommendation statements. Ultimately, I hope to have presented

that circumcision acts an enhancement technology and that circumcision policies construct masculine bodies in a nationally specific way that changes over time as medical science understandings of the human body continues to evolve.

My major findings of the policies constructed for both health practitioners and public are that language used in policies construct different individual and social male bodies through the body political discourse of policies. Canadians held more holistic views of individual bodies than Americans. This perspective seeped into how social bodies were implied, which created an American social male body that viewed the physical body as a machine whose parts could be removed to allow better functioning of the body, opposing to Canada's reticence in removing the foreskin. The body politic differed whereby, Americans emphasized efficacy of procedure, Canadians expressed the need for regulating and controlling pain and who can perform the procedure.

To conclude, policies under the sociocultural lens opens the perspective to their inadequacies to fully provide an understanding of 'risk management' to lead to the all important 'informed' choice to elect or not to elect for the surgery. Although, the focus of my research and analysis was upon policies, it must not be forgotten that policies and claims made are about the control of physical bodies. However, I posit that bodies are not just good to think with, but good to play with and one should not discount the messy, lived experiences of bodies. As such, while the investigation had a greater focus upon neonates, these policies in their attempt manage 'risk' enact permanent physical changes upon male bodies, and as Watson and Wilson (2014) demonstrate these changes even when made in the newborn period permanently alter their current and future lived realities.

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