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"What About Female Genital Mutilation?" and Why Understanding Culture Matters in the First Place

Richard A. Shweder

Female genital mutilation (FGM, also known as female circumcision) has been practiced traditionally for centuries in sub-Saharan Africa. Customs, rituals, myths, and taboos have perpetuated the practice even though it has maimed or killed untold numbers of women and girls. . . .

FGM's disastrous health effects, combined with the social injustices it perpetuates, constitute a serious barrier to overall African development.

—Susan Rich and Stephanie Joyce, "Eradicating Female Genital Mutilation" (n.d.)

On the basis of the vast literature on the harmful effects of genital surgeries, one might have anticipated finding a wealth of studies that document considerable increases in mortality and morbidity. This review could find no incontrovertible evidence on mortality, and the rate of medical complications suggest that they are the exception rather than the rule.

—Carla M. Obermeyer, "Female Genital Surgeries" (1999)

Early societies in Africa established strong controls over the sexual behavior of their women and devised the brutal means of circumcision to curb female sexual desire and response.

—Olayinka Koso-Thomas, *Circumcision of Women* (1987)

In fact, studies that systematically investigate the sexual feelings of women and men in societies where genital surgeries are found are rare, and the scant information that is available calls into question the assertion that female genital

surgeries are fundamentally antithetical to women's sexuality and incompatible with sexual enjoyment.

—Carla M. Obermeyer, "Female Genital Surgeries" (1999)

Those who practice some of the most controversial of such customs—clitoridectomy, polygamy, the marriage of children or marriages that are otherwise coerced—sometimes explicitly defend them as necessary for controlling women and openly acknowledge that the customs persist at men's insistence.

—Susan Moller Okin, *Is Multiculturalism Bad for Women?* (1999).

It is difficult for me—considering the number of ceremonies I have observed, including my own—to accept that what appears to be expressions of joy and ecstatic celebrations of womanhood in actuality disguise hidden experiences of coercion and subjugation. Indeed, I offer that the bulk of Kono women who uphold these rituals do so because they want to—they relish the supernatural powers of their ritual leaders over against men in society, and they embrace the legitimacy of female authority and particularly, the authority of their mothers and grandmothers.

—Fuambai Ahmadu, "Rites and Wrongs" (2000)

On November 18, 1999, Fuambai Ahmadu, a young African scholar who grew up in the United States, delivered a paper at the American Anthropological Association Meetings in Chicago that should be deeply troubling to all liberal free-thinking people who value democratic pluralism and the toleration of differences and who care about the accuracy of cultural representations in our public policy debates.¹

Ms. Ahmadu (2000, 283) began her paper with these words:

I also share with feminist scholars and activists campaigning against the practice [of female circumcision] a concern for women's physical, psychological and sexual well-being, as well as with the implications of these traditional rituals for women's status and power in society. Coming from an ethnic group [the Kono of Eastern Sierra Leone] in which female (and male) initiation and "circumcision" are institutionalized and a central feature of culture and society and having myself undergone this traditional process of becoming a "woman," I find it increasingly challenging to reconcile my own experiences with prevailing global discourses on female "circumcision."

BY RITES A WOMAN: LISTENING TO THE MULTICULTURAL VOICES OF FEMINISM

Coming-of-age and gender-identity ceremonies involving genital alterations are embraced by, and deeply embedded in the lives of, many African women, not only in Africa but in Europe and the United States as well. Estimates of the number of contemporary African women who participate in these practices vary widely and wildly between 80 million and 200 million. In general, these women keep their secrets secret. They have not been inclined to expose the most intimate parts of their bodies to public examination, and they have not been in the habit of making their case on the op-ed pages of American newspapers, in the Halls of Congress, or at academic meetings. So it was an extraordinary event to witness Fuambai Ahmadu—an initiate and anthropologist—stand up and state that the oft-repeated claims “regarding adverse effects [of female circumcision] on women’s sexuality do not tally with the experiences of most Kono women,” including her own (Ahmadu 2000, 308, 305). Ms. Ahmadu was twenty-two years old and sexually experienced when she returned to Sierra Leone to be circumcised, so at least in her own case, she knows what she is talking about. Most Kono women uphold the practice of female (and male) circumcision and positively evaluate its consequences for their psychological, social, spiritual, and physical well-being. Ms. Ahmadu went on to suggest that Kono girls and women feel empowered by the initiation ceremony, and she described some of the reasons why.

Fuambai Ahmadu’s ethnographic observations and testimony may seem astonishing. In the social and intellectual circles in which most liberal Americans travel, it has been so politically correct to deplore female circumcision that the alarming claims and representations by anti-FGM advocacy groups (images of African parents routinely and for hundreds of years disfiguring, maiming, and murdering their female children and depriving them of their capacity for a sexual response) have not been scrutinized with regard to reliable evidence. Nor have these claims been cross-examined by free-thinking minds through a process of systematic rebuttal. Quite the contrary; the facts on the ground and the “correct” moral attitude for “good guys” are taken to be so self-evident that merely posing the rhetorical question, “What about female genital mutilation?” is presumed an obvious counterargument to cultural pluralism and a clear limit to any feelings of tolerance for alternative ways of life. This is unfortunate because there is good reason to believe that this case is far less one-sided than one may suppose—the “bad guys” are not really all that bad, the values of toleration and pluralism should be upheld, and the “good guys” may have rushed to judgment and gotten an awful lot rather wrong.

Six months before Fuambai Ahmadu publicly expressed her doubts about the prevailing global discourse on female circumcision, readers of the *Medical Anthropology Quarterly* observed an extraordinary event of a similar yet (meth-

odologically) different sort. Carla Obermeyer, a medical anthropologist and epidemiologist at Harvard University, published a comprehensive review of the existing medical literature on female genital surgeries in Africa, in which she concluded that the claims of the anti-FGM movement are highly exaggerated and may not match reality (also see Larsen and Yan 2000 and Morison et al. 2001)

Obermeyer (1999, 80) began her essay by pointing out, "The exhaustive review of the literature on which this article is based was motivated by what appeared as a potential disparity between the mobilization of resources toward activism and the research base that ought to support such efforts." When she took a closer look at that research base (a total of 435 articles were reviewed from the medical, demographic, and social science literatures, including every published article available on the topic of female circumcision or female genital mutilation in the Medline, Popline, and Sociofile data bases), Obermeyer discovered that in most publications in which statements were made about the devastating effects of female circumcision no evidence was presented at all. When research reports containing original evidence were examined, Obermeyer discovered numerous methodological flaws (for example, small or unrepresentative samples, no control groups) and quality control problems (such as vague descriptions of medical complications) in some of the most widely cited documents. "Despite their deficiencies, some of the published reports have come to acquire an aura of dependability through repeated and uncritical citations" (Obermeyer 1999, 81).

In order to draw some realistic (even if tentative) conclusions about the health consequences of female circumcision in Africa, Obermeyer then introduced standard epidemiological quality control criteria for evaluating evidence (Obermeyer 1999, n24). For example, a research study would be excluded if its sampling methods were not described or if its claims were based on a single case rather than a population sample. On the basis of the relatively small number of available studies that actually passed minimum scientific standards (for example, eight studies on the topic of medical complications), Obermeyer reported that the widely publicized medical complications of African genital operations are the exception, not the rule; that female genital alterations are not incompatible with sexual enjoyment; and that the claim that untold numbers of girls and women have been killed as a result of this "traditional practice" is not well-supported by the evidence (Obermeyer 1999, 79).

It is noteworthy that in the liberal academy, even among typically skeptical and normally critical public intellectuals, there has been an easy acceptance of the anti-FGM representations of family and social life in Africa as dark, brutal, primitive, barbaric, and unquestionably beyond the pale. Several moral, political, and feminist theorists even suggest that these coming-of-age and gender-identity ceremonies of African women deserve a place on the list of absolute evils, along with human sacrifice, the Holocaust, rape, lynching, and slavery. "Frankly, I don't give a damn if opposing this is a violation of someone's culture.

To me, female genital mutilation is a violation of the physical and spiritual integrity of a person," states Tilman Hasche, a political asylum lawyer (quoted in Egan 1994), summarizing a not uncommon view among public intellectuals in the United States and Europe.

Much of the press in the First World similarly has been swayed. Media coverage that affects American opinion about African customs has been influenced extensively by anti-FGM activists and advocacy groups who represent the African practice of female genital alteration as a scourge or disease that needs to be eradicated, who write books with stirring titles such as *Women, Why Do You Weep?* and who presuppose that any deliberate alteration of that part of the female anatomy is an example of the patriarchal oppression of women and must be viewed as a mutilation. "Here is a dream for Americans, worthy of their country and what they would like it to be," writes A. M. Rosenthal, the distinguished columnist for the *New York Times*. "The dream is that the U.S. could bring about the end of a system of torture that has crippled 100 million people now living upon this earth and every year takes at least two million more into an existence of suffering, deprivation and disease. . . . The torture is female genital mutilation" (Rosenthal 1995, A25). In his op-ed essay Rosenthal then proudly advertises three advocacy groups, including the organization that publishes *The Hosken Report* (Hosken 1993), an anti-FGM document that has been widely distributed to opinion makers in the United States and has impressed many journalists.

Equally noteworthy, however, is that these judgments seem precipitous and fundamentally misinformed to many anthropologists who study gender, initiation, and life stages in Africa. Many anthropologists and other researchers who work on these topics have long been aware of discrepancies between the global discourse on female circumcision (with its images of maiming, murder, sexual dysfunction, mutilation, coercion, and oppression) and their own ethnographic experiences with indigenous discourses and with social and physical realities at their field settings and research sites (for example, Abusharaf 2001; Boddy 1989, 1996; Gruenbaum 1996, 2001; Johnson 2000; Kratz 1994, 1999; Obiora 1997, Parker 1995; Shell-Duncan and Hernlund 2000a; Walley 1997).

Perhaps the first anthropological protest against the global discourse came in 1938 from Jomo Kenyatta, who, prior to becoming the first president of post-colonial Kenya, published a doctoral thesis in anthropology at the London School of Economics and Political Science (Kenyatta 1938). He described both the customary premarital sexual practices of the Gikuyu (lots of fondling and rather liberal attitudes toward adolescent petting and sexual arousal) and the practice of female and male circumcision.

Kenyatta's words have an uncanny contemporary ring and relevance. First he informs us,

In 1931 a conference on African children was held in Geneva under the auspices of the Save the Children Fund. In this conference several European delegates urged that the time was ripe when this "barbarous custom"

should be abolished, and that, like all other "heathen" customs, it should be abolished at once by law. (Kenya 1938, 131)

Kenya goes on to argue that among the Gikuyu a genital alteration, "like Jewish circumcision," is a bodily sign that is regarded "as the *conditio sine qua non* of the whole teaching of tribal law, religion and morality"; that no proper Gikuyu man or woman would have sex with or marry someone who was not circumcised; that the practice is an essential step into responsible adulthood for many African girls and boys; and that "there is a strong community of educated Gikuyu opinion in defense of this custom" (Kenya 1938, 133, 132).

Nearly sixty years later, echoes of Jomo Kenya's message can be found in the writings of Corinne Kratz, who has written a detailed account of female initiation among another ethnic group in Kenya, the Okiek. The Okiek, she tells us, do not talk about circumcision in terms of the dampening of sexual pleasure or desire, but rather speak of it "in terms of cleanliness, beauty and adulthood." According to Kratz, Okiek women and men view "genital modification and the bravery and self-control displayed during the operation as constitutive experiences of Okiek personhood" (Kratz 1994, 346).

Many other examples could be cited of discrepancies between the global discourse and the experience of many field researchers in Africa. With regard to the issue of sexual enjoyment, for example, Robert Edgerton (1989, 254n22) remarks that "[G]ikuyu men and women, like those of several other East African societies that practice female circumcision, assured me in 1961-62 that circumcised women continue to be orgasmic." Similar remarks appear in other field reports (for example, Lightfoot-Klein 1989; Gruenbaum 2001, 139-43).

With regard to the global discourse that represents circumcision as a disfigurement or mutilation, Sandra Lane and Robert Rubinstein (1996, 35) offer the following caution.

An important caveat, however, is that many members of societies that practice traditional female genital surgeries do not view the result as mutilation. Among these groups, in fact, the resulting appearance is considered an improvement over female genitalia in their natural state. Indeed, to call a woman uncircumcised, or to call a man the son of an uncircumcised mother, is a terrible insult and noncircumcised adult female genitalia are often considered disgusting. In interviews we conducted in rural and urban Egypt and in studies conducted by faculty of the High Institute of Nursing, Zagazig University, Egypt, the overwhelming majority of circumcised women planned to have the procedure performed on their daughters. In discussions with some fifty women we found only two who resent and are angry at having been circumcised. Even these women do not think that female circumcision is one of the most critical problems facing Egyptian women and girls. In the rural Egyptian hamlet where we have conducted fieldwork some women were not familiar with groups that did not circumcise their girls. When they learned that the female researcher was not cir-

circumcised their response was disgust mixed with joking laughter. They wondered how she could have thus gotten married and questioned how her mother could have neglected such an important part of her preparation for womanhood.

These ethnographic reports are noteworthy because they suggest that instead of assuming that our own perceptions of beauty and disfigurement are universal and must be transcendental, we might want to consider the possibility that a real and astonishing cultural divide exists around the world in moral, emotional, and aesthetic reactions to female genital surgeries. No doubt, of course, our own feelings of disgust, indignation, and anxiety about this topic are powerful and may be aroused easily and manipulated rhetorically with pictures (for example, of Third World surgical implements) or words (for example, labeling the activity *torture* or *mutilation*). If we want to understand the true character of this cultural divide in sensibilities, however, we need to bracket our initial (and automatic) emotional-visceral reactions and save any powerful conclusive feelings for the end of the argument, rather than have them color or short circuit all objective analysis. Perhaps, instead of simply deploring the "savages," we might develop a better understanding of the subject by constructing a synoptic account of the inside point of view, from the perspective of those many African women for whom such practices seem both normal and desirable.

MORAL PLURALISM AND THE MUTUAL "YUCK" RESPONSE

People recoil at each other's practices and say "yuck" at each other all over the world. When it comes to female genital alterations—or lack thereof—the mutual yuck response among peoples is particularly intense and may even approach outrage or horror. From a purely descriptive point of view, this type of physical modification is routine and normal in many ethnic groups: for example, national prevalence rates of 80 percent to 98 percent have been reported for Egypt, Ethiopia, the Gambia, Mali, Sierra Leone, Somalia, and the Sudan (Shell-Duncan and Hernlund 2000a, 10–12). In African nations where the overall prevalence rate is lower—for example, Kenya (50 percent), Côte d'Ivoire (43 percent), and Ghana (30 percent)—it is typically because some ethnic groups have a tradition of female circumcision while others do not. Thus, for example, within Ghana ethnic groups in the north and east circumcise boys and girls, while ethnic groups in the south have no tradition of female circumcision.

In general, for both sexes the best predictor of circumcision (versus the absence of it) is ethnicity or cultural group affiliation. Circumcision is customary for the Kono of Sierra Leone, for example, but for the Wolof of Senegal it is not. For women within these groups, one key factor—their cultural affiliation as either Kono or Wolof—trumps other predictors of behavior, such as education level or socioeconomic status. Among the Kono, even women with a secondary school or college education (such as Fuambai Ahmadu) are circumcised, while

Senegalese Wolof women—including the illiterate and unschooled—are not. Notably, most African women do not think about circumcision in human rights terms or as a human rights violation. Women who endorse female circumcision argue that it is an important part of their cultural heritage or their religion, while women who do not endorse the practice typically argue that it is not permitted by their cultural heritage or their religion (see, for example, El Dareer 1983).

Moreover, among members of ethnic groups where female circumcision is part of their cultural heritage, approval ratings for the custom are generally high. According to the Sudan Demographic and Health Survey of 1989–1990 conducted in northern and central Sudan, of 3,805 women interviewed, 89 percent were circumcised. Of the women who were circumcised, 96 percent said they had or would circumcise their daughters. When asked whether they favored continuation of the practice, 90 percent of circumcised women said they favored its continuation (see Williams and Sobieszzyk 1997, table 1).

In Sierra Leone, the picture is pretty much the same and the vast majority of women are sympathetic to the practice and appear to feel at home in their way of life. Even Olayinka Koso-Thomas, an anti-FGM activist, makes note of the high degree of support for genital operations, although she expresses herself with a rather patronizing voice and in imperial tones:

Most African women still have not developed the sensitivity to feel deprived or to see in many cultural practices a violation of their human rights. The consequence of this is that, in the mid-80's, when most women in Africa have voting rights and can influence political decisions against practices harmful to their health, they continue to uphold the dictates and mores of the communities in which they live; they seem in fact to regard traditional beliefs as inviolate. (Koso-Thomas 1987, 2)

When it comes to maintaining their coming-of-age and gender-identity ceremonies, Koso-Thomas does not like the way many African women vote. While she thinks she is enlightened about human rights and health and that these women remain in the dark, Koso-Thomas indeed recognizes that most women in Sierra Leone endorse the practice of circumcision. (For recent evidence of high approval ratings among Mandinka women in the Gambia, see Morison et al. 2001.) Amy Kendoh, a member of the women's secret society in Sierra Leone, where more than 90 percent of adult women have been initiated, put it this way: "I have grown up to the age of fifty years, and this is the first time anyone has come forward to ask me why we do these ceremonies. It doesn't matter what other people think because we are happy with our customs. We will carry on with our lives" (French 1997, A4).

Further, although ethnic group affiliation is the best predictor of who circumcises and who does not, the timing and form of the operation are not uniform across groups. Thus, there is enormous variability in the age at which the surgery is normally performed (any time from birth to the late teenage years). There is also enormous variability in the traditional style and degree of surgery (from a

cut in the prepuce covering the clitoris to the complete "smoothing out" of the genital area by removing all visible parts of the clitoris and all external labia). In some ethnic groups (for example, in Somalia and the Sudan) the smoothing out operation is concluded by stitching closed the vaginal opening with the aims of enhancing fertility, tightening the vaginal opening, and protecting the womb (see Boddy 1982, 1989, 1996; Gruenbaum 2001). The latter procedure, often referred to as *infibulation* or Pharaonic circumcision, is not typical in most circumcising ethnic groups, although it has received a good deal of attention in the anti-FGM literature. The procedure occurs in an estimated 15 percent of all African cases, although it is rare or nonexistent in many of the ethnic groups where some form of genital alteration for both males and females is culturally endorsed.

In places where the practice of female circumcision is popular, including Somalia and the Sudan, it is widely believed by women that these genital alterations improve their bodies and make them more beautiful, more feminine, more civilized, and more honorable.

More beautiful because the body is made smooth and a protrusion or "fleshy encumbrance" removed that is thought to be ugly and odious to both sight and touch (see, for example, Abusharaf 2001; Koso-Thomas 1987, 7; Lane and Rubinstein 1996, quoted herein, Meinardus 1967, 394; El Dareer 1982, 73). Here a cultural aesthetics is in play among circumcising ethnic groups—an ideal of the human sexual region as smooth, cleansed, and refined—that supports the view that the genitals of women and men are unsightly, misshapen, and unappealing if left in their natural state.

More feminine because unmodified genitals (in both males and females) are perceived as sexually ambiguous. From a female's perspective, the clitoris is viewed as an unwelcome vestige of the male organ, and its removal is positively associated with several desirable things: attainment of full female identity, induction into a social network and support group of powerful adult women, and ultimately, marriage and motherhood (Ahmadu 2000; Meinardus 1967, 389). Many women who uphold these traditions of female initiation seek to empower themselves by getting rid of what they view as an unbidden yet dispensable trace of unwanted male anatomy.

More civilized because a genital alteration is a symbolic action that says something about one's willingness to exercise restraint over feelings of lust, and self-control over the antisocial desire for sexual pleasure.

More honorable because the surgery announces one's commitment to perpetuate the lineage and value the womb as the source of social reproduction (see, for example, Boddy 1982, 1989, 1996).

As hard as it may be for "us" to believe, in places where female circumcision is commonplace, it is not only popular but fashionable. And as hard as it may be for us to believe (and I recognize that for some of us this is really hard to believe), many women in places such as Mali, Somalia, Egypt, Kenya, or Chad indeed are repulsed by the idea of unmodified female genitals, which they view as ugly, unrefined, undignified, uncivilized and hence, not fully human. They associate unmodified genitals with life outside or at the bottom of civilized soci-

ety. They think to themselves, "Yuck, what kind of barbarians are these who don't circumcise their genitals?"

The "yuck" is, of course, mutual. Female genital alterations are not routine and normal for members of mainstream or majority populations in Europe, the United States, China, Japan, and other parts of the world, and it is not a common practice in the southern parts of Africa. For members of these cultures the very thought of female genital surgery produces an unpleasant visceral reaction; although it should be noted that for many of us the detailed visualization of any kind of surgery—a bypass operation, an abortion, a sex change, a breast implantation, a face lift, or even a decorative eyebrow or tongue piercing—produces an unpleasant visceral reaction. In other words, merely contemplating a surgery, especially on the face or the genitals, can be quite upsetting or revolting, even when the surgery seems fully justified from our own "native point of view."

In the United States and Europe, the practice of female genital surgery has been disparaged as "mutilation" (Hosken 1993; Rosenthal 1995). It has been associated with rape and torture and with the nightmare of some brutal patriarchal male (or perhaps a Victorian gynecologist) grabbing a young woman or girl, pulling her into the back room screaming and kicking, and using a knife or razor blade to deprive her of her sexuality. Various dramatic and disturbing claims have been made about the health hazards and harmful side effects of African genital operations, including the loss of a capacity to experience sexual pleasure.

Saying "yuck" to the practice has become a symbol of opposition to the oppression of women and of one's support for their emancipation around the world. Eliminating this practice thus has become a high priority for many Western feminists (and for some human rights activists in Africa, who very often, although not invariably, come from noncircumcising ethnic groups) and for some human rights organizations (for example, Amnesty International and Equality Now). Even some international organizations such as WHO and UNICEF have agreeably responded to the anti-FGM call to arms and have felt morally justified in expanding their mission statements to include the extermination of female circumcision as part of their own crusade. The technique for mission expansion is simple and direct. If their official aim is to rid the world of sickness, female circumcision gets classified as a health hazard or a disease. If their official aim is to protect political prisoners from torture, African parents get classified as "torturers" and African children defined as political prisoners held captive, coerced, and "mutilated" by their relatives.

Outside of Africa, especially in the United States and Europe, righteous opposition to female circumcision has become so commonplace and so politically correct that until very recently most anti-anti-FGM criticism has been defensive, superficial, or basically sympathetic. The sympathetic criticisms are mainly critiques of counter-productive "eradication" tactics. They provide advice on how to be more effective as an anti-FGM activist. For example, activists Susan Rich and Stephanie Joyce give this recommendation on how to gain the trust of African villagers in areas where circumcision is customary: bring them "malarial medicine, radios, and other gifts to 'smooth the path'" but wait until the sixth

visit before you drop any hints about why you are really there (Rich and Joyce n.d., 4).

Under such circumstances, the potential for counterproductive activism is great. For example, Daniel Arap Moi, the president of Kenya, has twice tried to ban female (although not male) circumcision, and without great success. His second attempt was in 1989. In a top-down gesture of political authority (and perhaps with an eye toward the West), he denounced the custom, and the next day thousands of girls from ethnic groups with a tradition of circumcision stepped forward to be initiated, as a form of social, moral, and political protest.

There have also been occasional complaints that anti-FGM campaigns displace attention and take resources away from battles against social injustice in the United States and Europe (for example, Tamir 1996). And there have been expressions of concern about the anguished state of mind of African children living in the United States who are told by the media and by social service agencies that their own mother is "mutilated" and potentially dangerous to them too (Beyene 1999).

But these types of criticisms do not go very deep. In general, the purported facts about female circumcision go unquestioned, the moral implications of the case are thought to be obvious, and the mere query, "What about FGM?" is presumed to function in and of itself as a knockdown argument against both cultural pluralism and any inclination toward tolerance.²

SO WHAT ABOUT FGM?

I shall treat this query as a real question deserving a detailed and considered response rather than as a rhetorical inquiry intended to shorten or terminate debate. For starters, the practice of genital alteration is a rather poor example of gender inequality or of society discriminating against women. Surveying the world, one finds few cultures, if any, where genital surgeries are performed exclusively on girls, although many cultures perform such surgeries only on boys or on both sexes. Male genital alterations often take place in adolescence and can involve major modifications (including subincision, in which the penis is split along the line of the urethra). Considering the prevalence, timing, and intensity of the relevant initiation rites and viewed on a worldwide scale, one is hard pressed to argue that this is an obvious instance of a gender inequity disfavoring girls. Quite the contrary; social recognition of the ritual transformation of both boys and girls into a more mature status as empowered men and women often is a major point of the ceremony. In other words, female circumcision, when and where it occurs in Africa, is much more a case of society treating boys and girls *equally* before the common law and inducting them into responsible adulthood in parallel ways.

The practice is also a poor example of patriarchal domination. Many patriarchal cultures in Europe and Asia do not engage in genital alterations at all, or (as in the case of Jews, many non-African Muslims, and many African ethnic groups) deliberately exclude girls from this highly valued practice and perform

the surgery only on boys. Moreover, the African ethnic groups that circumcise both females and males are very different from one another in kinship, religion, economy, family life, ceremonial practice, and so forth. Some are Islamic, some are not. Some are patriarchal, some—such as the Kono, a matrilineal society—are not. Some have formal initiations into well-established women's organizations, some do not. (On the connection between circumcision and entrance into powerful women's secret societies in Sierra Leone see Ahmadu 2000.) Some care greatly about female purity, sexual restraint outside of marriage, and the social regulation of desire, but others (such as Kenyatta's [K]Gikuyu) are more relaxed about premarital sexual play and are not puritanical.

Indeed, in cases of female initiation and genital alterations, the practice almost always is controlled, performed, and most strongly upheld by women, although male kin often provide material and moral support. Typically, however, men have little to do with these female operations, may not know very much about them, and may feel it is not really their business to interfere to try to tell their wives, mothers, aunts, and grandmothers what to do. Rather, the women of the society are the cultural experts in this intimate feminine domain, and they are not particularly inclined to give up power or share their secrets.

In those cases of female genital alterations with which I am most familiar (having lived and taught in Kenya, where the practice is routine for some ethnic groups; see Kenyatta 1938; Kratz 1994; Thomas 2000; Walley 1997), adolescent girls who undergo the ritual initiation look forward to it. The ordeal can be painful (especially if done without anesthesia), but it is viewed as a test of courage. This is an event organized and controlled by women, who have their own view of the aesthetics of the body—a different view from ours about what is civilized, dignified, and beautiful. The girl's parents are not trying to be cruel to their daughter—African parents love their children too. No one is raped or tortured. Indeed, a celebration surrounds the event.

What about the devastating negative effects on health and sexuality so vividly portrayed in the anti-FGM literature? Relatively few methodologically sound studies exist on the consequences of female genital surgeries on sexuality and health. As Obermeyer (1999) discovered in her medical review, most of the published literature is "data-free" or else relies on sensational testimonials, second-hand reports, or inadequate samples. Judged against basic epidemiological research standards, much of the published empirical evidence—including some of the most widely cited publications in the anti-FGM advocacy literature (including the influential 1993 *Hosken Report*)—is fatally flawed (see Obermeyer 1999). Nevertheless, there is some science worth considering in thinking about female circumcision, which leads Obermeyer to conclude that the global discourse about the health and sexual consequences of female circumcision is not sufficiently supplied with credible evidence.

The anti-FGM advocacy literature typically features long lists of short- and long-term medical complications of circumcision, including blood loss, shock, acute infection, menstrual problems, child-bearing difficulties, incontinence, sterility, and death. These lists read like the warning pamphlets that accompany

many prescription drugs, which enumerate every claimed negative side effect of the medicine that has ever been reported (no matter how infrequently). They are very scary to read, and they are very misleading. Stomach-churning, anxiety-provoking lists of possible medical complications aside, Obermeyer's comprehensive review of the literature on the actual frequency and risk of medical complications following genital surgery in Africa suggests that medical complications are the exception and not the rule, that African children do not die because they have been circumcised (rather, they die from malnutrition, war, and disease), and that the experience of sexual pleasure is compatible with the genital aesthetics and related practices of circumcising groups.

Obermeyer's conclusions converge with the findings of the very recent large-scale Medical Research Council study of the long-term reproductive health consequences of female circumcision (Morison et al. 2001). The study, conducted in the Gambia, compared circumcised women with those who were uncircumcised. In the Gambia the surgery most often involves a full clitoridectomy and either partial or complete excision of the labia minora. More than 1,100 women (ages fifteen to fifty-four) from three ethnic groups (Mandinka, Wolof, and Fula) were interviewed and also given gynecological examinations and laboratory tests. Very few differences were discovered in the reproductive health status of circumcised versus uncircumcised women. As noted in the research report, the supposed morbidities (such as infertility, painful sex, vulval tumors, menstrual problems, incontinence, and most endogenous infections) often cited by anti-FGM advocacy groups as common long-term problems of female circumcision did not distinguish between circumcised and uncircumcised women. The authors of the report caution anti-FGM activists against exaggerating the morbidity and mortality risks of the practice (see also Larsen and Yan 2000).

These findings are consistent with Edgerton's comments about female circumcision among the [K]Gikuyu in Kenya in the 1920s and 1930s, when Western missionaries first launched their own version of "FGM eradication programs." As Edgerton (1989, 40) remarks, the operation was performed without anesthesia and hence was very painful, "yet most girls bore it bravely and few suffered serious infection or injury as a result. Circumcised women did not lose their ability to enjoy sexual relations, nor was their child-bearing capacity diminished. Nevertheless the practice offended Christian sensibilities."

In other words, the standard alarmist claims in the anti-FGM advocacy literature that African traditions of circumcision have "maimed or killed untold numbers of women and girls" (Rich and Joyce n.d., 1) and deprived them of their sexuality may not be true. Given the most reliable (even if limited) scientific evidence at hand, these claims should be viewed with skepticism and not accepted as fact, no matter how many times they are uncritically recapitulated on the editorial pages of the *New York Times* or poignantly invoked on PBS.

If genital alteration in Africa really were a long-standing cultural practice in which parents, oblivious to intolerably high risks, disabled and murdered their pre-adolescent and adolescent children, there would be good reason to wish for its quick end. Carla Obermeyer's review suggests that this line of attack on the

practice may be as fanciful as it is nightmarish, or, at the very least, dubious and misleading.

In their reactions to this African cultural practice, the anti-FGM advocacy groups behave much like yesterday's Christian missionaries. Given the importance of accurate information in public policy debates in liberal democracies, now would be a good time for them to either revise their factoids or else substantiate their claims with rigorously collected data. An organization such as Amnesty International (USA) discredits itself as a balanced and reliable source of information when it begins playing the "factoid game; they do this when they recycle pseudo-evidence, posting website bulletins such as, "In Egypt the practices of clitoridectomy and excision predominate and dozens of FGM-related deaths have been reported in the press." One hopes for a more critical assessment of the unsubstantiated claim that female circumcision is a serious threat to the lives of children. The real facts, I would suggest, are quite otherwise. With regard to the consequences of genital surgeries, the weight of the evidence suggests that the overwhelming majority of youthful female initiates in countries such as Mali, Kenya, and Sierra Leone believe they have been improved (physically, socially, and spiritually) by the ceremonial ordeal and symbolic process (including the pain) associated with initiation. Evidence indicates that most of these youthful initiates manage to be (in their own estimation) "improved" without disastrous or major negative consequences for their health (Larsen and Yan 2000; Morison et al 2001; Obermeyer 1999). This is not to say that we should not worry about the documented 4 percent to 16 percent urinary infection rate associated with these surgeries, or the 7 percent to 13 percent of cases in which there was excessive bleeding, or the 1 percent rate of septicemia (see Obermeyer 1999, 93). It would be instructive, however, to compare these rates with rates of infection and bleeding for other types of less controversial Third World surgeries. The reaction of many people to unsafe abortions, for example, is not to do away with abortions. Perhaps some pro-life advocates might be tempted by the argument that because some abortions are unsafe, there should be no abortions at all. However, a far more reasonable reaction to unsafe abortions is to make them safe. Why not the same reaction in the case of female genital alterations? Infections and other medical complications that arise from unsanitary surgical procedures or malpractice can be corrected without depriving "others" of rites and meanings central to their culture, personal identities, and their overall sense of well-being. What I do want to suggest, however, is that the current sense of shock, horror and righteous "Western" indignation directed against the mothers of Mali, Somalia, Egypt, Sierra Leone, Ethiopia, the Gambia, and the Sudan is misguided, and rather disturbingly misinformed.

THE ENLIGHTENED FIRST WORLD AND THE DARK CONTINENT

Fifty years after the end of colonial rule, many First World intellectuals still think of Africa as the Dark Continent and imagine that genital surgery is a Dark Age

practice supported mainly by those who are unenlightened, uneducated, ignorant, and unsophisticated. Yet, contrary to such expectations, not only the uneducated, rural, or poor women of Africa promote the gender identity of their children and grandchildren and celebrate their coming of age in this way. As Jomo Kenyatta pointed out long ago, in many African ethnic groups, even high-status, highly educated members of the community remain committed to these ceremonies (see Ahmadu 2000). Meinardus (1967, 393) notes that in the eighteenth and nineteenth centuries, female circumcision was "universal in Egypt and that it was adhered to by members of all social classes extending from Lower Egypt to Aswan." From the viewpoint of education, urbanization, and economic development, a good deal has changed in Egypt since the eighteenth century. The prevalence rate of female (and male) circumcision, however, has remained pretty much the same. Obermeyer (1999) points out that female genital alterations are common even among the most educated groups of women in a number of countries. She notes that one cannot assume that more schooling necessarily will result in a dramatic reduction in the prevalence of genital surgery in a population for which it has been a customary practice. She indicates a 90 percent prevalence rate in Egypt for women with a secondary school education or beyond.

Dirie and Lindmark (1991, 70) make a similar point with regard to Somalia, noting, "Early studies have revealed that education and economic status have no influence on the practice of female circumcision, and the present study supports these findings." It is probably a mistake to expect that in Mali, Sierra Leone, or Egypt, women are going to give up a practice central to their sense of personal dignity and cultural identity just because they have received a high school diploma or even a Ph.D.

The following historical observation appears in a research report about circumcision in Nigeria (Olamijuto, Joiner, and Oyedeji 1983, 581).

In December 1929, a British parliamentary committee, formed to study conditions of women and children in the crown colonies, strongly lobbied the British Government to take steps to, among other things, abolish circumcision of girls in Africa. In his contribution to the British effort, A. C. Burns, the then Deputy Governor of Nigeria, expressed optimism that the practice would disappear with advance in education.

The authors point out that the British deputy governor's prediction has not come true, despite fifty years of top-down political concerns and a sharp rise in literacy since free primary education was introduced in 1955. It is noteworthy that in the face of "white man's burden" Christian missionary and colonial government efforts in Kenya and Nigeria in the 1920s, the customary practice of female circumcision turned out to be highly resistant to either coaxed or forced change. This was true even for sophisticated and educated members of society (Kenyatta 1938; Ahmadu 2000; Thomas 2000).

Jewish circumcision practices have a similar profile. Throughout millennia,

Jews have continued to circumcise sons despite variations in the historical context of their lives. Jews continue to circumcise their male offspring despite imagined medical benefits or harms (the medical establishment has not been consistent) and regardless of dominant majority opinion, which at times viewed them as “mutilators” of babies and their practice as “barbaric” (see Gilman 1999; Gollaher 2000, ch. 1). Among Jews, when it comes to circumcision, it does not matter whether you are rich or poor, urban or rural, educated or uneducated, religious or secular. And it does not really matter what the medical establishment or Amnesty International or the Save the Children Fund happen to think. If you are Jewish, you circumcise your son. The practice has to do with a covenant between Jews and their God, and it has to do (as Kenyatta put it) with “the whole teaching of tribal law, religion and morality” (Kenyatta 1938, 133).

One should not expect less from other cultural traditions, especially those that are already equitable in their ritual treatment of the sexes—where girls too are promoted in this way into full membership in society. It is not ignorance that keeps the practice of female circumcision going, any more than it is ignorance that has kept male circumcision going for over three thousand years, even among highly educated Jews. Indeed, circumcision is an issue over which even the most highly educated and rational people can reasonably disagree.

THE FIRST WORLD CURRICULUM ON NORMAL BODIES

When considering the connection between education and attitudes toward circumcision, it is useful to ask, “What precisely do we think these women in Sierra Leone (or in Mali or the Gambia or Somalia) don’t know about normal human bodies?” And what might an enlightened curriculum incorporating the latest knowledge from our social, biological, and medical sciences offer that would change these women’s minds about the importance and benefits of circumcision? Here I confess that I find it hard to imagine and to describe such a curriculum without sounding sardonic, or at least ironical, but I will try.

For example, perhaps we might teach them that we in the “First World” had a medicine man named Dr. Sigmund Freud, who taught us that women really want to be men and suffer from something called *penis envy*. On second thought, this is probably not a good idea, as Freud’s thesis is a disempowering claim that circumcised African women may well have proved wrong.

Perhaps we might teach them that normal human beings don’t engage in cosmetic surgery. Yet, could we say that with a straight face, when there are thousands of aesthetic surgeries licensed by the American Medical Association, including clitoridectomies for young women who don’t like the way their genitals look or feel?

Or perhaps we might teach them that a genital alteration makes it impossible to enjoy sex—but where is the scientific evidence to support that claim? Obermeyer (1999) searched for it in vain. One suspects that the claim derives from our own ethno-anatomical folk beliefs rather than from any hard science. Most

highly educated "First World" intellectuals are not biologists, and typically, most highly educated nonbiologists underestimate the true size and anatomical depth of the clitoris, much of the tissue structure of which (about 50 percent) is not external or visible to the human eye—thus much of it remains intact after any external modification of the genitals (Shell-Duncan and Hernlund 2000a, 26–27). Indeed, in spite of a lack of systematic investigations into this topic, circumcised African women have talked about their sexual experiences in ways that strongly suggest that they can and do enjoy sex (Ahmadu 2000; Edgerton 1989, 254; Lightfoot-Klein 1989; Gruenbaum 2001, 139–43).

Or perhaps we could teach these women that the medical risks of circumcision are too great to tolerate. Yet it seems likely that the risk of death associated with these operations compares quite favorably with the risks associated with many activities that are routine in our own lives, such as driving a car. Moreover, circumcised African women likely know that most initiates do not suffer medical complications from the surgery, as Obermeyer (1999) has shown (see also Morison et al. 2001). Malpractice does occur, of course, and these and other Third World operations certainly are not risk-free: Asma El Dareer (1982, iii) had a bad experience with circumcision, having developed an infection that was then treated with five injections of penicillin administered by the registered Sudanese nurse who performed the operation. Yet her experience is atypical. Most circumcised African women know that unsafe procedures can be made safer—without doing away with the practice.

Or we could teach African women that (without anesthesia) a circumcision ceremony is extremely painful and will leave them with scars—a customary point of the initiation ceremony of which they are fully aware, since the rite is a test of their courage and a proof of adulthood. This gives them an opportunity to prove to themselves and to others (including their parents) that they are tough enough to be adults.

Moreover, where female genital alterations are customary, the women don't view their scars as mutilations. With regard to West Africa, Koso-Thomas (1987, 55) writes,

[The scar] may even be a stamp of identification for admission to other branches of the [women's secret] society, and, therefore, may be sought after. It is traditional for youths to mark and scar themselves as a sign of courage and endurance; women's initiation societies also include training in these qualities. Thus they see no disadvantage in being scarred.

Will higher schooling be designed to teach women that sexual behavior has nothing to do with honor or fertility? The anthropological literature on female circumcision contains some useful discussions of cultural variations in conceptions of the body and in the socially constructed ideals of sexual gratification associated with personal well-being (Parker 1995, 519–20; Boddy 1982, 1989, 1996; see also Lâm 1994). For women in many societies, the womb is thought to be the body part that is the biological essence of femininity and is treasured

because of its association with fertility, fecundity, and the project of social reproduction. This is not true for all women, particularly in the United States and Europe. As a result of the women's liberation movement in the 1960s in the United States and Europe, a variation on the ethnoanatomy of femininity was constructed according to which the womb was devalued precisely because it was associated with "bad" things, such as big families, domesticity, and a sexual division of labor in which women stayed at home and were not paid for their work. A new body part—the clitoris—was valorized and reconceptualized as the biological essence of femininity and associated with "good" things, such things as autonomy, sexual freedom, orgasm, and even an independent capacity for pleasurable self-stimulation.

In effect, for a particular subculture of women in the West, the clitoris became the ultimate symbol of female emancipation from men, marriage, and the domestic life. During the 1960s, 1970s, and 1980s, this conception of femininity and its symbolic anatomy emerged and was embraced by many in the professional and white middle class in the United States and Europe. It was even embraced by women who in any other context would strongly oppose all forms of "essentialism" and "biological reductionism" and reject the idea that there is only one way to have normal sexual relations, or only one ideal body type for all women.

To avoid misunderstanding I wish to emphasize that I am not raising an objection to the aims of the women's liberation movement, or to the view that love and sex can be separated from marriage and pursued for their own sake. Nor is this meant to be a criticism of the doctrine of hedonism. I am simply reiterating a central message of many gender studies programs at colleges and universities in the United States. The point here is that definitions of femininity (or masculinity) and of normal sexual relations are essentially contestable. There is no single, essential, inherent or universally binding objective ideal for femininity or masculinity. Hence, it is hard to see why any one particular set of aims, views, and doctrines about sex, marriage, and femininity should be embraced by all rational human beings, regardless of cultural or religious background. Where and when norms are essentially contestable, education is not going to make difference go away.

Finally, to bring this travesty of education to an end, perhaps an enlightened school curriculum might teach African men and women that from an objective point of view uncircumcised genitals (male and female) are really beautiful. I am not even sure that most educated people in Europe and the United States really believe that, but let's assume they do. Is that attitude something you should learn in school? What we currently teach in our finest (and most liberal) colleges is that "beauty is in the eye of the beholder," and that Western eyes (or Christian missionary eyes or American feminist eyes) are not the only ones that count.

A good education certainly can correct erroneous beliefs. Some African men undoubtedly have fantastical views about what will happen to a woman's clitoris (its ultimate size) if she is not circumcised. There are also African men who share with many American men and women an incomplete picture of the anatomical structure of the clitoris and subscribe to the false belief that circumcised

women do not enjoy sex. Perhaps also some women in Egypt, Somalia, or the Sudan choose infibulation as the preferred mode of genital surgery only because they subscribe to groundless views about the hazards of an unprotected or open vagina for reproduction and fertility. Challenging such beliefs is a good idea. Nevertheless, it will not bring an end to genital surgeries, because the main reasons for those surgeries and the initiation ceremonies in which they play their part have little to do with such mistaken beliefs.

Within ethnic groups that have a tradition of circumcision, prevalence rates are typically high; within groups that do not have this tradition, the rates approximate zero. For this reason, ethnic group membership (rather than education or literacy or socioeconomic status) is the best predictor of whether or not you circumcise. From the distribution of circumcision practices and beliefs both within and across societies in Africa and around the world, circumcision is one of those "path-dependent" phenomena that institutional economists talk about. Whichever way a social group happens to evolve (circumcise versus don't circumcise), the costs of going against the local current are very high and the benefits of being within the community's definition of "normal" are substantial.

This is not simply a matter of self-interested instrumental calculation—although deliberate cost-benefit analysis of the type described by Mackie (2000) likely plays a part in the perpetuation of the traditions of a social group. Within each of the two types of social groups described here—circumcising versus non-circumcising—is a developed set of attitudes, beliefs, and feelings about what is considered normal versus alien.

The psychological by-product of this type of divergent cultural evolution is a mutual "yuck" response between different ethnic groups. Majority populations in London and Paris feel repulsed or offended by (or at least out of sympathy with) the behavior of majority populations in Cairo or Timbuktu, and vice versa. The same is true within multicultural nation-states for the reactions of majority and minority groups to each other. Witness, for example, the adverse reaction of middle-class feminists in the United States to an American hospital proposal to allow Somali immigrant parents—with the informed consent and approval of their daughter—to safely and painlessly perform a minor and culturally meaningful genital surgery (see Coleman 1998). From a medical point of view, the proposed procedure (a small cut in the prepuce that covers the clitoris) was less severe than a typical American male circumcision. Nevertheless, the mainstream response to the unfamiliar practice was intensely negative, and the proposal, developed at Harborview Medical Center in Seattle, was discarded. The practice, however, is not unfamiliar for most in the Somali immigrant community, and many Somalis, male and female, living in the United States, deem a genital alteration to be practically and emotionally essential for their sense of dignity and well-being.

Perhaps that says something about the way communities are held together and perpetuate themselves through sex and marriage, which presupposes the sharing and coordination of very intimate judgments about what is beautiful or ugly, good or bad, honorable or dishonorable, and so forth.

The result, however, is that there are rational and morally decent people on both sides of this cultural divide. This may be the kind of case in which those who are rational, moral, and divided, but also wise, permit each other enough space to live and let live, and to disagree reasonably. Liberal free-thinking people in the United States need to debate openly the validity of that last suggestion—that a politically liberal, pluralistic society needs to accommodate both circumcising and noncircumcising ethnic groups and their associated cultural commitments and religious beliefs.

IMPERIAL LIBERALISM AND ITS TOTALITARIAN IMPLICATIONS

In his book on the foundations of political liberalism, the philosopher John Rawls (1993, 61) cautions us, “it is unreasonable for us to use political power, should we possess it, or share it with others, to repress comprehensive doctrines [conceptions of the world elaborated from different standpoints] that are not unreasonable.” Rawls contrasts *political liberalism* with *comprehensive liberalism*. Political liberalism means the minimum ground rules for social cooperation among free and equal citizens in a genuinely pluralistic democracy. Comprehensive liberalism is a particular and single-minded doctrine about the proper selection and ordering of values, and about ideals for a good life. I wish to invoke a further contrast between political liberalism (as Rawls defines it) and *imperial liberalism*.

Imperial liberalism is the general attitude that it is desirable for us to spread and enforce our liberal conceptions and ideals for the good life in all corners of society and throughout the world. More specifically, imperial liberalism is the doctrine that all social institutions and dimensions of social life (not just political but associational and family life as well) should be ruled by principles of autonomy, individualism, and equality—and by the particular ordering of values and ideals for gender identity, sexuality, work, reproduction, and family life embraced by liberal men and women in the United States today; and that those liberal principles and conceptions should be upheld using the coercive power of the state and, if possible, exported to foreign lands using the coercive powers of international institutions (such as the World Bank, the IMF, NATO, and the United Nations).

From such a stance of imperial liberalism, Susan Okin (1999, 14), for example, implies that virginity, domesticity, childbearing, and fidelity to marriage should not be selected as high ideals anywhere in the world. From the same imperial stance, Katha Pollitt (1999, 29–30) suggests that secular governments around the world should empower children to be autonomous and free of their parents’ influence and religious beliefs. Pollitt especially would like to empower children against illiberal Muslim parents who subscribe to such notions as female modesty, family honor, and sexual restraint, and therefore want their daughters to wear a head scarf, or hijab, in school. This is the same stance, to cite a third example, that leads Olayinka Koso-Thomas (1987, 2) to discredit the women of

Sierra Leone for actually choosing to perpetuate the customs of their ethnic groups and to admonish them for not using their full voting rights and political power to liberate themselves from "tradition."

The imperial messages of this type of comprehensive liberalism are simple and powerful, and they appeal to many progressive secular individualists and cosmopolitan elites in the postmodern world. These messages may be summed up as follows.

- Acknowledging social distinctions is invidious and implies vicious discrimination.
- Where there are ethnic groups and social categories let there be individuals.
- Where there are individuals let them transcend their tradition-bound commitments and experience the quality of their lives solely in secular and ecumenical terms (for example, as measured by health or wealth or years of life).

Given that particular imperial liberal view of the world, Fuambai Ahmadu's self-empowering act of initiation into Kono womanhood, West African-style, can only seem retrograde, like a glimpse at some unwelcome and archaic past, when the marks of social, cultural, and gender identity ran deep into both body and soul.

Political liberals, I believe, ought to be concerned about the totalitarian implications of imperial liberalism. They should worry about the coercion that would be needed to enforce the imperial doctrine that our gender ideals are best, that our ideas about sexuality and reproduction are best, that our ideas about work and family are best, and moreover, good for everyone. They should be especially cautious with such an emotionally charged and poorly understood issue as circumcision (both male and female), where the temptation to demonize others and impose one's will is especially great and there is a general reluctance to recognize the particularity, even the peculiarity, of one's own point of view.

But to reasonably debate the issue, we need first to discount, or at least bracket, our own culturally shaped visceral reactions to the very thought of female genital alterations. If we don't, there will be no fair, informed, and even-handed engagement with the voices of the many African women who think that an "eradication program," or a threat to withdraw foreign aid, or a prison sentence, or some other means of compulsion, are not really appropriate responses to their valued way of life, and may be more a measure of our brutality and barbarism than theirs.

SHOULD WE TOLERATE IT HERE?

Any public debate in the United States about female genital alterations must address the question: How much toleration of the practice ought to be reasonable in the context of the scientific, medical, legal, and moral traditions of a politically liberal, pluralistic democracy such as the United States?

On the scientific front, we have good reason to discount the horrifying repre-

sentations in the anti-FGM advocacy literature. The most plausible account of the facts is that a real cultural divide exists in the world in moral, emotional, and aesthetic reactions to female (and male) genital alterations. What is thought to be virtuous, rational, beautiful, and normal by most members of some ethnic groups is seen as vicious, ignorant, ugly, and abnormal by most members of other ethnic groups. As a result of labor migration and the flow of political refugees, this cultural divide has reproduced itself within several European countries (for example, France and Norway) and in the United States, to the detriment of those minority groups who uphold the practice.

As discussed earlier, despite evidence that suggests circumcision is a source of esteem for men and women and that women are not typically injured or sexually incapacitated by the surgery, the practice of female circumcision continues to offend the sensibilities of majority populations in the "First World." If that evidence is reliable (and clearly we need more and better research on these issues), then every "political liberal" has a responsibility to ask whether an offense to one's own culturally shaped sensibilities alone is sufficient reason to eradicate someone else's way of life.

On the medical front, the issue is straightforward. Genital alterations for both girls and boys can be done safely, hygienically, and without major risks to physical health. Cosmetic genital surgeries for women are not customary in the United States, but cosmetic surgeons know how to do them, and they are safely done. Given the state of our medical sciences, unwanted pain can be controlled or eliminated. For some young women, however, enduring the pain may continue to be part of the point of the experience, just as it is for others who endure tests of courage and character, such as running a marathon.

Another relevant, less obvious scientific fact has to do with the justification of male circumcision and its bearing on claims about gender equity. One widely held folk belief in the United States is that surgical removal of the foreskin of the penis protects the health of men, but this is not strongly supported by evidence. During the 1990s, about 65 percent of male babies in the United States were circumcised, and the medical establishment did little to discourage the dubious claim that circumcision is salubrious for males. In fact, the medical case for male circumcision is so flimsy that in other English-speaking countries such as Canada, England, and Australia, medical doctors do not typically recommend the operation and only about 10 percent to 15 percent of infant boys are circumcised.

A relatively recent set of recommendations of the American Academy of Pediatrics (as of March 1, 1999) reads as follows: "The weight of the evidence would have to be significant for the academy to recommend an elective surgical procedure on every newborn male, and the evidence is not sufficient for us to make such a recommendation." The authors of the AAP recommendations recognize, however, that not all decisions about a normal or properly developed body can be reduced to medical or health criteria. They do not therefore recommend against the elective surgery for males, acknowledging that the decision really rests on religious and cultural grounds, not medical ones.

Thus, on the basis of our medical traditions the following two conclusions

may be drawn, both of which will have a bearing on the question of tolerance for female genital alterations: genital surgeries for both males and females can be done safely; and if there are good reasons for the common American practice of male circumcision—as I believe there are—such reasons remain beyond the realm of modern medicine.

What about our legal and moral traditions? United States Supreme Court Justice William Brennan (*Michael H. v. Gerald D.*, 491 U.S. 110, 141 [1989], dissenting) has written, “We are not an assimilative, homogeneous society, but a facilitative, pluralistic one, in which we must be willing to abide someone else’s unfamiliar and even repellent practice because the same tolerant impulse protects our own idiosyncrasies.” Justice Brennan’s pluralistic ideals may be theoretically appealing, but in the case of customary African genital alterations, the initial impulse in our society has been intolerant, single-minded, and assimilative in the extreme.

In September 1996, the Congress of the United States, without holding public hearings or seeking expert testimony and certainly without any attempt to understand the “native point of view,” passed a statute targeted at the practice of female genital surgery among African immigrants. United States Representative Patricia Schroeder played a significant part formulating and lobbying for the legislation. The law, which went into effect in March 1997, criminalizes “female genital mutilation” and penalizes with fines or a prison sentence (up to five years) anyone who knowingly engages in surgery on any part of the genitals of a female under eighteen years of age. Exceptions are made for established medical practitioners engaging in already established surgical procedures thought to be necessary to the health of the person (for example, surgery on the genitals that might facilitate the delivery of a baby). The law explicitly states that in punishing offenders no account shall be taken of their belief that the surgery is required as a matter of custom or ritual.

In February 1999, a court in Paris went a step further and actually sentenced someone, Hawa Greou, a Malian immigrant who is a ritual circumciser, to eight years in prison. She is a woman whose services as an expert surgeon had been sought by other women in her ethnic group. The stiff prison sentence was imposed by the court despite the fact that neither Hawa Greou nor most other Malians believed she was morally culpable or had done any harm.

The *New York Times* journalist Celia Dugger writes that when passing “The Federal Prohibition of Female Genital Mutilation Act,” the U.S. Congress also required “United States representatives to the World Bank and other international financial institutions that have lent billions of dollars to the 28 African countries where the practice exists to oppose loans to governments that have not carried out educational programs to prevent it” (Dugger 1996, A1). Further, in recent years the State Department’s Annual Report on Human Rights has been publishing a list of African governments that have officially banned female genital alterations. Through the use of carrots and sticks, various First World international agencies and ambassadors who think that circumcision is a human rights violation have been actively trying to induce or force the political leaders of Africa to comply with our desire to eradicate their custom. Indeed, in response

to pressure from international benefactors, some African governments (for example, Egypt, Senegal, Togo, Côte D'Ivoire) have agreed to prohibit female circumcision. The list of formally compliant African governments grows. Understandably, this gesture is not appreciated by a considerable number of women (and their male kinsmen) in these countries, which may explain why many African officials under pressure from the First World pass the required laws, take the money, then don't do anything. This is one way that tactical African leaders react to an unwelcome, unpopular, or difficult-to-implement yet unavoidable external demand in a situation of enormous material enticement or unequal bargaining power.

This rush to criminalize and penalize African female genital surgeries is distressing for several reasons. First, as we have seen, the decision is based on unsupported claims about the consequences of the genital surgery and highly dubious representations of African customs.

Second, the federal statute in the United States appears to be targeted at and causes selective injury to African immigrant and minority groups. The law treats their ritual life (and associated ideas about beauty, honor, femininity, marriage, and family life) with official contempt. The ban thereby causes distress to relatively powerless African immigrant families while allowing more highly placed citizens to make use of the coercive power of the state to further their particular single-minded vision of the good life.

Finally, by selectively criminalizing and penalizing female but not male genital surgeries, our lawmakers have overlooked several important normative issues that ought to guide any just consideration of this provocative and controversial case.

How might a fair consideration of the case proceed? To start such a discussion, it is useful to draw some distinctions between types of body alterations, in particular between: consensual versus nonconsensual alterations; major versus minor alterations; and reversible versus nonreversible alterations. With these distinctions in place, the following type of argument can be made in favor of limited toleration.

In order for the argument for limited toleration to succeed, one must first secure agreement on the following three principles.

Principle 1. *Certain types of genital alterations are permissible for boys.* Thus, for parents to surgically remove the foreskin of a male infant is permissible, even though the infant has not given consent, even though the procedure is irreversible, and even though no compelling medical justification exists for performing the operation. Circumcision is permissible in this case because the alteration is minor in two senses. From a medical viewpoint, the procedure is easy to perform and, aside from some short-term pain (in the absence of anesthesia), the operation is inconsequential with regard to its effects on basic biological functioning. The procedure also is minor from the viewpoint of social and psychological functioning, in the sense that circumcised males remain perfectly capable of attaining mental health and participating in a normal social life.

Male circumcision in infancy also is permissible because in our liberal plu-

realistic society we are willing to respect the cultural and religious traditions of the family, acknowledging and respecting, for example, the idea that circumcision is what Jewish people do to their sons because of their covenant with their God. Moreover, circumcision is permissible because we are willing to make room for family privacy and leave child care to parents rather than to the state, except under extreme circumstances. Indeed, in the case of infant male circumcision the procedure is so commonplace and tolerated that a sufficient reason for conducting the surgery is that the father does not want his son's genitals to look different from his own, or simply because he thinks it looks good.

This is not to suggest that this principle is incontestable or has never been contested. There are and have been anti-male circumcision advocates who view the removal of the foreskin as a mutilation. These advocates and other activists in the anti-male circumcision movement are prepared to be unmoved by claims of religious freedom, cultural rights, family privacy, or pluralism, and they seem prepared to disparage and castigate all religious and cultural traditions in which male circumcision is condoned. This is not a new phenomenon. Various historical and virulent attacks on Judaism (for example, the severe penalties imposed on mohels [one who is ordained to perform circumcisions] and mothers of circumcised infants by Antiochus Epiphanes, the ruler of Judea in the second century B.C.; and the English "Jew Bill" of 1753) have been associated with assaults on the practice of male circumcision (Gollaher 2000, 15, 28).

Moreover, it is quite possible for a surgical procedure to be minor in the two senses previously mentioned (biological and social functioning are not fundamentally impaired) yet still be substantial in its social implications. Imagine if Jews lived as a small minority group in a society where only Jews circumcised their sons. Imagine also that as a matter of cultural aesthetics and individual taste (judgments of beauty and ugliness, attraction and disgust), most non-Jewish women in this society were personally disinclined to marry a circumcised male and most Jewish women personally disinclined to marry an uncircumcised male. Then this minor medical procedure in effect would amount to a significant parental and cultural influence on the personal marriage choices of children and effectively would help perpetuate a sense of in-group identity and social distinction.

Sander Gilman (1999, 53), in a critique of some intellectual tempers that are much like the stance of imperial liberalism, quotes an Italian physician of the late nineteenth century who writes,

I shout and shall continue to shout at the Hebrews, until my last breath: Cease mutilating yourselves: cease imprinting upon your flesh an odious brand to distinguish you from other men; until you do this you cannot pretend to be our equal. As it is, you, of your own accord, with the branding iron from the first days of your lives, proceed to proclaim yourselves a race apart, one that cannot, and does not care to, mix with ours.

Under such circumstances, in which the distinctive family life practices of different ethnic groups result in the development of divergent tastes that then

function as personal inhibitions to marrying outside the group, would we want the government to step in to level the playing field? This could be done in either of two ways, mandating circumcision for all males in society or, alternatively, banning male circumcision for all. Under the banner of justice and equality in marriage choices, the law might require all American citizens to circumcise their sons or, alternatively, the government could just criminalize the ancient Jewish custom and start throwing Jewish circumcisers in prison along with Malian women, for up to five years. The latter alternative is the more likely, given that Jews are a small minority group. In either case, the government, in its wisdom, would be trying to ensure that men and women from different ethnic backgrounds find each other attractive so that patterns of preferential in-group marriage (like marrying like, on the basis of tastes and preferences acquired by virtue of ethnic background) would disappear from society. In either case, the state in effect would be promoting the cultural assimilation of Jews, and of any other minority group, bound together by selective marriage preferences related to its distinctive way of life. Perhaps even some imperial liberals might balk at that prospect.

Nevertheless, principle 1 as stated allows for minor genital alterations for boys, regardless of any social implications that may follow (unless the surgery makes it impossible for the person to have a meaningful and rewarding social life, in which case the social consequences of circumcision cannot be overlooked).

Principle 2. *Major body alterations are permissible if you know what you are doing and why such alterations are being done.* In other words, it is permissible for someone who has reached the appropriate age for autonomous decision making (or the age at which discretion is permitted, with parental consent) to alter his or her body in ways that are more substantial than would be allowed by principle 1 alone.

At some point in growing up we are granted rights of discretion over our own body. If a girl is old enough to get pregnant, we believe that she is old enough to have considerable discretion (either on her own or with parental backing) over any decision to abort the fetus. If she is old enough to experience her own body as ugly or hideous or distressing (or even just ordinary) and if she is mentally healthy and old enough to be cognizant of the costs and benefits of altering her body, we grant her considerable discretion to do so (either on her own or with parental permission) in major or irreversible ways.

If you have the support of your parents (and even in some cases if you don't), you do not have to wait until you are eighteen to have a breast implant or nose job, pierce your nipples, radically stretch your earlobes, or even engage in a sex-change operation. These more major body alterations are permitted because of *consent*. We believe that people who are old enough to care about themselves ought to be able to have the things they want that make them "happy," by their own lights. This holds true even if the things they want done don't make us happy, as long as the body alterations they bring upon themselves cause us no greater harm than offending our tastes or deviating from our idea of correct body politics.

Principle 3. *No major irreversible alterations of your body should be permitted without your consent.* In other words, we should have a strong presumption against non-consensual alterations of the body that have major consequences for either normal biological functioning or participation in a meaningful and fulfilling social life, and even more so if such alterations are irreversible. (There are some circumstances where even this strong presumption might be overturned—for example, in the case of someone who is unconscious and certain to die unless a leg is amputated.)

If we agree on those three principles, then the prevailing “First World” intolerance and repressive attitudes towards African genital alterations should be looked upon with suspicion. We should at least be willing to listen to the claims of those African immigrant mothers (see Coleman, 1998; Obiora, 1997) who believe that, in a tolerant pluralistic liberal democratic society such as the United States, there ought to be some room for their conceptions of femininity, family life ideals, and ideas of the good life.

For example, if genital alterations are permitted for boys on the grounds of family privacy, religious freedom, and the fact that they are not harmful to health or sexual functioning (principle 1), then to the extent that the same conditions hold, genital alterations should be permitted for girls as well. The determination of which types of procedures or styles of surgery should be allowed should rest entirely on scientific and medical evidence concerning the consequences of different procedures. There is no doubt that there are existing forms of female genital surgery which already are (or can be made to be) no more consequential for health and sexual functioning than the typical male operation as currently practiced in the United States.

Imagine an African mother who holds the following convictions. She believes that her daughters as well as her sons should be able to improve their looks and their marriage prospects, enter into a covenant with God, and be honored as adult members of the community via circumcision. Imagine that her proposed surgical procedure (for example, a cut in the prepuce that covers the clitoris) is no more substantial from a medical point of view than the customary American male operation. Why should we not extend that option to, for example, the Kono parents of daughters as well as to the Jewish parents of sons? This is basically what was proposed at the Harborview Medical Center in Seattle, Washington, until U.S. Representative Patricia Schroeder objected and raised the possibility of a violation of federal law (Coleman, 1998). Nevertheless, principles of gender equity, due process before the law, religious and cultural freedom, and family privacy would seem to support the option. The constitutional status of the federal prohibition remains untested.

And if body alterations such as breast implants or sex change operations are allowable with consent at an appropriate age (principle 2) then why not consensual genital alterations aimed at enhancing beauty and confirming appropriate gender identity (which, for some African immigrants, means getting rid of the male element in the female, and the female element in the male), as long as the

procedure is done safely and is compatible with sexual and reproductive functioning? As Obermeyer's (1999) review of the medical evidence suggests, such procedures are not only feasible, they already exist.

Needless to say, there is plenty of room for argument about the appropriate age of discretion and the conditions for establishing informed consent. In ethnic groups with a heritage of both male and female circumcision, the psychological burden of being uncircumcised (of feeling ugly, sexually ambiguous, immature and unmarriageable) is likely to intensify as one begins to sexually mature, which might be a lower bound for an age of discretion (with permission from one's parents). But such issues are not unique to this case. One might start by considering the age at which young people are permitted (with parental consent) to have a breast implant or an abortion or a sex change operation.

There is also plenty of room for argument about what counts as a major body alteration and what counts as minor. There may be types of body alterations that are benign from the point of view of health and sexuality, yet nevertheless radically reduce a person's chances of having a meaningful and rewarding social and family life. Sane and rational parents do not do things to their child's body that they think will ruin the child's life or turn them into "freaks." The more uncertainty there is about whether this body alteration will ruin rather than enhance the child's life, the more the procedure should be viewed as major rather than minor, and the more the need for informed consent (principle 3). In the case of circumcision (for both males and females) the judgment about what is good for your child not only depends upon, but also affects, what is considered by relevant others beautiful or ugly, normal or monstrous. There is little risk that parents will circumcise their children in the absence of a community of relevant others who share the same tastes. Fortunately, there are many ways for men and women to live meaningful social lives without securing universal agreement about the aesthetics of the human body, especially when the body parts in question are private and not meant to be open to everyone's inspection. If happiness in life depended upon being physically attractive to all members of the opposite sex, happiness would be in short supply.

Under this scenario, all circumcisions would be either minor (and hence permissible at an early age) or would have to wait until some reasonable age of consent. Infibulations of young children would be out of the question, although that procedure might be freely chosen after the appropriate age of discretion. As infibulation is a relatively infrequent procedure even in Africa, it seems unlikely that in the United States it would emerge as a popular style of genital alteration. Of course, who would have predicted ear lobe plugs, tongue or nipple piercings or elaborate tattoos to become fashionable in the United States? If you grant to others various liberties or freedoms (of choice, association, expression, religion) and various protections (of bodily privacy), then what they do with and to themselves may offend your (Christian or feminist or bourgeois) sensibilities. It is the price you pay for freedom and equality in a politically liberal democratic society. Under such circumstances, it is the virtue of tolerance that makes it possible for people to be quite different from one another, yet socially cooperate with each other at the same time.

Imagine a sixteen-year-old female Somali teenager living in Seattle who believes that a genital alteration would be "something very great." She likes the look of her mother's body and her recently circumcised cousin's body far better than she likes the look of her own. She wants to be a mature and beautiful woman, Somali style. She wants to marry a Somali man, or at least a man who appreciates the intimate appearances of an initiated woman's body. She wants to show solidarity with other African women who express their sense of beauty, civility, and feminine dignity in this way, and she shares their sense of aesthetics and seamliness. She reviews the medical literature and discovers that the surgery can be done safely, hygienically and with no great effect on her capacity to enjoy sex. After consultation with her parents and the full support of other members of her community, she elects to carry on the tradition. What principle of justice demands that her cultural heritage should be "eradicated" and brought to an end?

AFRICAN CUSTOMS AND POLITICAL PERSECUTION

In recent years in the United States, two political asylum requests related to female circumcision have been highly publicized, the 1996 case of Fauziya Kassindja, a refugee from Togo, and the 1999 case of Adelaide Abankwah, a refugee from Ghana. These cases are worth examining, in part, because of their peculiarities. (For a more comprehensive discussion of the circumstances surrounding both cases see Kratz, ch. 15 herein.)

The concept of political persecution as it has evolved in political asylum law has little relevance to the circumcision and initiation experiences of most African men and women. As we have seen, African men and women from ethnic groups with a heritage of circumcision generally endorse and identify with the practice and do not construe their own coming-of-age ceremonies as forms of political terror—despite what anti-FGM activists have to say about it. Those activists might like to redefine the situation in that way—adding "political persecution" to their discourse about maiming, murder, torture, sexual dysfunction and mutilation—but in general one should beware of characterizing other peoples' valued customs from such an inaccurate, ideologically loaded and ethnocentric point of view. Nevertheless, it is not impossible to imagine extreme or unusual political situations in which either a fear of being forcibly circumcised or, alternatively, of persecution for performing a circumcision (the former Soviet Union penalized Jews for circumcising their sons) might be grounds for an asylum request. Whether that was the case in either of the two most celebrated recent cases is quite another matter.

Legitimate requests for political asylum are supposed to be based on "a well-founded fear of persecution [in one's native land] on account of race, religion, nationality, membership in a particular social group, or political opinion" (*Abankwah v. INS*, U.S. 2d Circuit Court of Appeals, No. 98-4304). The concept of persecution means that you are being unreasonably harmed and unfairly picked

on owing simply to one of the aforementioned characteristics, and that no relief is possible short of migration. To consider a not-so-hypothetical case for example, a Chinese couple who is forced by their government to abort the pregnancy of their prospective child might have the basis for a political asylum request. Or, to consider an entirely hypothetical case, a man or woman in some African country who is forced by the government to have a genital alteration against his or her will, he or she might have the basis for a political asylum request as well.

The selective use of the coercive power of the state directed against particular ethnic groups in a country would be an obvious example of persecution. In addition, within any particular country, one might be vulnerable to persecution by organizations other than those of the state, especially if the state is in no position to protect an individual. In Kenya, male circumcision (customarily done in adolescence) is embraced and upheld by all ethnic groups, with the notable exception of the Luo. Imagine the following entirely hypothetical situation. The Kenyan government adopted a policy of forced circumcision of Luo males, rounding them up in adolescence and removing their foreskins so as to make sure that Luo males don't stand apart from any other males in Kenya. Perhaps they do this with the aim of promoting intermarriage between Luos and everyone else, or because health officials convince them that male circumcision reduces the risk of AIDS. Such an action might justify a request for political asylum in the United States.

The merits of the aforementioned types of political asylum cases are contestable. Is the coercive action truly unreasonable, or, for example, can the use of government force be justified in light of a population or health crisis? Is the coercive action arbitrary, discriminatory, or unfair to particular categories of persons, or is it applied to all members of society regardless of race, religion, nationality, or political opinion? Are remedies possible through normal political and legal institutions within the country of origin? Given that race, religion, and nationality are explicitly admissible grounds for establishing "a well-founded fear of persecution," should gender be included as admissible grounds as well? Is a person automatically a member of "a particular social group" simply by virtue of his or her sex? These are the types of tough-minded questions that need to be asked in such cases. Unlike the formal legal restrictions on male circumcision in the former Soviet Union or on childbirth in China, however, African coming-of-age and gender identity ceremonies and procedures are not matters of government policy. In African ethnic groups where both male and female circumcision is part of the cultural landscape, the surgery is customary of family life and social practice, and not a form of political persecution. It may occur so early in life that it never enters consciousness. Or it may occur in middle childhood, where it unfolds as a routine expectation in which parents entice, coax, or if necessary, insist that their child do what well-intended adults in Africa believe is in their child's best interest (just as we entice, coax, and if necessary, force our children to go to school, have their teeth drilled, or undergo a beneficial medical procedure, even when we know it may be painful). Or, as

noted earlier, the operation may occur just before or during adolescence and unfold as a test of courage, a source of personal empowerment and an eagerly awaited step into mature adulthood (see Kratz 1994; Johnson 2000). It is not typically the case in Africa that an uncircumcised adult woman who does not want to be circumcised is forced into the operating theater or placed in an intolerably coercive situation where political asylum from her country of origin is the only remedy. Political asylum requests for uncircumcised African females are few and far between, and they tend to arise under strange and unusual (and in some instances, unbelievable) circumstances.

Adelaide Abankwah comes from an ethnic group in Ghana in which women are not circumcised, in a country where a majority of ethnic groups have no tradition of female circumcision, and the government does not endorse the practice. She claimed that she was going to be forcibly circumcised as punishment for not being a virgin, and that she could not receive protection anywhere in Ghana. Anti-FGM advocacy groups such as Equality Now were moved by her incredible and unique story (most of which was undocumented and almost all of which, including her name, turned out to be fraudulent; see Branigin and Farah 2000). Instead of first doing some basic fact-checking, these groups rallied to her side, enlisted celebrity, senatorial, and White House support, and she was granted asylum (see the case of *Adelaide Abankwah v. INS* and related news coverage; see also Kratz, ch. 15 herein).

Other cases seem more meritorious, but they appear to arise from unusual circumstances and reveal little about characteristic features of the local African scene. Fauziya Kassindja is a sympathetic figure from Togo. She asked for political asylum due to an unusual domestic situation in which one part of the family endorsed a tradition of female circumcision while her own parents did not. As a teenager, she grew up with no expectation or anticipation of being circumcised. Nevertheless, when her father died, her father's siblings arranged for her to be married into a family where female circumcision was part of the family tradition. She fled Togo and landed in Newark, New Jersey, where in 1994 Kassindja was arrested for trying to enter the United States illegally (see Kratz, ch. 15 herein). Two years later, just after she was granted political asylum and then heralded by anti-FGM advocacy groups as a feminist heroine who had been liberated from the "oppressive and barbaric" customs of Africa, Fauziya Kassindja was interviewed on Ted Koppel's television program "Night Line." In that interview, Kassindja surprised her host by announcing that most young women in Togo who come of age this way are happy to be circumcised and "think it is something very great." She spoke the truth, but her response did not compute within the terms of the global anti-FGM discourse. Since African genital alterations are torture and everyone must want to flee Togo—the basic assumption of the program—Koppel pressed on with his prepared story line (Walley 1997, 421). It remains to be seen whether other liberal, freethinking Americans—all of "us"—will be more able to "break frame," open our minds, uncover our ears, and listen.

CONCLUSION: ON THE VIRTUES OF BEING SLOW TO JUDGE THE UNFAMILIAR AND HAVING A HARD SECOND LOOK

I can think of no better way to conclude than by quoting the legal scholar Lawrence Sager (ch. 8 herein), who writes,

Epistemic concerns and the principle of equal liberty require that we be slow to judge the unfamiliar, and that we take a hard look at our own factual beliefs and normative judgments before we condemn culturally endorsed practices. They also require that extant legal categories of excuse and mitigation be open to the distinct experience of cultural minorities. Finally, they require that our robust tradition of constitutional liberty—including the rights of speech and belief, the right of parents to guide their children's development, and the right of people to be free from governmental intrusion into decisions that ought to be theirs alone—be available on full and fair terms to cultural minorities. (ch. 8, 173)

As a matter of epistemic concern, this chapter has tried to suggest that we should be skeptical of the anti-FGM advocacy literature and global discourse that portrays African mothers as mutilators, murderers, and torturers of their children. We should be dubious of representations that suggest African mothers are bad mothers, or that First World mothers have a better idea of what it means to be a good mother. We should be slow to judge the unfamiliar practice of female genital alterations, in part because the horrifying assertions by anti-FGM activists concerning the consequences of this practice (that is, claims about mortality, devastating health outcomes, and loss of a capacity to enjoy sex) are not well-supported with credible scientific evidence. That is reason enough to take a hard second look and hesitate before even using the epithet "FGM" ("female genital mutilation") to describe the coming-of-age and gender identity practices embraced by many millions of African women. African women too have rights to personal and family privacy, to guide the development of their children in light of their own ideals of the good life, and to be free of excessive and unreasonable government intrusion.

This chapter also has suggested that merely posing the question, "What about FGM?" is not an argument against cultural pluralism. With accurate scientific information and sufficient cultural understanding, it is possible to see the not unreasonable point of such practices for those for whom they are meaningful. The toleration begins with seeing the cultural point and getting the scientific facts straight. Our cherished ideals of tolerance (including the ideal of having a "choice") would not amount to very much if all they consisted of was our willingness to eat each other's foods and to grant each other permission to enter different houses of worship for a couple of hours on the weekend. Tolerance means setting aside readily aroused and powerfully negative feelings about the

practices of immigrant minority groups long enough to get the facts straight and engage the "other" in a serious moral dialogue. It should take far more than overheated rhetoric and offended sensibilities to justify a cultural eradication campaign. Needless to say, the question of toleration versus eradication of other people's valued way of life is not just a women's issue.

The controversy over female circumcision in Africa is not an open-and-shut case. Given the high stakes involved, cultural pluralists—both men and women—who are knowledgeable about African circumcision practices have a responsibility to step forward, speak out, and educate the public about this practice. Many African women, out of a sense of modesty, privacy, loyalty, or a well-founded fear of political persecution, may hesitate to speak for themselves. Everyone has a responsibility—anti-FGM activists and cultural pluralists alike—to insist on evenhandedness and the highest standards of reason and evidence in any public policy debate on this topic—or at least to insist that there is a public policy debate, with all sides and voices fully represented.

Many friends, colleagues, and experts on African initiation ceremonies have generously (and tolerantly) discussed this topic with me or critiqued an earlier version of the chapter. Without in any way holding them responsible for my perspective on this controversial issue, I wish to express my deepest gratitude to Fuumbai Ahmadu, Margaret Beck, Janice Boddy, David Chambers, Jane Cohen, Elizabeth Dunn, Robert Edgerton, Arthur Eisenberg, Ylva Hernlund, Albrecht Hofheinz, Sudhir Kakar, Jane Kaplan, Frank Kessel, Corinne Kratz, Dennis Krieger, Maivân Lâm, Heather Lindkvist, Saba Mahmood, Hazel Markus, Martha Minow, Carla Obermeyer, Anni Peller, Jane Rabe, Lawrence Sager, Lauren Shweder, Gerd Spittler, and Leti Volpp. This chapter was prepared while I was a Fellow at the Wissenschaftskolleg Zu Berlin (The Institute for Advanced Study in Berlin). A much shorter version of this chapter appeared in the Fall 2000 issue of *Daedalus: Journal of the American Academy of Arts and Sciences* 129(4).

NOTES

1. Fuumbai Ahmadu is a Kono woman from Sierra Leone. She grew up in the United States and is a Ph.D. candidate in anthropology at the London School of Economics and Political Science. At age twenty-two she returned to Sierra Leone to be initiated into the women's secret society and to be circumcised according to the customs of her ethnic group.
2. Things are starting to change. Essays that are more incisive, ethnographically informed, nondefensive, or profoundly skeptical of the current anti-FGM global discourse are beginning to appear. See, for example, Abusharaf 2001; Ahmadu 2000; Boddy 1996; Coleman 1998; Gilman 1999; Gosselin 2000; Gruenbaum 2001; Johnson 2000; Kratz 1994, 1999; Larsen and Yan 2000; Morison et al. 2001; Obermeyer 1999, Obiora 1997; Parker 1995; Thomas 2000. For a sample of views and representations

concerning female initiation and circumcision also see Abusharaf 2000; Boddy 1989; Cooper 1999, El Dareer 1982; Gruenbaum 1988; Gunning 1991–1992; Hernlund 2000; Horowitz and Jackson 1997; Kenyatta 1938; Lane and Rubinstein 1996, Meinardus 1967; Slack 1988; Walley 1997; Williams and Sobieszzyk 1997.

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