1.4.2018

Frumvarp til laga er varða breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja), 148. löggjafarþing - þingskjal 183 - 114. mál.

Kæri móttakandi, ég vona að bréf mitt komi ykkur að góðum notum. Mig langar mjög að hjálpa Íslendingum í þessum málum. Þið eruð ekki ein. Meðfylgjandi er framlag mitt."

Bestu kveðjur frá Ahmed Subhy Mansour

The Stance of Islam Regarding Male Circumcision

By Shiekh Dr. Ahmed Subhy Mansour

President, The International Quranic Center (IQC)

- **Introduction:** Islam as a religion is one thing, and Muslims are another. It is enough that God Almighty sent his messenger Mohamed to be a mercy for all worlds, but Muslims instead have now converted Islam into terrorism and random killing for all. Muslims have incorporated laws that aggrieve the religion of Islam. One of them is circumcision for males and females.
- **Let us put the issue in the form of questions and answers:**

1. Did God Almighty create humans with a congenital defect that requires surgical intervention from humans to fix, by cutting the foreskin on the male and amputating the clitoris on the female?
    - Answer: No, because God Almighty created mankind (male and female) in the best shape. God Almighty said, "We created mankind in the best shape" (verse 4, chapter 95). And He the Almighty said, "He is the One who made everything which He created good" (verse 7, chapter 32). And He the Almighty said, "O man! What has deceived you about your generous Lord? It is He who created you, shaped you, and made you well-proportioned. In whatever form He wants, He sets you" (verse 8, chapter 82).
2. Does true Islamic law allow shedding the blood of a human, especially if that person is a young child?
    - Answer: This is a crime, and there is a legitimate penalty for that. This means it is a crime that requires a retribution of the same kind from the perpetrator; God Almighty said, "and for wounds, like for like" (verse 45, chapter 5).
3. Is it correct to start a rule that did not exist in the noble Quran? And is it correct to fabricate evidence for it by telling lies and false stories?
    - Answer: This is one of the biggest taboos. God Almighty said, "Tell them: 'My Lord has only forbidden indecent acts, whether overt or hidden; sins; transgressions without right; associating things with God that He has not sent down a strong order for; and ascribing things to God of which you have no knowledge [that they are from Him]'" (verse 33, chapter 7). In that verse, God limited the taboos. Among them are associating other people with God, saying something and attributing it to God while He did not actually say that, and making up religious rules that are not in Islam.
4. Where did the religious rule of male circumcision come from?
    - Answer: Male circumcision existed in ancient Egypt. Judaism was influenced by it, and so considered it a divine rule. They mentioned it in the Old Testament in the story of Abraham (peace be upon him) in Genesis. It also exists among Arabian Christians and some Christians in Asia and Africa.

5. How did Muslims include male circumcision within their rules?
    - Answer: After the Arab Conquests, the natives of the conquered nations entered into Islam carrying the same heritage and rules that they were accustomed to. And they trumped up statements and anecdotes, ascribing them to the prophet Mohamed (peace be upon him) centuries after he died. And this is how real Islam became pariah and forgotten.
6. And what did they say regarding male circumcision?
    - Answer: They claimed a laughable teaching (ascribed to Mohamed). It says that the prophet Abraham got circumcised when he was 80, cutting his foreskin using an axe. That is a false teaching. No human can do that.
7. Did the prophet Mohamed get circumcised?
    - Answer: This is not mentioned in the noble Quran. Moreover, in the biography written about him, it was not mentioned. The first written biography about Mohamed was written by Ibn-Es-hak a century and a half after the prophet had died. It does not include whether he got circumcised. The later biographies written about him also do not say whether he got circumcised.
8. Is the pronunciation "circumcision" mentioned in the noble Quran?
    - Answer: The exact pronunciation of "circumcision" is not there in the noble Quran. A word (close in pronunciation) that means "cheating" (verse 187 chapter 2 and verse 107 chapter 4) is there.
9. And what about female circumcision?
    - Answer: There is no circumcision for males in Islam, so how would there be circumcision and defilement of their childhood for females?!
10. How did they make circumcision a religious rule?
    - Answer: By slandering. They attributed statements to Mohamed that allow it, centuries after his death.

- **Conclusion:** Male circumcision contradicts Islam and human dignity. So we ask legislators to ban it and criminalize male infant and child circumcision.

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https://www.youtube.com/watch?v=26ZsXWxo8QY
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28.3.2018

Viðfangsefni: Endurskoðun á drög að lögum um breytingu á hegningarlögum (Bann við .umskini karlkyns stráka), Löggjafarráð 148, mál 114

Kæru þingmenn

Ég er Ahmed Tariq múslími Arabic frá Sultanate Óman, bjóða ég þér þakkir fyrir athygli þína á þessu máli sem er að bíða eftir ákvörðun sem fyrir löngu síðan, sannleikurinn er enn sveinbörn þjást af áhrifum feðraveldi á þeim, enn við ekki að klára málið af líkamlegum og sálrænum eineltis sem verða honum eftir foreldrar þeirra, og það er ekki þyngri en umskurn, þvingunar barnið í frumbernsku eða er enn lítil og grimmd þessa trú, gera það ómögulegt að vera trúarleg óhjákvæmilega, það er óraunhæft að höfundur syndin er ekki skynsamleg að hann biður þræla Adho honum stykki af líkama sínum, og Það er hugsanlegt að Anjas skapaði þau til að ljúka siðleysi með því að skera úr hluta kynfærum þeirra Brenglast eilífu, ég leitaði í Kóraninum, sem er helsta uppspretta af kenningum íslamska trú sem ég hafði ekki fundið neitt röð Drottins slík athöfn, en þvert á móti, ég fann vísur sem mælir þörfina á að vernda sál og líkama úr meiðslum og dauða, og að ég skrifa þér í dag að ganga með raddir Hver kallar til enda á æfingu .karlkyns kynfærum karlkyns barna og lög til að vernda þá frá krafti móðgandi foreldra sinna

Ég stjórna hóp á Facebook öfugt við karlkyns umskurn gegn börnum, og það eru hundruðir af múslima Bræðralag Aaidona og óska eftir þeim degi þegar draumur þeirra er náð að vernda .drengir frá umskurn

Kveðjur Ahmed Tarik

Dear Sir/Madam,

Re: Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)

As I am sure you are aware, a Bill affecting circumcision in Iceland is getting its' first reading in the Icelandic Parliament. Progressive Party MP Silja Dögg Gunnarsdóttir is the driving force behind the legislation, a law that would criminalise the act of circumcision.

As you can imagine, despite the small size of the Jewish community in your country, the reaction to the Bill and repercussions stemming from it have been met with great concern by jews across the continent.

The chairman of the European Jewish Association, Rabbi Menachem Margolin and myself met a week ago here in brussels with her Exxcellency Ambassador Mrs Bergdís Ellertsdóttir and her Deputy Minister Mr Ragnar Kristjansson.

We had a very common-sense and pragmatic discussion on this issue. It is clear from this meeting that this is a party-led initiative and not one that enjoys the initiative or direct support of the Icelandic Parliament as a whole. This on its own is a good start.

Our expressed concern to the Ambassador is the origin of such legislation, given that it only affects, at best 3 Icelandic children per year who would be circumcised for the purposes of the Jewish faith. Why is a such a bill is even required in the first place? It reeks of the type of populism that is all too sadly manifesting itself across the European Continent at the present time. Her Excellency assured us that our remarks would be reported directly back to the Government in Iceland, and we trust this was done.

The import of such legislation ever becoming law is that it sets precedence for other European nations, and normalises the branding of the entire Jewish population as "criminals" for performing this important, vital and precious rite of ours. It cannot be allowed to happen.

We will travel to Iceland where we are already in the process of making representations to the parliament via established channels and consultative protocols.

Yours Faithfully,

Alex Benjamin
Director of Public Affairs
European Jewish Association

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27 March 2018

Alþingi
Kirkjustræti
150 Reykjavík

RE: Circumcision Legislation

Ágæta Alþingi,

I am writing to ask that members of Parliament vote in favor of the proposed legislation banning male circumcision in your country. Iceland has the ability to make history as the first nation to ensure that all of its children are protected from forced genital cutting. Being born male should not mean that children suddenly have less agency over their own bodies, regardless of their parents' religious beliefs. Just as your nation rightfully protects girls from the removal of healthy, functional genital tissue in the name of religion and tradition, please set an example for the world and do the same for boys.

Thank you for your thoughtful consideration of this matter. Iceland truly has the power to be a global agent of change for boys everywhere by setting this monumental precedent. I look forward to seeing you taking full advantage of such an opportunity.

Sincerely,

Alexis Lanzillotta
United States

ADL
Anti-Defamation League®

Jonathan A. Greenblatt
CEO and National Director

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Comments regarding: Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)

Submitted by Jonathan Greenblatt, CEO, Anti-Defamation League (New York, USA)

March 19, 2018

The Anti-Defamation League (ADL) is one of America's premier human relations and civil rights agencies and is dedicated in purpose and program to combating anti-Semitism and all forms of bigotry, defending democratic ideals and protecting civil rights for all.

We write to offer three compelling reasons against the adoption of a ban on male circumcision.

Religious freedom

The proposal to ban male circumcision is and contrary to basic principles of religious freedom and deeply offensive to Jews and Muslims. The commandment of *brit milah*, circumcision on the eighth day, is a fundamental religious rite in Judaism and universally practiced by all families who identify as Jewish across the broad spectrum of practice. Such a ban would mean that no Jewish family could be raised in Iceland, and it is inconceivable that a Jewish community could remain in any country that prohibited *brit milah*.

Finland's Supreme Court ruled in 2008 that ritual male circumcision is protected under the European Convention on Human Rights by the right to personal autonomy, as part of the right to privacy, (Article 8), the right to family life (Article 8), and the freedom of religion and conscience (Article 9), when "appropriately performed."

Medical benefit

According to the American Academy of Pediatrics, "Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV." (https://www.ncbi.nlm.nih.gov/m/pubmed/22926180/)

With a U.S. population of over 325 million and a circumcision rate of 81 percent among U.S. males age 14 to 59, the opinion of the American Academy of Pediatrics should be considered more authoritative than European study which asserts the contrary.

Iceland's international standing and negative economic impact

The Anti-Defamation League is the leading monitor of far-right extremism and foremost expert in the United States. Should Iceland ban male circumcision, making it impossible for Jews and Muslims to raise families in your country, we guarantee that Iceland will be celebrated by neo-Nazis, white supremacists, and other extremists. Even though anti-Semitism was surely not the impetus for the proposal, the result of its adoption will be the glorification of Iceland by the most despicable bigots. They will celebrate the ban as the first legislation in Europe since World War II towards making a country *Judenrein*, free of Jews.

ADL has studied the pervasiveness of anti-Semitic content on social media, and we know that a relatively small number of extremists are able to amplify their message quickly and broadly through social media. ADL regularly reports on such phenomena, and we will report on extremist praise for Iceland. We urge you to consider the significant media attention, in the U.S. and internationally, paid to ADL reports on extremism. In the past six months alone, our research and experts have been featured on CNN and other cable TV channels, NBC and other broadcast TV, on *60 Minutes*, the most watched TV news magazine in America, and in leading newspapers, including *The New York Times* and *The Washington Post*.

Given that 28% of Iceland's tourists came from North America in 2016, Iceland's standing in the U.S. should be of great concern from an economic perspective. We are confident that the vast majority of American tourists will avoid a country whose reputation is associated with Nazism, even if that association is not justified.

Individually, any of these three arguments should convince you to oppose a ban on male circumcision. Collectively, they should compel you to make the right decision and oppose the proposed ban.

Efni: Umsögn um breytingu á almennum hegningarlögum nr. 19/1940, þingskjal 183-114. mál (umskurn drengja)

Nú á 148. löggjafarþingi 2017–2018 liggur fyrir frumvarp til laga er varða hegningarlög og bann við umskurn drengja. Lög sem þessi eru langt frá því að vera nýstárleg eins og sumir virðast halda. Lög af þessu tagi hafa reglulega verið lögfest frá fornu fari og settu sterkan svip á síðustu öld. Blóði drifin saga slíkra laga er óumdeilanleg staðreynd sem ekki er hægt að líta framhjá. Lög um bann við umskurn sveinbarna er samofin sögu Gyðinga sem hafa umskurn inngróna í menningu sína og þjóðarvitund. Lög um umskurn sveinbarna hafa nánast alltaf verið undanfari grimmilegra ofsókna og ofbeldis þeim á hendur.

Þegar stiklað er á stóru má meðal annars nefna Antiochus Ephihanes 175 f.k sem réð yfir landsvæði Gyðinga og bannaði umskurð með hörðum refsilögum. Hann háði herferð til að útrýma siðum þeirra og trú og ofsótti gyðinga af mikilli hörku, slátraði miklum fjölda og kúgaði.(Wisthon,1999) Gyðingar halda enn á okkar tímum árlega Hanukkah hátíð, hátíð ljóssins, í desember til að fagna því þegar þeir náðu að losna undan þeirri grimmilegu kúgun. Hadrian Rómar keisari setti árið 135 e.k. alheimsbann við umskurn sveinbarna og í kjölfarið fylgdu tilheyrandi ofsóknir sem enduðu með því að 580.000 Gyðingar voru myrtir samkvæmt rómverska sagnaritaranum Cassius.(Cassius,) Ekkert er nýtt undir sólinni..

Tiltölulega stutt er síðan Jósef Vissarionovich Stalín komst til valda í Sovétríkjunum. Hann er af mörgum talinn hafa látið drepa fleiri Gyðinga en sjálfur Hitler. Margir núlifandi einstaklingar lifðu þennan tíma. Kommúnistaflokkur Stalíns bannaði umskurn eins og þau lög gera sem núna eru til umfjöllunar á Alþingi Íslendinga.(Slepak,)(Bloomberg,) Í framhaldinu komu ofsóknir, illska og ofbeldi af stærðargráðu sem heimurinn hafði ekki séð og milljónir lágu í valnum. (Arkady, 1994) Undrast einhver þótt Gyðingum hrylli við lagasetningunni sem nú er fyrirhuguð? Lög ber að skoða í ljósi sögu þeirra, reynslu af lögunum og samfélagslegra áhrifa nær og fjær. Það er engum vafa undirorpið að dómur sögunnar er að þessi lög hafa aldrei leitt af sér annað en gríðarlegan skaða. Áhrif laganna eru því að fullu fyrirsjáanleg og skaðinn verður augljóslega því meiri eftir því hversu mikinn hljómgrunn þau fá á alþjóðlegum vettvangi. Ábyrgð háttvirtra Alþingismanna er skýr við innleiðingu laga og nær til áhrifa þeirra hérlendis og á alþjóðavettvangi.

Umskurn drengja á Íslandi eru með eindæmum fáar. Öllum er það ljóst. Það gæti því hæglega virðst sem tilgangur laganna sé að gera Ísland að kyndilbera nýrrar rétttrúnaðarstefnu í alþjóðlegri herferð? Íslendingum er almennt mjög umhugað um ímynd lands og þjóðar. Fulltrúar Íslendinga á Alþingi fara fremstir í að móta hana með því að endurspegla gerð þjóðarinnar við innleiðingu þeirra laga sem einkenna samfélagið. Mikilvægt er því að háttvirtir Alþingismenn athugi gaumgæfilega svarið við eftirfarandi spurningu:

Eru Íslendingar í raun vissir um að vilja vera frægir fyrir að bera fram þessi fornu lög í nýjum búningi og heiðra þannig minningu þessara frægu manna sem hér hafa verið nefndir? Umræða um refsilög við umskurn er ný á Íslandi og nokkuð sýnt er að stór hluti Íslendinga er ekki að gera sér fyllilega grein fyrir í hvaða fótspor er verið að feta. Í Þýskalandi fyrir 1933 áttu sér stað áralangar pólítískar umræður um tvo siði gyðinga; umskurn og Kosher slátrun. Áróðursmaskína Nazista undir handleiðslu Joseph Goebbels lagði mikla áherslu á að mála umskurn sem gimmdarlegan sið (Judd, 2007). Þeir náðu síðan völdum og allir þekkja eftirleikinn. Á Íslandi þarf upplýstari og ýtarlegari umræðu til að taka svona alvarlega

ákvörðun. Íslendingar hafa unnið ötullega að því að byggja upp þjóðfélagsmynd þar sem lýðræðisleg gildi eru höfð í hávegum, mannréttindi virt , trúfrelsi ríkir, virðing er borin fyrir mismunandi menningarheimum og minnihlutahópar eru ekki kúgaðir. Mannkynið þarf á slíku að halda og Ísland getur vel verið góð fyrirmynd að slíku samfélagi. Með því að setja svona bann eru Íslendingar hugsanlega búnir að fyrirgera slíkri ímynd langt út þessa öld.

Arnljótur Davíðsson, Maríubakki 12, 109 Reykjvík, S:6937805

Heimildir:

The Complet work of Josephus, William Wihston, 1999
Cassuis Dio, The Roman History, 1987
The Gates of November, Vladimir Slepak, 2010.
The Jewish World in the Modern Age, Jon Bloomberg, 2004
Stalins against the Jews, Vaksberg Arkady, 1994
Contested Rituals, Robin Judd, 2007

Barnaheill

Nefndasvið Alþingis
Allsherjar- og menntamálanefnd
Austurstræti 8-10
150 Reykjavík

Reykjavík 23. mars 2018

Meðfylgjandi er umsögn Barnaheilla - Save the Children á Íslandi um frumvarp til laga um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja). (Þingskjal 183 — 114. mál.)

Virðingarfyllst,
f.h. Barnaheilla - Save the Children á Íslandi

Erna Reynisdóttir,
framkvæmdastjóri

Barnaheill - Save the Children á Íslandi - Háaleitisbraut 13, 108 Reykjavík
s. 553 5900 - barnaheill@barnaheill.is - www.barnaheill.is

Umsögn Barnaheilla – Save the Children á Íslandi um frumvarp til laga um breytingu á almennum hegningarlögum nr 19/1940 (bann við umskurði drengja)

Barnaheill – Save the Children á Íslandi hafa fengið til umsagnar ofangreint frumvarp og þakka fyrir það.

Afstaða Barnaheilla til umskurða á drengjum er eftirfarandi:
Samtökin hvetja til þess að settar séu lágmarksreglur um framkvæmd á umskurðum á drengjum. Barnaheill eru þeirrar skoðunar að umskurð eigi ekki að framkvæma nema í samráði við barnið sjálft þegar það hefur þroska og aldur til að taka upplýsta ákvörðun um umskurð á sér, nema að læknir telji nauðsynlegt af heilsufarsástæðum að umskurður verði gerður á barninu.

Afstaða samtakanna byggist á ákvæðum Barnasáttmálans:

12. gr. og 13. gr. sem kveða á um að barn eigi rétt til að láta frjálslega í ljós og tjá skoðun sína um málefni sem það varða,
14. gr. sem varðar sjálfstætt trúfrelsi barns,
16. gr. sem kveður á um friðhelgi einkalífs barns,
19. gr. sem kveður á um skyldur ríkja til að vernda barn gegn líkamlegu og andlegu ofbeldi, meiðingum og/eða illri meðferð,
24. gr. sem kveður á um rétt barns til bestu mögulegu heilbrigðisþjónustu og heilsufars og sérstaklega 3. mgr. sem skyldar ríki til að gera allar viðeigandi ráðstafanir til að vinna gegn hefðum sem eru skaðlegar heilbrigði barna.
Og jafnframt á 2. gr., bann við mismunun, 3. gr., sem skyldar ríki til að taka ákvarðanir byggðar á því sem barni er talið fyrir bestu og 6. gr., sem kveður á um að barn skuli eiga rétt til að lifa og þroskast við bestu mögulegu aðstæður.

Að mati Barnaheilla á að virða sjálfsákvörðunarrétt barns um aðgerðir eins og umskurð og aðrar óafturkræfar aðgerðir sem ekki eru metnar nauðsynlegar af læknisfræðilegum ástæðum. Vitað er að umskurður á getnaðarlim ungbarns er afar sársaukafull aðgerð sem veldur barninu alvarlegu áfalli sem getur haft mikil áhrif á líf þess. Slík ónauðsynleg aðgerð sem m.a. er ekki gerð með deyfingu eða svæfingu, því það er ekki hægt vegna ungs aldurs barnsins, er að mati Barnaheilla ómannúðleg meðferð á barni og með engu réttlætanleg.

Barnaheill virða rétt barna til að velja sjálf hvaða trú og lífsafstöðu þau vilja eiga og iðka, en virða jafnframt rétt og skyldu foreldra til að veita barni kærleiksríkt og leiðbeinandi uppeldi í siðum og venjum sem tilheyra menningu þeirra, sbr. 30. gr. Barnasáttmálans. Foreldrar bera sameiginlega ábyrgð á að ala upp barn og koma því til þroska. Það sem barninu er fyrir bestu skal vera þeim efst í huga eins og segir í 18. gr. Barnasáttmálans.

Að mati Barnaheilla er ekki þörf á eða viðeigandi að kveða á um bann við umskurði drengja í almennum hegningarlögum. Sú skoðun byggist aðallega á því að í fæstum tilfellum er um að ræða ásetning um ofbeldi af hálfu þess sem framkvæmir umskurð eða af hálfu forsjáraðila sem fara fram á að barn sé umskorið. Því má ætla að ógerlegt sé að beita ákvæðinu þar sem ekki verður sýnt fram á ásetning um að skaða barnið. Þvert á móti eru miklar líkur á að þeir sem standa að ákvörðun um að láta umskera sveinbarn vilji því það besta og telji sig vera að gera barninu gott. Um er að ræða viðkvæmt málefni sem þarf að vinna með samfélagslegri viðhorfsbreytingu og í sem mestri sátt. Að mati samtakanna á betur við að settar verði reglur í barnalög eða barnaverndarlög þar sem því verði lýst að ekki skuli framkvæma umskurð á barni, í öðrum tilgangi en læknisfræðilegum nema í fullu samráði við barnið og að beiðni þess sjálfs, t.d. þegar barn hefur náð 16 ára aldri í samræmi við lög um réttindi sjúklinga. Ákvæði þess efnis gætu m.a. átt heima sem viðbót við 3. mgr. 28. gr. barnalaga nr. 76/2003 og/eða sem viðbót við 98. eða 99. gr. bvl., nr. 80/2002.

Um framkvæmd umskurða á börnum í læknisfræðilegum tilgangi skuli gilda lög um réttindi sjúklinga og aðrar reglur um viðeigandi aðbúnað við framkvæmd aðgerða. Einnig mæla Barnaheill með að sett verði sérstök reglugerð um framkvæmd umskurða á ungbörnum í læknisfræðilegum tilgangi, í samráði við barnalækna.

Barnaheill – Save the Children á Íslandi leggja mikla áherslu á að börn eiga sjálfstæð mannréttindi og ber foreldrum að þekkja þau og virða. Að mati Barnaheilla eiga börn að hafa sjálfsákvörðunarrétt um líkamlegar aðgerðir sem ekki teljast nauðsynlegar í læknisfræðilegum tilgangi. Jafnframt eiga börn rétt á að velja sér eigin trú og lífsafstöðu eftir því sem aldur og þroski gerir þeim kleift. Ef barn er umskorið á unga aldri áður en það sjálft getur myndað sér sjálfstæða skoðun á hvaða trúarbrögð það aðhyllist og vilji iðka er verið að taka fram fyrir rétt barns til að velja sjálft, að mati Barnaheilla.

Alþingi, nefndasvið
Austurstræti 8 - 10
150 REYKJAVÍK

Reykjavík, 27. mars 2018
2018010037

Efni: Umsögn - frumvarp til laga um almenn hegningarlög (bann við umskurði drengja) - 114. mál

Barnaverndarstofa vísar til erindis nefndasviðs Alþingis, dags. 7. mars 2018, þar sem stofunni var gefið tækifæri á að gefa allsherjar- og menntamálanefnd Alþingis umsögn um frumvarp til laga um almenn hegningarlög (bann við umskurði drengja), 114. mál. Þakkar Barnaverndarstofa fyrir að fá tækifæri til þess að tjá sig um frumvarpið.

Í upphafi telur Barnaverndarstofa rétt að taka fram að stofan er sammála því meginmarkmiði frumvarpsins sem lýtur að því grundvallaratriði að banna inngrip í líkama barna sem ekki eru nauðsynleg af læknisfræðilegum ástæðum.

Barnaverndarstofa telur þó nauðsynlegt að umræða um inngrip í líkama barna sé tekin á almennari grundvelli en frumvarp þetta gerir ráð fyrir og telur nauðsynlegt að samfélagið taki heildstætt til skoðunar hvers konar inngrip í líkama barna án læknisfræðilegrar nauðsynjar eru framkvæmd hér á landi og hvar samfélagið telur rétt að draga mörkin.

Einnig telur Barnaverndarstofa mikilvægt að öll börn á Íslandi upplifi að þau séu velkomin og tryggja þurfi að börn sem alast upp við trúarlegan bakgrunn sem er ólíkur þeim sem flestir Íslendingar alast upp við fái það ekki á tilfinninguna að þau séu óvelkomin hér á landi eða litin hornauga. Hætt er við því að með því að gera umskurð refsiverðan þá upplifi drengir í þeim trúarhópum þar sem umskurður viðgengst að þeir séu ekki velkomnir eða að þeim sé mismunað hér á landi.

Rétt er að vekja athygli allsherjar- og menntamálanefndar á því að veruleg hætta er á því að ef umskurður verður gerður refsiverður þá mun það auka verulega líkur á að slíkar aðgerðir verði framkvæmdar í skjóli nætur við hættulegar aðstæður slíkt þar sem ekki er notuð deyfing eða sótthreinsað og aðrir e heilbrigðisstarfsmenn framkvæma aðgerðina og getur slíkt verið drengjunum lífshættulegt.

Barnaverndarstofa fagnar því ef Ísland ætlar að skipa sér í fremstu röð hagsmunagæsluaðila barna en hvetur til þess að það verði gert með fræðslu og samtölum bæði hérlendis og erlendis. Ísland getur orðið leiðandi afl í að breyta viðhorfum heimsbyggðar gagnvart umskurði en það verður ekki gert með því að gera athöfnina refsiverða.

Barnaverndarstofa veitir allsherjar- og menntamálanefnd Alþingis fúslega allar nánari upplýsingar og skýringar sem þörf er á verði óskað eftir því og er reiðubúin að mæta á fund nefndarinnar verði þess óskað.

Virðingarfyllst
f.h. Barnaverndarstofu

Heiða Björg Pálmadóttir

Dear Sir or Madam,

Please find below the Belgian Federation of Jewish Organizations' comments on the proposed bill with reference: "Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja"

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In my capacity as president of the Belgian Jewish community, I am writing to express my profound concern over the proposed anti-circumcision bill, which threatens religious freedom in Iceland and may constitute a dangerous precedent elsewhere.

This proposed legislation most probably violates the Right to Freedom of Thought, Conscience and Religion (Art. 9 ECHR). Although the ECHR allows for limitations on the grounds of public health, these restrictions must be necessary and proportionate to the objective pursued and have to be balanced against the need to preserve genuine religious pluralism, which is a vital right in any democratic society.

Because of the unbearable burden it poses on Jewish communities, restrictions on Brit Milah on grounds of public health are disproportionate.

In Finland, the Supreme Court ruled in 2008 that male circumcision on social and religious grounds when 'appropriately performed', is not illegal and covered by the right to personal autonomy (as part of the right to privacy) under Art. 8 of the ECHR, the right to family life (also under Art. 8 of the Convention) and the freedom of religion and conscience (Art. 9 of the Convention).

Irrespective of any legal considerations, I ask that you assess the political signal given to Jews worldwide, and draw your attention to the resolution adopted by the Executive of the World Jewish Congress in September 2017 (attached to this email).

***

Best regards,
Yohan Benizri, President of the Belgian Federation of Jewish Organizations
Member of the Executive of the European Jewish Congress

Resolution EC 170910 -5

Brit Mila

The Executive Committee of the World Jewish Congress, meeting in London on September 11, 2017,

NOTES that circumcision [Brit Milah] of eight-day-old Jewish males is a three-thousand-year-old fundamental tenet of Jewish life, through which the child is recognized as having entered into the ancient covenant of his people with G-d;

NOTES WITH CONCERN that recently, an increasing number of European governments and parliaments have introduced legislation and regulations limiting practices such as non-medical male circumcision, which is performed by Muslims and Jews;

STRESSES that all proposals to ban Brit Milah are unacceptable and constitute an infringement on the basic human right of freedom of religion and belief;

ENCOURAGES the creation of interfaith advocacy coalitions to combat ignorance, intolerance, and discrimination, as exemplified by the July 2017 summit in Amsterdam for European Jews, Muslims, and anti-racism activists, organized by the Organization for Security and Co-operation in Europe (OSCE), on topics including the nonmedical circumcision of male minors.

ADOPTED BY THE WJC EXECUTIVE COMMITTEE, MEETING IN LONDON ON 11 SEPTEMBER 2017

Frá: BILLIE BECKWITH-COHEN [mailto:billie@berkeley.edu]
Sent: 2. febrúar 2018 18:53
Til: Silja Dögg Gunnarsdóttir ; Ólafur Þór Gunnarsson ; Inga Sæland ; Bjarkey Olsen Gunnarsdóttir ; Ólafur Ísleifsson ; Jón Þór Ólafsson ; Guðmundur Ingi Kristinsson ; Líneik Anna Sævarsdóttir ; Björn Leví Gunnarsson ; Ritstjóri vefsins
Efni: Against Circumcision of Children - Israeli Jews support bill 183

Dear Parliament Member,

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls, when it is not medically necessary (99.5% of the cases).

As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israeli's to leave our children intact (not-circumcised). Personally, I chose to not circumcise my son when he was born, as we now know that this is painful- even with local anesthesia, irreversible, medically unnecessary and performed without consent.

The biggest concern that would need to be addressed is how religious individuals cope with this, as we would not wish to have rogue circumcisions that later would not get medical attention if they develop complications.

I hope that the age for consent would not be set as younger than 18, because 13-15 year old boys would be subject to too much pressure from their families.

Thank you for having the courage to protect children and fight for this important bill.

Sincerely,

--

Billie Beckwith-Cohen, DVM, MBA, FAAO

PhD Candidate, Kramer Lab

Department of Vision Science

University of California, Berkeley

Alþingi
Kirkjustræti
150 Reykjavík

Reykjavík, 27.mars 2018

Efni: *Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál.*

Við viljum fá að gefa okkar umsögn um frumvarp um bann við umskurði drengja. Við teljum að frumvarpið sé gallað og byggt á skoðunum fólks frekar en rannsóknum, staðreyndum og reynslu. Við undirritaðar erum íslenskar mæður og höfum allar reynslu af umskurði drengja og okkur finnst mikilvægt að okkar skoðun komist á framfæri. Margir sem hafa verið að tjá sig um umskurð drengja hafa ekki þá reynslu sem að við höfum. Margar mæður eins og við af íslenskum uppruna höfum látið umskera syni okkar bæði hér á Íslandi og erlendis án erfiðleika og það er algjörlega óskiljanlegt að það skuli vera vilji til þess að refsa okkur með 6 ára fangelsisvist. Áhyggjur okkar er að umræðan um umskurð drengja hefur verið stýrð af andúð gegn hefðum minnihlutahópa og staðreyndirnar settar fram í röngu samhengi til að auka neikvæð viðhorf almennings gagnvart þessum hópum. Þessi andúð myndi útskýra af hverju flutningsmenn frumvarpsins sóttust ekki eftir ráðum og/eða upplýsingum hjá trúarleiðtogum og þeim sem málið varðar og þess vegna inniheldur frumvarpið margar rangar "staðreyndir". Hér á eftir lýsum við okkar persónulegu reynslu af umskurði drengja og hvaða galla og rangfærslur við teljum vera í frumvarpinu.

Reynsla Guðrúnar: Sonur minn fæddur árið 2012 var umskorinn hérna á landi um eins árs aldur. Það var gert í stuttri svæfingu og tók ekki lengur en hálskirtlataka. Eftir aðgerð fékk hann staðdeyfikrem og hann var alveg búinn að ná sér eftir viku. Nú á ég annan dreng sem er fæddur árið 2014 en hann hefur ekki verið umskorinn vegna þess að skurðlæknarnir vildu bíða eftir áliti landlæknis, og nú líklega þessa frumvarps. Nú hef ég áhyggjur af því að honum muni finnast hann öðruvísi en stóri bróðir hans og faðir, sem eru einmitt þeir sem hann lítur mest upp til. Ef frumvarpið er samþykkt og umskurður drengja varðar við hegningalög þá er búið að gera alla múslima, gyðinga og fleiri sem velja að umskera syni sína að glæpamönnum. Ég get alls ekki verið sammála því að ég sé glæpamaður vegna þess að ég lét umskera drenginn minn, þar sem ég trúi að þetta sé honum fyrir bestu, ef ég tryði því ekki hefði ég ekki látið umskera hann. Einnig tek ég undir þær áhyggjur sem landlæknir ber fram, að þá sé viss hópur fólks sem færi erlendis og framkvæmdi umskurð þar. Betra held ég að það sé gert hérna undir eftirliti og á sem öruggastan hátt.

Reynsla Birgittu: Ég á tvo drengi sem að eru umskornir. Áður en mínir drengir voru umskornir var ég búin að kynna mér málin í þaula. Þeir voru umskornir undir læknishöndum og hlutu engan skaða af. Þetta er lítið inngrip, og í báðum tilvikum voru þeir innan við viku að jafna sig. Annar var umskorinn í Marokkó, á sjúkrahúsi í svæfingu. Hinn var umskorinn á Barnaspítala Hringsins, einnig í svæfingu. Það sem að mér finnst ekki hafa komið fram í þessari umræðu er hvaða áhrif þetta frumvarp getur haft á þá drengi á Íslandi sem að eru umskornir. T.d. fordóma og einelti? Drengirnir mínir eru á viðkvæmum aldri, í grunnskóla þar sem að börn sýna oft litla miskunn. Þeir fara í skólaíþróttir og

sund, og stunda þar fyrir utan íþróttir fyrir utan skóla, þar sem þeir fara í sturtu með öðrum drengjum. Er það sanngjarnt að þeir þurfi að líða fyrir það að vera umskornir á Íslandi, þar sem á að ríkja trúfrelsi? Það er búið að vera mikil umræða í öllum fjölmiðlum um þetta frumvarp, og börn heyra fullorðna tala um þetta á neikvæðan þátt (í flestum tilfellum), og ég spyr sjálfa mig hvar þetta endar. Við búum í litlu samfélagi og það fer ekkert á milli mála að þetta á eftir að leiða til fordóma í garð bæði gyðinga og múslima. Og eru þeir nú nógu miklir fyrir.

Reynsla Julie: Sonur minn er fæddur á Englandi og fór í umskurð á sérstakri stofu í London þegar hann var innan mánaðar gamall. Hann var deyfður og fann svo lítið fyrir aðgerðinni að hann var ánægður með að sjúga puttann minn og svaf eiginlega allan tímann sem þessi 15 mínútna aðgerð tók. Læknarnir gáfu skýr fyrirmæli um hvernig ætti að sjá um svæðið til að forhúðin dytti af sjálf (Plastibell aðferð var notuð). Með því að fara í 15 mín. saltbað tvisvar á dag og bera vandlega vaselín á liminn eftir það, áður en bleyjan var sett á. Sonur minn varð ekki fyrir neinum skaða og forhúðin datt af eftir 7 daga. Ég hef engar neikvæðar athugasemdir við þetta og kosturinn að láta gera þetta við ungbörn sem eru með litla hreyfigetu, er að húðin grær miklu betur og fyrr, og líka að þeir munu ekki muna neitt eftir þessu. Ég tel að mín reynsla og margra foreldra í mínum sporum vera öll góð því umskurður drengja í Bretlandi er algeng og margar læknisstofur mæta þörfum þeirra sem kjósa þetta fyrir börnin sín. Það er sjálfsagt að það sé fylgst vel með hvernig og hverjir framkvæma aðgerðina en hingað til hefur aldrei verið minnst á það að umskurður drengja (circumcision) sé það sama og limlesting kvenna (female genital mutilation) og það er alveg með ólíkindum að þetta frumvarp skuli bera það tvennt saman. Þess má geta að íslenskir læknar hafa framkvæmd aðgerðina á Íslandi hingað til.

Reynsla Stefaníu: Ég er móðir tveggja drengja sem eru umskornir, þeir voru umskornir í Marokkó með góðum árangri, áður en það var gert var ég búin að eyða mikilli vinnu í það að kynna mér allar hliðar sem kynnu að hafa áhrif á mína ákvörðun varðandi þetta. Þar sem að ég er ekki alin upp við þessa hefð en aftur á móti er maðurinn minn það, þá vildi ég hafa þetta gulltryggt að ég væri ekki að gera eitthvað við drengina mína sem myndi skaða þá. Mér finnst að þingmenn og aðrir sem að þessu máli koma tali einsog þeir hafi meiri velferð fyrir okkar börnum en við sjálfir foreldrarnir. Og að líkja þessu við limlestingar er ekkert nema fáfræði og fordómar. Að tala um að þeir eiga að geta tekið ákvörðun um þetta sjálfir við 18 ára aldur er einnig mjög sérstakt þar sem að foreldrar taka ákvarðanir fyrir börnin sín alveg frá fæðingu um það sem að er þeim fyrir bestu. T.d það að taka úr þeim hálskirtla, bólusetningar, gata eyrun á nýfæddum stelpum því að það er svo sætt! Ekki er deyfing við því. Einsog hvernig umræðan er í dag um þetta þá líður mér eins og fólk sé að dæma mig sem glæpamann og að ég eigi skilið að fara í 6 ára fangelsi fyrir það eitt að ég var að hugsa um velferð drengjanna minna. Þið ættuð að taka það inní umræðuna hjá ykkur að það er líka verið að níðast á fólki sem að hefur nú þegar látið umskera drengina sína.

Frumvarpið er óstyðjanlegt af eftirfarandi ástæðum:

1. Í heildina, eiga þær lýsingar og fullyrðingar sem settar eru fram í frumvarpinu lítið með okkar reynslu og raunveruleika á Íslandi að gera. Í greinargerðinni kemur fram að ekki sé notast við svæfingar eða þetta sé gert með engri eða lítilli deyfingu. Varðandi íslenska reynslu og það sem er algengast annars staðar er þetta rangt. Það er mjög algengt að það séu notaðar staðdeyfingar og svæfingar, og er það gert á Íslandi. Einnig kemur fram í frumvarpinu að það sé algengast að þetta sé gert í kringum tíu ára aldurinn í íslamskri trú. Flestir sem við þekkjum

persónulega og einnig það sem við höfum kynnt okkur í múslimalöndum, er miðað við innan árs frá því að barnið fæðist. Eins og nefnt var ofar eru góð rök fyrir að gera þetta við ungan aldur.

2. Flutningsmenn hafa kosið og skilgreint orðið umskurð fyrir bæði drengi og stúlkur með þeirri meiningu að aðgerðirnar tvær séu sambærilegar, og rökstyða að bann á umskurði kvenna ætti að leiða að banni við umskurði drengja. Með því að nota "umskurð" hér, í staðinn fyrir limlestingu, eins og er notuð á ensku í þessu samhengi (þ.e. mutilation) og sem er réttilega bönnuð, er verið að fela stóran eðlismun á milli þessara aðgerða og þá sérstaklega hvað lífsgæði varðar á heilsu og kynferðislegri getu í framtíðinni. Ástæðan fyrir því að það er ekki réttlátt að bera saman umskurð drengja og limlestingu stúlkna er fyrst og fremst að í raun og veru hafa rannsóknir sýnt að umskornir menn verða ekki fyrir kynferðislegum skaða eða ónæmi, minni getu eða ánægju við að vera umskornir þegar þeir eru bornir saman við óumskorna menn (sjá Morris og Krieger, 2013 sem taka saman niðurstöður 36 rannsókna af þessu tagi í *Journal of Sexual Medicine*). Margar rannsóknir hafa sýnt að umskurður hjá mönnum verji bæði kynin gegn allskonar sjúkdómum og vill Alþjóða Heilbrigðisstofnunin auka umskurð á fullorðnum karlmönnum, t.d. í Afríku því sú aðferð dregur úr hættu á sýkingum, allt að 60% fyrir HIV (sjá Low, Broutet, Sarkodie, Barton, Hossain og Hawkes, 2006 í *Lancet*). Aðrar víðamiklar rannsóknir sýna að umskurður drengja verndar þá gegn mörgum tegunda krabbameina í limi seinna meir, og t.d. hefur Ísrael lægstu slíka tíðni í heiminum (Douglawi og Masterson, 2017 í *Transl Androl Urol*). Konur eru líka ólíklegri að fá leghálskrabbamein og HPV sýkingu ef þær eru makar umskorinna manna (Wawer, Tobian, Kigozi et al., 2011 í *Lancet*). Aftur bendum við á að aðferð framkvæmd löglega undir læknishöndum, sem felur í sér miklu vægari, skammtíma aukaverkanir þegar hún er framkvæmd við ungan aldur vegur meira en mun erfiðari reynsla umskurðs við tánings/fullorðinsaldur. Bandaríska Barnalæknafélagið (American Academy of Pediatrics) og Samband Bandaríska kvensjúkdóma- og fæðingalækna (American College of Obstetricians and Gynecologists) styðja aðgerð á smábörnum því þessir drengir þjást miklu minna af þvagsýkingum heldur en óumskornir drengir, en þessar sýkingar koma oftast upp á fyrsta aldursárinu. Þessar sýkingar valda miklum sársauka, og oftast þarf þá inngrip með lyfjum og fleiru, sem hægt væri að komast framhjá með einfaldri aðgerð með minniháttar aukaverkunum.

3. Það er litið svo á að verið sé að verja rétt barnanna. Í fyrsta lagi, þekkjum við ekki neinn sem kaus umskurð til að refsa, pína eða skaða drengi sína. Ætlunin er ekki að skaða og tilhugsunin er ólíðandi. Við berum fulla virðingu fyrir Barnasáttmála Sameinuðu þjóðanna en umræðan á ekki að koma frá þeim sem hafa ekki reynslu umskurði, heldur ætti það að koma frá þeim sem hafa fundist brotið á réttindum sínum og lífsgæðum (eins og umræðan um limlestinu stúlkna og kvenna) og þá á Íslandi, af foreldrum sem kusu þetta með hag barnanna í fyrirrúmi. Það ætti ekki að skipta máli hvort þetta val var tekið til þess að barninu finnist það vera fyllilega partur af sínum trúarlegu eða menningarlegum uppruna **(sem er réttur verndaður af Barnasáttmálanum)** eða af læknisfræðilegum ástæðum. 14. grein í sáttmálanum segir: "*The Convention respects the rights and duties of parents in providing religious and moral guidance to their children. Religious groups around the world have expressed support for the Convention, which indicates that it in no way prevents parents from bringing their children up within a religious tradition. At the same time, the Convention recognizes that as children mature and are able to form their own views, some may question certain religious practices*

or cultural traditions" (https://www.unicef.org/crc/files/Participation.pdf). Öll greinin hér er mikilvæg, því sem foreldrar, höfum við öll rétt á að ala börnin okkar upp samkvæmt okkar hefðum en berum virðingu fyrir þeirra vali, þegar þeir ná þroska til þess. Við einfaldlega teljum umskurð vera partur af þessum ákvörðunum sem okkur ber að taka.

Til að koma á jafnvægi, þurfum við að líta fram hjá trúarlegum hefðum, og rökin sem styðja frumvarpið á þeim forsendum að aðferðin sé ekki "til gagns heilsufarslega séð" og þannig óþarfi. Við bendum á að samkvæmt Bandarísku Læknasambandinu hefur nú verið ýtt undir nýja reglugerð um að læknar eigi að bjóða nýjum foreldrum að láta umskera drengi. Í nýjustu reglugerð þeirra um umskurð drengja frá 2012: "*Although health benefits are not great enough to recommend routine circumcision for all male newborns, the benefits of circumcision are sufficient to justify access to this procedure for families choosing it and to warrant third-party payment for circumcision of male newborns. It is important that clinicians routinely inform parents of the health benefits and risks of male newborn circumcision in an unbiased and accurate manner.*" (American Academy of Pediatrics, Task Force on Circumcision. Circumcision policy statement.*Pediatrics*.2012;http://pediatrics.aappublications.org/cgi/doi/10.1542/peds.2012-1989).

Við viljum líka vitna í aðra samantekt sem útskýrir í miklum smáatriðum niðurstöður Bandarísku læknasambandsins (Morris, Krieger og Klausner, 2017 í *Global health Science and Practice*) og sérstaklega þessi rök í síðustu málsgrein þeirra:

> "*Convincing arguments have been made that it would be unethical to withhold information about the risks and benefits of MC from parents of boys.130–132,134,135 as recommended by the AAP and CDC. Curiously, those who condemn parent-approved infant MC are not as quick to condemn procedures that provide no medical benefit to children (e.g., cosmetic orthodontia, correction of harelip, surgery for tongue-tie, treatment of dwarfism by growth hormone injections, and surgery for removal of supernumerary digits).135 Why then do some regard MC as controversial?135 Article 24(1) of the United Nations Convention on the Rights of the Child states, "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health" and "shall strive to ensure that no child is deprived of his or her right of access to health care services."136Therefore, we assert that the CDC's draft MC recommendations do nothing more than advocate appropriately the right of male infants, children, adolescents, and adults to access health care services with medical benefits—that is, MC—and that adoption of the draft CDC recommendations into formal policy should improve public health in the United States.*"

4. Slík lagabreyting ýtir undir fordóma á drengjum sem eru nú þegar umskornir, því refsing á umskurði kallar fram ólögmæti aðgerðarinnar sem myndi vekja neikvæð viðhorf af öðrum. Umræðan í kringum frumvarpið hefur nú þegar varpað neikvæðu ljósi á umskorna drengi á Íslandi, sem og orðstír okkar sem frjálslynt samfélag út fyrir landsteinanna. Skaðað ímynd minnihlutahópa og ýtt undir fordóma innanlands.

5. Þingmenn hafa ekki sótt álit trúarleiðtoga eða minnihlutahópa sem þetta snertir sem sýnir andúð gagnvart hefðum okkar, og virðingarleysi gagnvart okkar þörfum sem partur af íslensku samfélagi.

6. Aðgerðin sjálf er aðeins gerð í tuga tali og varla ástæða að koma í lög nema það sé af sama mæli og aðrar læknisfræðilegar aðgerðir.. Við teljum fyrst og fremst að aðgerðin eigi að fara fram undir læknisfræðilegu eftirliti til að vernda heilsu barnanna. En á sama tíma erum við **algjörlega á móti að refsa eða/og fordæma foreldra og þá sem eru umskornir**.

Til stuðnings okkar máli viljum við benda á eftirfarandi greinar:
Morris, Krieger og Klausner (2017) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478224/#b42
Freeman, (1999)https://onlinelibrary.wiley.com/doi/pdf/10.1046/j.1464-410x.1999.0830s1074.x
Grein eftir Ian Watson í Kjarnanum:
https://kjarninn.is/skodun/2018-03-12-umskurdur-drengja-skodanir-og-stadreyndir/

Við Íslenskar mæður, teljum að það sé okkur í hag að Alþingi beri virðingu gagnvart öllum minnihlutahópum sem slík frumvörp beinast að. Við erum mjög vonsviknar að ekki hafi talist mikilvægt að sækjast eftir okkar áliti né barna okkar, eða þeirra karlmanna sem eru umskornir á Íslandi áður en frumvarpið var lagt fram. Við erum ekki ósýnileg og raddlaus, og ölum okkar börn með það viðhorf að þau og við séum fyllilega íslensk þótt við fylgjum að nokkru leyti öðrum hefðum en meirihlutinn. Að gera greinamun í lögum á milli okkar og meirihlutans er rangt. Það mikilvægasta er að við, sem heild, vinnum SAMAN, tölum SAMAN og eigum betri samskipti um hvernig við ætlum öll að bæta okkar samfélag í dag og í framtíðinni.

Virðingarfyllst,

Julie Sigurðardóttir
Guðrún Lára Aðalsteinsdóttir
Stefanía Ingólfsdóttir
Birgitta Kara Árnadóttir
Þorgerður Sigurðardóttir
Ásdís Pétursdóttir

Nefndasvið Alþingis, nefndasvid@althingi.is
Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)
Þingskjal: 183-114. mál
Sendandi: Biskup Íslands
Dagsetning: 17. 2. 2018

Í framkomnu frumvarpi til laga um breytingu á almennum hegningarlögum nr. 19/1940 um bann við umskurði drengja, þingskjal 183 – 114. mál, er snert á máli sem hefur marga fleti.

Tillagan hefur það að markmiði að stuðla að vernd gegn líkamsárás sem veldur tjóni á líkama eða heilsu barna eða kvenna.

Undir það markmið skal tekið og ber samfélaginu öllu að vinna að þess háttar markmiðum með öllum tiltækum ráðum.

Í greinargerðinni sem fylgir frumvarpinu er vísað til þess að Ísland hafi verið ein þeirra þjóða sem lögðu til ályktun um bann við limlestingum á kynfærum kvenna sem samþykkt var á allsherjarþingi Sameinuðu þjóðanna árið 2012. Biskup Íslands er stolt af þátttöku Íslands í þeirri baráttu og fagnar þeim árangri sem þar hefur náðst.

Umskurn drengja er víða um heiminn algeng aðgerð. Þjóðkirkjan hefur ekki sérstaklega rætt um hana á sínum vettvangi enda tíðkast slíkar aðgerðir almennt ekki meðal kristinna manna.

Biskup og þjóðkirkjan bera almennt virðingu fyrir siðum og venjum annarra trú- og lífsskoðunarfélaga. Hins vegar er það skoðun biskups Íslands að sjálfsagt sé að hlusta á bæði rök og reynslu þeirra sem þekkja til og fá fram umræðu um málið.

Biskup telur þó varasamt að frumkvæði að þeirri umræðu sé í formi frumvarps til breytinga á hegningarlögum þar sem lagt er til að viðurlög við umskurði drengja verði allt að sex ára fangelsi.

Greinargerð:

Í tillögunni mætast tvö ólík mannréttindasjónarmið. Annars vegar óafturkræft inngrip í líkama barna (drengja) og hins vegar réttur barna til að fá að alast upp við trúarlegar og menningarlegar grundvallarhefðir foreldra sinna og alls síns fólks, sem getur mótað sjálfsmynd þeirra.

Um leið og því er fagnað að Ísland hafi verið ein þeirra þjóða sem lögðu til ályktun um bann við limlestingum á kynfærum kvenna sem samþykkt var á allsherjarþingi Sameinuðu þjóðanna árið 2012, er mikilvægt að Alþingi og samfélaginu öllu beri gæfa til að veita umræðu um þetta viðkvæma mál í þann farveg að svigrúm sé til hlustunar á sjónarmið ólíkra menningarheima. Dregið skal í efa að frumvarpið feli í sér að vera slíkur farsæll farvegur upplýstrar umræðu.

Hættan sem blasir við verði frumvarpið að lögum, er sú að Gyðingdómur og Islam verði gerð að glæpsamlegum trúarbrögðum og að einstaklingar sem aðhyllast þau verði bannaðir hér á landi eða óvelkomnir. Allar slíkar öfgar skulum við forðast.

Bann við umskurn án öruggra aðstæðna mætti líka ræða og hvort hægt væri að tryggja þá heilbrigðisþjónustu í íslensku heilbrigðiskerfi sem mætir þörfum hinna ólíku trúar- og menningarheima.

Virðingarfyllst,

Agnes M. Sigurðardóttir,

biskup Íslands.

Athugasemdir við frumvarp gegn umskurn sveinbarna

Reykjavík, 27. mars 2018

Efni: Umsögn um frumvarp til laga um breytingar á almennum hegningarlögum nr. 19/1940, mál 183-114 (bann við umskurn drengja).

Ég hef séð lögmenn halda því fram undanfarið að lagatexti frumvarpsins leggi ekki bann við raunverulegri umskurn drengja því að aðeins sé talað þar um „líkamsárás" sem valdi „tjóni á líkama eða heilsu barns eða konu með því að fjarlægja kynfæri að hluta eða öllu leyti". Þar sem umskurn drengja sé ekki líkamsárás leggi lagatextinn ekki bann við slíkri aðgerð.[1] Af greinargerð frumvarpsins er engu að síður ljóst að tilgangurinn með því er að leggja bann við umskurn drengja og gera slíka aðgerð refsiverða með allt að sex ára fangelsi nema því aðeins að hún „sé talin nauðsynleg af heilsufarslegum ástæðum". Ég mun því miða athugasemdir mínar við markmið frumvarpsins eins og því er lýst í greinargerð þess en tek ekki afstöðu til þess hvort sjálfur lagatexti frumvarpsins hafi fyllilega náð að fanga það markmið í núverandi mynd sinni. Ennfremur kýs ég að nota hugtakið „umskurn" í stað hugtaksins „umskurður" en í íslensku biblíuþýðingunum frá 1841, 1981 og 2007 er eingöngu talað um „umskurn". Í Guðbrandsbiblíu frá 1584 er jafnframt oftast talað um „umskurn" en á stöku stað er hugtakið „umskurður" einnig notað þar.

Ég aðhyllist ekki umskurn, hef engan áhuga á að sækjast eftir slíku og myndi aldrei láta umskera sveinbarn nema því aðeins að læknar myndu telja slíkt óhjákvæmilegt barnsins vegna. Best væri ef enginn þyrfti á umskurn að halda. En ég tel óhjákvæmilegt að skoða allar hliðar þessa máls, þau mismunandi mannréttindasjónarmið sem tekist er á um, hvernig Barnasáttmáli Sameinuðu þjóðanna er túlkaður með mismunandi hætti, sjónarmið þeirra fjölmörgu lækna og alþjóðastofnana sem umbera eða styðja umskurn, vægi umskurnar fyrir stóran hluta mannkyns og innan trúarlegra minnihlutahópa hér á landi og hvaða afleiðingar það hefði ef umskurn sveinbarna yrði gerð að sakamáli sem kostað getur fólk margra ára fangelsi.

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[1] Einar Gautur Steingrímsson hrl. skrifar á *Facebook* vegg sinn 22. mars 2018: „Verður umskurður refsiverður ef "umskurðarfrumvarpið" verður samþykkt? Svarið er nei. Í frumvarpinu, að breyttum lagatexta, er hvergi minnst á umskurð. Aðeins talað um líkamsárás. Umskurður drengja hefur ekki verið felldur undir það hugtak hingað til. Frumvarpið gerir það ekki heldur. Umskurður verður því refsilaus eftir samþykkt þess eins og verið hefur hingað til. Ekki stoðar að vísa til ætlunar löggjafans því stjórnarskráin og mannréttindasáttmáli Evrópu stemma stigu við að mönnum verði refsað fyrir annað en leiða megi af sjálfum lagatextanum. Í því sambandi þarf reglan, m.v. lagatextann sjálfan, vera gegnsæ og fyrirsjáanlegt hvernig honum verði beitt. Ef umskurður drengja teldist líkamsárás er hann nú þegar refsiverður og þá þarf ekki lagasetningu. M.ö.o. lagasetning samkvæmt fyrirliggjandi frumvarpi breytir engu um hvort umskurður drengja sé refsiverður eður ei." (Vefur: https://www.facebook.com/einargautur/posts/10216254792911363.) Og Jón Steinar Gunnlaugsson fyrrverandi hæstaréttardómari talar á svipuðum nótum þegar hann segir m.a.: „Það þarf enga lagabreytingu til að banna mönnum að valda börnum líkamsmeiðslum. Ákvæði um þetta eru nú þegar í lögum." („Nú þykir mér tíra!" *Morgunblaðið*. 26. febrúar 2018. Bls. 17.)

Tvö mannréttindasjónarmið sem stangast á

Um eða yfir þriðjungur karlmanna um allan heim er umskorinn og er það ýmist á trúar-, menningar- eða heilbrigðisforsendum. Það eru einkum gyðingar og múslimar sem aðhyllast umskurn á trúarlegum forsendum en innan kristindóms hefur hún í langflestum tilfellum ekkert vægi. Páll postuli sagði umskurn engu skipta fyrir kristna menn enda sé aðalatriðið í samfélaginu við Jesúm Krist „trú sem verkar í kærleika" (Gl 5:6). Hann viðurkenndi hins vegar og virti að umskurn hefði mikið gagn á allan hátt fyrir gyðinga vegna þeirrar merkingar sem í hana væri lögð (Rm 3:1-2). Þegar kristnir menn m.a. í Bandaríkjunum láta umskera er það alfarið að ráði þarlendra lækna eða vegna viðtekinna menningarhefða. Innan íslensku þjóðkirkjunnar eru skiptar skoðanir um frumvarpið en þeir sem helst gagnrýna það telja það fela í sér afar skaðlega aðför að minnihlutahópum og trúarhefð þeirra.

Tekist er á um tvö mannréttindasjónarmið sem stangast á, annars vegar það sjónarmið að börn eigi ekki að þurfa að sæta óafturkræfu inngripi á eigin líkama nema líf þeirra og heilsa sé í hættu og hins vegar það sjónarmið að það sé réttur barna að fá að alast upp við trúarlegar og menningarlegar grundvallarhefðir foreldra sinna sem móta sjálfsmynd þeirra og þess samfélags sem þau tilheyra. Það er því rangt sem haldið hefur verið fram að hér sé alfarið um að ræða árekstur milli sjálfsákvörðunarréttar barns og trúfrelsis foreldra þess því að þetta snýst ekki síður um rétt barnsins til þess samfélags sem það fæðist í og alls þess sem einkennir það.

Þeir sem segja að réttindi hópa verði ávallt að víkja fyrir réttindum einstaklinga óháð aldri þegar þau fari ekki saman þurfa að gæta að því að það getur einmitt talist grundvallarréttur sveinbarna úr röðum gyðinga og múslima að vera umskorin strax á áttunda degi eða því sem næst í ljósi þess vægis sem umskurn hefur fyrir sjálfsmynd þeirra og stöðu innan samfélags síns fólks. Ef stjórnvöld beita sér gegn þeim rétti barns að það fái að njóta fullrar aðildar að því samfélagi, setja þau sjálfsmynd þess skorður sem eru óafturkræfar á æskuárunum. Slíkt gæti skaðað viðkomandi börn.

Hér ber að spyrja hversu alvarlegt inngrip umskurn sé á líkama drengja. Ekki eru allar trúarlegar eða menningarlegar hefðir af hinu góða og ýmsar þeirra geta stórskaðað viðkomandi börn til lífstíðar eins og sá siður að reyra fætur stúlkubarna í Kína fyrr á tímum. Athygli vekur að heilbrigðisyfirvöld og læknasamtök víða um heim sjá ýmist ekkert athugavert við umskurn drengja eða hreinlega styðja hana. Sömuleiðis hafa komið fram íslenskir læknar sem andmælt hafa frumvarpinu á ýmsum forsendum og er þar á meðal Landlæknisembættið.[2] Flutningsmenn frumvarpsins telja ennfremur umskurn drengja ekki alvarlegri en svo að þeir mæla með því að þeir „drengir sem vilja láta umskera sig af trúarlegum eða menningarlegum ástæðum taki ákvörðun um slíkt þegar þeir hafa sjálfir náð aldri og þroska til þess að skilja hvað felst í slíkri aðgerð".

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[2] Sjá t.d.: Birgir Jakobsson: *Umsögn Embættis landlæknis um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál*. 13. mars 2018. Vefur: http://www.althingi.is/altext/erindi/148/148-663.pdf.; Guðmundur Pálsson: *Umsögn um breytingu á almennum hegningarlögum nr. 19/1940, þingskjal 183- 114. mál (umskurn drengja).* 28. febrúar 2018. Vefur: http://www.althingi.is/altext/erindi/148/148-424.pdf.; Kári Stefánsson: „Leyfið foreldrunum – Opið bréf til Alþingis Íslendinga." *Fréttablaðið*. 22. febrúar 2018. Bls. 18.; Óttar Guðmundsson: „Judenfrei." *Fréttablaðið*. 17. febrúar 2018. Bls. 72.; Páll Torfi Önundarson: *Facebook*. 23. febrúar 2018. Vefur: https://www.facebook.com/pall.onundarson/posts/10204419436082402.

Stuðningsmenn frumvarpsins úr röðum almennings hafa margir uppi stór orð um alvarleika umskurnar sveinbarna og tala þar m.a. um limlestingar, pyntingar og barnaníð. Grundvallarmunur er þó á umskurn drengja þar sem aðeins forhúðin er skorin burt að hluta eða í heild og limlestingum á kynfærum stúlkna. Vissulega er ágreiningur meðal lækna um alvarleika umskurnar sveinbarna en þeir læknar eru samt fjölmargir víða um heim sem halda því fram að hún sé ekki skaðleg eða í það minnsta ekki skaðlegri en aðrar læknisaðgerðir.

Þá ber að gæta þess að svo framarlega sem lífi og heilsu barna sé ekki stefnt í hættu hafa foreldrar ríkan rétt til að neita börnum sínum um læknismeðferð sem heilbrigðisstarfsfólk telur að sé þeim fyrir bestu. Um þetta segir í áliti umboðsmanns barna frá janúar 2014 í tengslum við erindi þar sem óskað var „eftir áliti embættisins á því hvernig best sé að fagfólk á heilbrigðissviði bregðist við þegar foreldrar ákveða að börn þeirra sem eru heyrnarlaus eða verulega heyrnarskert fái ekki kuðungsígræðslu“:

> Samkvæmt íslenskum lögum þurfa foreldrar að samþykkja læknismeðferðir á börnum sínum, sbr. 1. mgr. 26. gr. laga um réttindi sjúklinga nr. 74/1997. Ef foreldrar neita að samþykkja kuðungsígræðslu á barni er hlutverk heilbrigðisstarfsfólks fyrst og fremst að veita foreldrum viðeigandi fræðslu. Ef heilbrigðisstarfsfólk telur að foreldrar séu ekki að taka ákvarðanir í samræmi við bestu hagsmuni barnsins er hægt að leita til barnaverndar.[3]

Fyrst foreldrar hafa rétt til að synja ungum börnum sínum um slíka læknismeðferð þrátt fyrir að slíkt gæti mögulega átt eftir að veita þeim heyrn og gert þeim kleift að læra talmál má spyrja hvort þeir hafi ekki sömuleiðis rétt til að fara fram á læknismeðferð í formi umskurnar sem tíðkuð er um stóran hluta heimsins á trúar-, menningar- eða heilbrigðisforsendum og er viðurkennd sem nauðsynleg a.m.k. undir vissum kringumstæðum af þorra lækna m.a. hér á landi. Þessi niðurstaða umboðsmanns barna sýnir að ákvörðunarréttur foreldra geti haft meira vægi en læknisfræðilegt álit þegar líf barna og heilsa þeirra er ekki að veði.

Barnasáttmáli Sameinuðu þjóðanna

Í greinargerð frumvarpsins er það gert að meginatriði að umskurn sveinbarna sé brot á barnasáttmála Sameinuðu þjóðanna[4] sem hafi verið lögfestur hér á landi 2013 og því beri að dæma þá sem gerast sekir um slíkt í allt að sex ára fangelsi. Því er haldið fram að umskurn sé „brot gegn 3. mgr. 24. gr. sáttmálans sem tryggir börnum vernd gegn hefðum sem eru skaðlegar heilbrigði barna“ og samrýmist að auki illa 12. gr. sáttmálans „sem fjallar um rétt barna til þess að hafa áhrif á eigið líf“.

Texti greinargerðarinnar er að stórum hluta sóttur orðréttur til álits umboðsmanns barna á Íslandi frá 2013 sem birt var þegar umboðsmenn barna á Norðurlöndunum og nokkrir heilbrigðisstarfsmenn sendu frá sér sameiginlega yfirlýsingu þess efnis að umskurn sveinbarna sé brot á barnasáttmálanum og ekki

[3] Margrét María Sigurðardóttir: „Kuðungsígræðsla.“ *Umboðsmaður barna*. 13. janúar 2014. Vefur: https://barn.is/frettir/2014/01/kudungsigraedsla/.
[4] „Barnasáttmálinn – heildar texti.“ *Barnasáttmáli Sameinuðu þjóðanna.* [Án árs.] Vefur: http://www.barnasattmali.is/barnasattmalinn/barnasattmalinnheildartexti.html.

beri að veita neinum hana fyrr en viðkomandi einstaklingar hafi „sjálfir náð aldri og þroska til þess að skilja hvað felst í slíkri aðgerð".[5]

Þessi túlkun á barnasáttmálanum verður að teljast óvenjuleg og í ósamræmi við viðteknar túlkanir á honum.[6] Hvergi er minnst þar á umskurn sveinbarna og ekkert er það heldur í honum sem andmælir henni berum orðum. Aðeins með því að djöfulgera umskurn sveinbarna með því orðfæri sem notað er í greinargerð frumvarpsins er hægt að segja að um brot sé að ræða en í því er fullyrt að umskurn sveinbarna sé líkamsárás, limlesting og ofbeldi og því haldið fram að hún sé skaðleg, grimmúðleg og niðurlægjandi refsing sem fari gegn mannlegri reisn og líkamlegum heilindum.

Þessi málflutningur er algjörlega á skjön við sjónarmið fjölda lækna víða um heim og er hvergi gengið út frá honum í landslögum nokkurs lands. Vægi umskurnar sveinbarna á trúarlegum, félagslegum og heilbrigðislegum forsendum er slíkt í stórum hluta heimsins að barnasáttmálinn hefði aldrei verið samþykktur á vettvangi Sameinuðu þjóðanna ef hann hefði verið túlkaður sem andstæður henni. Meðal þeirra sem staðfest hafa barnasáttmálann eru Ísrael og nánast öll ríki múslima og hafa Bandaríkin undirritað hann. Ennfremur er ljóst að Sameinuðu þjóðirnar líta ekki svo á að umskurn sveinbarna sé brot á barnasáttmálanum í ljósi þess að Alþjóðaheilbrigðismálastofnun Sameinuðu þjóðanna setur hana sjálf á oddinn sem forvörn sem dragi úr líkum á ýmis konar sýkingum og sjúkdómum.[7]

Því hefur ennfremur verið haldið fram í ýmsum ritrýndum fagtímaritum að umskurn sveinbarna sé í samræmi við barnasáttmálann og megi jafnvel meta synjun á umskurn sem brot á honum. Athygli vekur að þar er vísað til sömu greinar sáttmálans (3. mgr. 24. gr.) sem umboðsmenn barna á Norðurlöndunum og frumvarpið fullyrða að sé brotið á. Allan J. Jacobs prófessor við Stony Brook læknisfræðiháskólann í Bandaríkjunum segir í grein í ritrýnda fagtímaritinu *IMAJ* (2013) að þar sem umskurn sveinbarna sé ekki skaðlegri heilsu þeirra en margar aðrar aðgerðir og áhrif hennar séu í heild jákvæð fyrir heilsu þeirra sé ekki um brot að ræða á þessari grein sáttmálans og í þeim tilfellum sem umskurn sé í þágu viðkomandi sveinbarna verði synjun á henni að teljast brot á honum. Hann bendir jafnframt á að samkvæmt 30. gr. barnasáttmálans sé það brot að meina barni úr trúarlegum minnihlutahópi um að njóta þeirrar menningar sem einkennir hann m.a. í þjóðháttum. Hann segir:

> Monist critics characterize religion as strictly an adult choice [...]. Religious people and pluralists are likely to regard children as belonging to the religion of their families. The United Nations Convention on the Rights of the Child Article 30 implicitly agrees with the pluralist point of view. So does ordinary practice. Religious families provide a religious environment and education for their children, who generally identify with the religion in which they are being raised. Even religions that officially require mature consent for membership implicitly regard members' children as being part of their religious community. [...] But Art. 24 § 3 does not in fact call for

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[5] „Umskurður brýtur gegn réttindum ungra drengja." *Umboðsmaður barna.* 1. október 2013. Vefur: https://barn.is/frettir/2013/10/umskurdur-brytur-gegn-rettindum-ungra-drengja/.

[6] Sigurvin Lárus Jónsson: „Bann við umskurði drengja." *Fréttablaðið*. 26. febrúar 2018. Vefur: https://www.frettabladid.is/skodun/bann-vi-umskuri-drengja.

[7] *Neonatal and Male Circumcision: A Global Review.* UNAIDS. Geneva. 2010. Vefur: http://www.who.int/hiv/pub/malecircumcision/neonatal_child_MC_UNAIDS.pdf.; *A Framework for Voluntary Medical Male Circumcision: Effective HIV Prevention and a Gateway to Improved Adolescent Boys' & Men's Health in Eastern and Southern Africa by 2021.* World Health Organization. Geneva. 2016. Vefur: http://www.who.int/hiv/pub/malecircumcision/vmmc-policy-2016/en/.; „Male circumcision for HIV prevention: publications." *World Health Organization.* 2018. Vefur: http://www.who.int/hiv/pub/malecircumcision/en/.

> abolishing infant circumcision. First, its language does not do so. The net health effects of infant circumcision are positive, at least according to the AAP and the WHO. If infant circumcision is not prejudicial to the health of children, it does not violate Art. 24, § 3. Second, Art. 24, § 3 never was intended to eliminate circumcision. Almost all Islamic states have signed or ratified UNCRC, as has Israel. They never would have agreed to the abolition of an essential practice of their established religions. In fact, one can construe Art. 24, § 3 to require infant circumcision. The Article seeks to abolish "traditional practices prejudicial to the health of children." If circumcision of minors is traditional in Turkey and Israel, abstention from infant circumcision is traditional in the UK and Scandinavia. The latter tradition is conducive to transmission of various serious illnesses, including HIV, among sexually active minors.[8]

Michael Freeman prófessor við lagadeild UCL háskólans í London í Bretlandi vísar sömuleiðis í barnasáttmálann máli sínu til stuðnings þegar hann segir í hinu ritrýnda tímariti *BJU International* (1999):

> This article [...] constructs a male child's rights to a ritual circumcision, using international instruments, primarily the United Nations Convention on the Rights of the Child. [...] To deny a Jewish or Muslim child a circumcision is to undermine that child's right to cultural heritage and identity. That there is necessarily an interference with bodily integrity does not mean that the child's right to bodily integrity is thereby infringed. Parents are only doing to their children what the overwhelming preponderance of them would wish done were they able to express a view. The ritual removal of a child's foreskin enhances that child's bodily integrity.[9]

Prófessorarnir Brian J. Morris við Háskólann í Sidney í Ástralíu, John N. Krieger við Washington háskóla í Bandaríkjunum og Jeffrey D. Klausner við Háskóla Kaliforníu í Bandaríkjunum vísa til þessarar sömu greinar barnasáttmálans þegar þeir gera grein fyrir læknisfræðilegu og siðfræðilegu vægi umskurnar í grein sinni í ritrýnda fagtímaritinu *World Journal of Clinical Pediatrics* (2016) en þar vitna ég fyrst í *abstract* hluta greinarinnar og síðan í megintexta hennar:

> An argument that circumcision should be delayed to allow a boy to make up his own mind as an adult fails to appreciate the psychological, scheduling and financial burdens later circumcision entails, so reducing the likelihood that it will occur. In contrast, early infant circumcision is convenient, safer, quicker, lower risk, healing is faster, cosmetic outcome is routinely good and the lifetime benefits accrue immediately. Benefits include reduction in urinary tract infections, inflammatory skin conditions, foreskin problems, and, when older, substantial protection against sexually transmitted infections and genital cancers in the male and his female sexual partners. Some authorities regard the failure to offer parents early infant circumcision as unethical, just as it would be unethical to fail to encourage the vaccination of children. In conclusion, the criticisms of evidence-based infant male circumcision policy are seriously flawed and should be dismissed as unhelpful to evidence-based development and implementation of pediatric policy intended to improve public health and individual wellbeing. [...] Scholarly assessments suggest circumcision of male minors is ethical [...]. Given the wide-ranging protection against multiple medical conditions and infections, including STIs in boys who

[8] Jacobs, Allan J.: „The Ethics of Circumcision of Male Infants." *IMAJ*. Janúar 2013. Bls. 60-65. Vefur: https://www.ima.org.il/MedicineIMAJ/viewarticle.aspx?year=2013&month=01&page=60.
[9] Freeman, M.D.A.: „A child's right to circumcision." *BJU International*. 1999. Bls. 74-78. Vefur: https://onlinelibrary.wiley.com/doi/pdf/10.1046/j.1464-410x.1999.0830s1074.x.

> become sexually active early, it has been argued that it would be unethical to leave boys uncircumcised [...]. Article 24(3) of the United National Convention on the Rights of the Child has been construed as mandating circumcision, since not circumcising boys should be deemed as prejudicial to their health [...].[10]

Sömu prófessorar vísa síðan áfram í barnsáttmálann máli sínu til stuðnings um vægi umskurnar í annarri grein í ritrýnda fagtímaritinu *Global Health: Science and Practice* (2017):

> Curiously, those who condemn parent approved infant MC are not as quick to condemn procedures that provide no medical benefit to children (e.g., cosmetic orthodontia, correction of harelip, surgery for tongue-tie, treatment of dwarfism by growth hormone injections, and surgery for removal of supernumerary digits). Why then do some regard MC as controversial? Article 24(1) of the United Nations Convention on the Rights of the Child states, "States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health" and "shall strive to ensure that no child is deprived of his or her right of access to health care services." Therefore, we assert that the CDC's draft MC recommendations do nothing more than advocate appropriately the right of male infants, children, adolescents, and adults to access health care services with medical benefits—that is, MC [...][11]

Eins og áður segir lítur frumvarpið umskurn ekki alvarlegri augum en svo að það mælir með að sjálfráða einstaklingar eigi rétt á henni á m.a. trúarlegum forsendum og að læknar eigi að hafa heimild til að umskera sveinbörn sem þurfi á því að halda á læknisfræðilegum forsendum. Það segir sig sjálft að umskurn sveinbarna getur ekki talist limlesting í ljósi slíkra aðstæðna og er slíkt orðfæri því lítilsvirðing gagnvart þeim sem þurfa á henni að halda. Ef umskurn sveinbarna er limlesting er sú umskurn sem læknar framkvæma á læknisfræðilegum forsendum ekkert annað en limlesting.

Ennfremur vekur athygli að í greingerð frumvarpsins er það viðurkennt að umskurn sveinbarna sé ekki brot á 12. gr. barnasáttmálans sem fjallar um rétt barna til þess að hafa áhrif á eigið líf því að höfundar þess kjósa að orða það einungis svo að umskurn samræmist greininni illa. Svo lengi sem umskurn skaðar ekki sveinbörn, hún er flokkuð sem læknisfræðilega nauðsynleg undir vissum kringumstæðum og er órjúfanlegur hluti sjálfmyndar þess samfélags sem þau fæðast inn í er ekki um brot við þessa grein sáttmálans að ræða.

Loks segir það sig sjálft að það er ekki eining um það meðal lækna á alþjóðavettvangi hvort umskurn sveinbarna gangi gegn læknaeiðinum, Genfaryfirlýsingu lækna eða Helsinkiyfirlýsingu lækna um sjálfsákvörðun og upplýst samþykki í læknisfræðilegum rannsóknum. Þeir læknar sem styðja umskurn sveinbarna gera það vegna þess að þeir telja að hún sé þeim fyrir bestu, í þágu heilsu þeirra og í samræmi við læknaskyldur þeirra.

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[10] Morris, Brian J., John N. Krieger & Jeffrey D. Klausner: „Critical evaluation of unscientific arguments disparaging affirmative infant male circumcision policy." *World Journal of Clinical Pediatrics.* 8. ágúst 2016. Bls. 251-261. Vefur: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978617/.

[11] Morris, Brian J., John N. Krieger & Jeffrey D. Klausner: „CDC's Male Circumcision Recommendations Represent a Key Public Health Measure." *Global Health: Science and Practice*. 24. mars. 2017. Bls. 15-27. Vefur: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5478224/.

Gyðingdómur og íslam

Þótt færa megi rök fyrir því að umskurn drengja geti reynst varasöm ef rangt er að henni staðið ber ekki síður að spyrja hvort lagasetning, sem geri hana refsiverða og þar með gyðingdóm og íslam að glæpsamlegum trúarbrögðum, geti valdið mun meiri skaða.

Umskurn drengja er algjört grundvallaratriði í trúarbrögðum gyðingdóms og forsenda þess að viðkomandi geti talist gyðingur (1M 17).[12] Í gyðinglegu handbókinni *The Jewish Book of WHY* eftir Alfred J. Kolatch segir:

> Circumcision is considered more important than any other commandment. The Rabbis state in the Talmud that circumcision outweighs all other commandments in the Tora; consequently, no deviation from biblical law is permitted.[13]

Þeir sem afneitað hafa umskurn eins og Páll postuli gerði í tilfelli kristinna manna af heiðnum uppruna hafa sagt skilið við gyðingdóm eða endurskilgreint sig á eigin forsendum. Lagasetningin hefði það í för með sér að gyðingar gætu ekki lengur stofnað hér fjölskyldu nema snúa baki við gyðingdómi sem trúarbrögðum.

Í íslam getur óumskorinn karlmaður að vísu strangt til tekið flokkast sem múslimi við ítrustu aðstæður en engu að síður er litið svo á að fylgja beri fordæmi spámannanna sem allir hafi verið umskornir. Ágreiningur er milli helstu sharíaskólanna hvort fullorðnir einstaklingar sem gerast múslimar þurfi sjálfir að umskerast en það er ýmist sagt skylda eða eindregið mælt með því. Innan shía greinar íslams flokkast umskurn sveinbarna sem skylda en ágreiningur er innan helstu sharía skóla sunní greinar íslams hvort um skyldu sé að ræða (Shafi'i og Hanbali) eða fordæmi sem eindregið sé mælt með (Hanafi og Malaki). Rökin fyrir umskurn drengja og þar með karlmanna eru sótt í Hadíðurnar en í tilfelli sunní greinar íslams er hún flokkuð þar sem *fitra*, eitt af grundvallareinkennum múslima (t.d. Bukhari 7:777, 7:779 & 8:312;[14] Muslim 2:16:597-598),[15] og áhersla lögð á böl þeirra karlmanna á efsta degi sem ekki hafi verið umskornir (t.d. Bukhari 6:264 & 8:531-534;[16] Muslim 51:14:7198).[17] Barnfæddir múslimar telja það djúpstæða skömm að hafa ekki verið umskornir annað hvort strax í æsku eða á fyrstu æviárunum. (Það

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[12] Sáttmálshugtakið („berit" á hebresku) er algjört grundvallaratriði í Gamla testamentinu og sjálf þungamiðja helgiritasafns þess að mati fræðimanna. Umskurnin er ekki bara einhver einn helgisiður meðal margra hjá gyðingum heldur sjálft tákn sáttmálans (1M 17) og þar með afgerandi (*par excellence*) tákn þess að tilheyra þjóð Drottins (Jahve) rétt eins og tákn hvíldardagsins. Bæði þessi tákn, umskurnin og hvíldardagurinn, fengu aukið vægi á tímum babýlónsku útlegðarinnar (586-538 f. Kr.) þegar musterinu í Jerúsalem var eytt með því helgihaldi sem þar fór fram og landið Júda var hernumið. Umskurnin, sem í senn er talin náðargjöf og boð, er tákn þeirra fyrirheita sem ættföðurnum Abraham voru gefin. (Zimmerli, Walter: *Old Testament Theology in Outline*. John Knox Press. Atlanta. 1978. Bls. 132.; Eichrodt, Walther: *Theology of the Old Testament*. John Knox Press. Westminster. 1961.) Þessi rit eru talin þau áhrifamestu á 20. öld á sviði gamlatestamentisfræða og eru skrifuð með það að leiðarljósi að sáttmálinn sé samnefnarinn og þungamiðjan fyrir allt hið fjölbreytilega efni sem hið mikla ritsafn Gamla testamentisins hefur að geyma.

[13] Kolatch, Alfred J.: *The Jewish Book of WHY.* Jonathan David Publishers. Middle Village. 1981. Bls. 17.

[14] Al-Bukhari, Muhammad: *The Hadith. Volume 5.* [Án útg.] Lexington. 2017. Bls. 2014-2015 & 2143.

[15] Muslim bin al-Hajjaj, Imam Abul Hussain: *English Translation of Sahih Muslim. Volume 1.* Þýðing: Nasiruddin al-Khattab. Ritstjórn: Huda Khattab. Darussalam. Riyadh. 2007. Bls. 383.

[16] Al-Bukhari, Muhammad: *The Hadith. Volume 4.* [Án útg.] Lexington. 2017. Bls. 1623.; Al-Bukhari, Muhammad: *The Hadith. Volume 5.* [Án útg.] Lexington. 2017. Bls. 2217-2218.

[17] Muslim bin al-Hajjaj, Imam Abul Hussain: *English Translation of Sahih Muslim. Volume 7.* Þýðing: Nasiruddin al-Khattab. Ritstjórn: Huda Khattab. Darussalam. Riyadh. 2007. Bls. 251-252.

er rangt sem segir í frumvarpinu að í íslam sé „algengast að drengir séu umskornir í kringum tíu ára aldurinn" því að þar er þvert á móti talað um að slíkt þurfi að hafa gerst í síðasta lagi þá eða við upphaf kynþroska. Ennfremur er það mismunandi eftir löndum og svæðum hversu fljótt umskurn eigi sér stað hjá börnum múslima en hún getur allt eins átt sér stað um svipað leyti og hjá gyðingum.)[18] Þar sem flestir múslimar telja að hvers kyns sharíaákvæði víki fyrir landslögum myndu margir sækjast eftir umskurn erlendis við misæskilegar aðstæður eða í sumum tilfellum hreinlega flytjast af landi brott ef þeir sjá kost á slíku. Það er helst kóransinnar, sem hafna ritningarlegu gildi Hadíðanna og viðurkenna eingöngu Kóraninn, sem eiga auðveldara með að sniðganga umskurn en þar er um mikinn minnihluta múslima að ræða.[19] Öll trúfélög múslima á Íslandi tilheyra sunní grein íslams og samþykkja Hadíðurnar en einnig má finna hér múslima úr röðum shía.

Foreldrar drengja sem í ljós kemur að hafi verið umskornir hér heima eða erlendis eftir að frumvarpið hefur verið fært í lög geta lent í verulegum vandræðum enda um glæp að ræða sem kallar á aðkomu barnaverndaryfirvalda og lögreglurannsókn. Þessir foreldrar gætu misst börn sín og verið dæmdir í allt að 6 ára fangelsi.

Stuðningsmenn frumvarpsins benda á að til séu ýmis refsiákvæði í trúartextum gyðingdóms og íslams sem séu á skjön við landslög. Þegar betur er að gáð eru slík refsiákvæði háð margvíslegum skilyrðum og flokkast fremur sem heimild til valdhafa eða samfélagsins undir vissum sögulegum kringumstæðum en eru ekkert endilega og jafnvel alls ekki talin eiga við nú á tímum. Þá ber einnig að gæta þess að bókmenntaform helgirita gyðinga eru margvísleg og þeir líta ekki svo á að textar þeirra séu jafngildir eða að leggja beri ávallt bókstaflega merkingu í allt sem þar stendur. Auk þess geyma þessi helgirit mismunandi og jafnvel andstæð sjónarmið um margt í sögu, trú og sjálfskilningi þess fólks sem um ræðir.[20] Sömu sögu er að segja af múslimum en allir viðurkenna þeir að Hadíður geti haft mismunandi vægi og að til séu Hadíður sem jafnvel beri að vísa á bug.[21] Það sem skiptir samt mestu máli hér er að umskurn sveinbarna flokkast hvorki sem refsiákvæði innan gyðingdóms né íslams og er þvert á móti órjúfanlegur þáttur í sjálfsmynd viðkomandi fólks og grundvallaratriði í helgiritum þess.

Ennfremur benda stuðningsmenn frumvarpsins á að Vottar Jehóva hafi ekkert um það að segja hér á landi hvort læknar veiti börnum þeirra blóðgjöf og því beri gyðingum og múslimum að sætta sig við að umskurn sveinbarna á trúarlegum forsendum verði bönnuð. Það heyrir hins vegar til undantekninga að Vottar Jehóva þurfi á blóðgjöf að halda og á síðari árum hefur náin samvinna myndast milli öldunga trúfélags Votta Jehóva og lækna um að finna aðrar leiðir sem krefjist ekki blóðgjafar. Þegar ekki er um slíka valkosti að ræða í tilfelli barna sem eru í lífshættu er ákvörðun um blóðgjöf til barns samt alfarið í höndum lækna.[22] Umskurn er hins vegar grundvallaratriði í gyðingdómi þar sem hún telst forsenda þess að viðkomandi drengir geti flokkast sem gyðingar og er þannig grundvallarþáttur í jákvæðri sjálfsmynd þeirra. Sömuleiðis flokkast umskurn ýmist sem skylda eða því sem næst í íslam og er sem slík mikilvægur

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[18] Maqsood, Ruqaiyyah Waris: *Islam*. Teach Yourself. Abingdon. [1994.] 2006. Bls. 188.

[19] Forvitnilegt dæmi um ágreining milli kóransinna og þá sem samþykkja ritningarlegt vægi Hadíðanna í tengslum við umskurn sveinbarns er að finna hér: Bowen, John R.: *On British Islam. Religion, Law and Everyday Practice in Shari'a-Councils.* Princeton University Press. Princeton. 2016. Bls. 181.

[20] Sjá t.d.: Whitelam, Keith W.: „The Former Prophets." *Creating the Old Testament. The Emergence of the Hebrew Bible.* Ritstjórn: Stephen Bigger. Basil Blackwell. Oxford. 1989. Bls. 151-168.

[21] Brown, Jonathan A.C.: *Misquoting Muhammad. The Challenge and Choices of Interpreting the Prophet's Legacy.* Oneworld Publications. London. [2014.] 2017.

[22] Bjarni Randver Sigurvinsson: „Vottar Jehóva og blóðgjafir." *Orðið*. 1995. Bls. 99-125.

þáttur jákvæðrar sjálfsmyndar þeirra. Blóðgjöf getur reynst nauðsynleg til að bjarga lífi þeirra barna sem á henni þurfa að halda en umskurn er trúarlegt samfélagstákn.

Í ljósi þess vægis sem umskurn sveinbarna hefur í gyðingdómi, íslam og fjölmörgum öðrum þjóðfélögum víða um heim að sjálfum Sameinuðu þjóðunum meðtöldum er ekki að undra að m.a. landlæknir og Félag hjúkrunarfræðinga skuli leggjast gegn því að hún sé gerð að saknæmu athæfi hér á landi sem varði allt að sex ára fangelsi. Ástæða er til að taka undir með landlækni að löggjafinn eigi fremur að taka mið af þeim ströngu reglum sem settar hafa verið um umskurn sveinbarna í Svíþjóð.

Niðurstaða

Ég mæli eindregið með því að alþingismenn taki mark á umsögn landlæknis við frumvarpið og fari að ráðum hans þegar hann mælir gegn því að umskurn sveinbarna verði gerð refsiverð hér á landi og hvetur þess í stað til þess að settar verði strangar reglur um tilhögun og framkvæmd umskurnar með hliðsjón af þeim lögum sem gilda um slíkt í Svíþjóð. Það er eðlilegt og nauðsynlegt að sett séu lög þess efnis að aðeins læknar megi framkvæma umskurn og að sjálfsögðu á ekki að framkvæma slíka aðgerð nema forsjáraðilar séu báðir eða allir henni samþykkir.

Sömuleiðis tek ég undir með Félagi íslenskra hjúkrunarfræðinga að í stað þess að setja bann við umskurn drengja sem viðbót inn í núverandi hegningarlög þurfi að skoða betur með hvaða öðrum leiðum sé hægt að vernda sjálfsákvörðunarrétt barna um eigin líkama. Farsæl leið í þeim efnum er upplýst samræða lækna við trúarlega minnihlutahópa gyðinga og múslima hér á landi sem og alla aðra sem aðhyllast mikilvægi umskurnar um þær afleiðingar og þá fylgikvilla sem mögulega geti fylgt aðgerð á kynfærum drengja. Undir þetta tiltekna atriði get ég tekið í umsögn Læknafélags Íslands um frumvarpið og styð jafnframt að það verði útbúið „fræðsluefni fyrir verðandi foreldra um réttindi bama skv. íslenskum lögum og alþjóðasamþykktum sem íslensk stjómvöld hafa undirgengist að framfylgja" eins og segir þar. Slíkt fræðsluefni ætti þó ekki að vera bundið við umskurn sveinbarna heldur ná til sem allra flestra álitamála sem varða líkama og heilsu barna með hliðsjón af því félagsmenningarlega samhengi sem þau tilheyra.

Ég sé hins vegar ekki að umskurn sveinbarna geti talist brot á barnasáttmála Sameinuðu þjóðanna og tel að Alþingi verði að gæta að því mannréttindasjónarmiði að börn fái að njóta þeirra grundvallareinkenna sem móta jákvæða sjálfsmynd þess fólks sem þau tilheyra og þess samfélags sem þau fæðast inn í. Umskurn sveinbarna getur ekki talist limlesting, líkamsárás, refsing eða annað slíkt og það er ekki hægt að horfa framhjá þeirri staðreynd að fjöldi lækna víða um heim og alþjóðastofnanir á borð við sjálfa Alþjóðaheilbrigðismálastofnun Sameinuðu þjóðanna styðja hana.

Verði það fest í lög hér á landi að umskurn sveinbarna sé glæpur sem varði margra ára fangelsi kemst Ísland á blað sótsvartrar sögu Evrópu í málefnum gyðinga sem fyrsta land álfunnar frá síðari heimsstyrjöld sem nær því marki með sérstakri löggjöf að verða *Judenfrei* í tilfelli þeirra gyðinga sem taka trúarbrögð sín alvarlega. Ennfremur yrði löggjöfin niðurlægjandi fyrir þá landsmenn sem þurft hafa á umskurn að halda að læknisráði og alla aðra sem hingað koma frá löndum og menningarsvæðum þar sem umskurn sveinbarna þykir sjálfsögð. Með frumvarpinu eru allir þeir drengir og allir þeir karlmenn sem umskornir hafa verið víðsvegar um heim jaðarsettir í íslensku samfélagi og þeim send skýr skilaboð

þess efnis að þeir séu fórnarlömb alvarlegs glæps og ef þeir reyni að verja umskurnina séu þeir talsmenn ofbeldis og alvarlegrar glæpastarfsemi.

Glæpavæðing umskurnar sveinbarna mun valda fjölda fólks úr hinum ýmsu minnihlutahópum ómældri þjáningu og stórskaða orðspor landsins á alþjóðavettvangi. Frumvarpið hefur þá hliðarverkun að gyðingdómur og íslam verða gerð glæpsamleg trúarbrögð vegna þess vægis sem umskurn drengja hefur innan þeirra, gyðingar geta ekki komið sér upp fjölskyldu hér á landi nema því aðeins að snúa baki við trúarlegum gyðingdómi og múslimum verður gert verulega erfitt að búa hér á landi vegna ýmist þeirrar skyldu sem hvílir á umskurn innan sharíaskóla íslams eða þess fordæmis sem múslimar eru þar eindregið hvattir til að fylgja. Alþingi mun takast það sem öfgahreyfingar gyðingahatara og múslimahatara berjast svo mjög fyrir að loka landinu að verulegu leyti fyrir þeim gyðingum sem fylgja gyðingdómi og gera múslimum lífið erfitt. Þetta verður ímynd landsins.

Bjarni Randver Sigurvinsson
guðfræðingur, trúarbragðafræðingur og stundakennari í trúarbragðafræði og kvikmyndafræði við Háskóla Íslands

BOARD OF DEPUTIES OF BRITISH JEWS
ADVOCACY FOR THE COMMUNITY

Parliament of Iceland (Althingi)
101 Reykjavík
Iceland

Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940
(bann við umskurði drengja)

25 March 2018

Dear ladies and gentlemen,

The Board of Deputies of British Jews is the democratically elected, cross-communal, representative body in the Jewish community. It comprises nearly 300 deputies directly elected by synagogues and communal organisations, from youth movements, to social welfare charities and regional councils.

In your House of Parliament (Althingi), there is currently a bill making its way through parliament which aims to make the practice of Brit Milah – non-therapeutic neonatal Jewish male circumcision, as part of a traditional ceremony – illegal. The effect of this bill would be to make a core Jewish practice a criminal offence.

The Board of Deputies is deeply troubled by the proposed anti-circumcision bill, which poses a threat to Jewish and Muslim life in Iceland by infringing upon religious freedom in the country. Banning circumcision would set a precedent and encourage other countries to follow suit.

A key hallmark of liberal democracy, as is the case in Iceland, is that a state should not, except in absolute extremis, seek ways to criminalise hitherto completely law-abiding citizens. Indeed, it should find the idea repugnant. Activities of citizens are only made illegal if there is overwhelming evidence that they cause significant harm or are an unqualified infringement of rights. The question that needs to be answered is: have either of these tests been passed? We believe that the answer to both of these questions is no, but, to respond to these questions in more detail, we must first address the question: "What is Brit Milah?"

What is Brit Milah?

Brit Milah literally means "Covenant of the Circumcision". When Jews undergo Brit Milah, they follow every generation of Jewish men, going back to the father of the religion, Abraham, in entering into a covenant with God. It is a covenant that they enter into not only as an individual, but also as part of a people, which explains why Brit Milah is regarded both as an expression of faith and of deep identity. The covenant indicated by Brit Milah underpins the obligations and practices that define Jewish life, both personally and communally.

There is a stark contrast between Brit Milah and Female Genital Mutilation (FGM). Making analogies between them maligns the Jewish traditions. FGM is carried out in several cultures as an act of sexual control over women, frequently causing permanent pain and interfering with sexual intercourse. None of these elements are features of Brit Milah.

It is important that Brit Milah should not be considered exclusively as a surgical procedure. It is performed according to specific instructions. The most obvious example of this is the biblical injunction to perform it at eight days old, or as soon as the health of the baby allows. This is part of a structured ceremony during which the boy is usually given his name.

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Does Brit Milah cause harm?

Common sense tells us that Brit Milah, when carried out correctly, does not cause harm.

Almost all Jewish men in history have been circumcised. A majority of American men have been circumcised. The vast majority of Muslim men – around one billion people – have been circumcised. If circumcision caused significant harm, injuring the physical, mental or emotional development of men, entire societies would be affected, which they are not.

In the UK Brit Milah is carried out in clean conditions by a trained person, known as a Mohel (Plural: Mohelim). Mohelim operate under a regulated scheme which includes audit and appraisal. There are two UK reference groups for this: the Initiation Society, and the Association of Reform and Liberal Mohelim. Brit Milah is recognised by the UK General Medical Council as a procedure that can be performed for religious, social, and cultural reasons.

Does Brit Milah infringe a child's rights?

The argument that Brit Milah infringes a child's rights is based on the idea that it is an irreversible procedure to which the child has not given consent. It is true that a circumcision is an irreversible physical procedure. But so is the decision not to undertake Brit Milah.

There are many ways that parents make choices for their children which have a profound impact on them: where they sleep, what they eat, and whether they should have their ears pierced. Vaccination has known therapeutic advantages. Indeed, there is robust scientific evidence that not immunising children creates serious risk of illness or even death, but the parental option of non-immunisation is permitted. A liberal democracy would not criminalise parents if they do not follow the majority view on such matters.

In contrast with these choices, a Jewish man who has undergone Brit Milah in the traditional way, at the traditional time, knows that he has entered his covenant with God in the way his people have done for milennia. This profound knowledge is a keystone of his faith and identity. Failing to enter a relationship with God at the earliest opportunity undermines his sense of Jewish identity. His parents will have made an irreversible decision without his consent. They will have denied him his right to his own cultural heritage. They will have removed from him a key element in his ability to participate in the religious life of his community and thus also interfered with his freedom of religion.

It may be difficult for some people in an increasingly secular society to understand this element of spiritual irreversibility in comparison to physical irreversibility, but the regret and sorrow of an observant Jewish man would be considerable, and go beyond the physical way that he would be different from all his Jewish male relations.

Those parents who opt for Brit Milah make their decision based on the only data available to them – the experience and opinion of most Jewish men they know, who would say either that they are glad to have gone through Brit Milah as an expression of their faith and identity, or that they are indifferent. The number of Jewish men who express dissatisfaction is relatively small.

Professor Freeman, the leading British authority on children's legal rights, maintains that in all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the "best interests" of the child must be the primary consideration. He says that this is an overarching mandate; and that "best interests" does not exist in a vacuum - it must be situated in its cultural context. Thus, he believes that "best interests" of Jewish (and Muslim) boys can be abstracted from the generality of children - ritual circumcision is in their "best interests". Furthermore "best interests" should not be looked at in the short-term only: "a longer-term perspective must be taken, and long-term benefit will override transient trauma".

In summary performing Brit Milah is how centuries of law-abiding Jews have raised their children, as part of an interwoven matrix of beliefs and practices that have guided them and their children spiritually, ethically and practically.

Conclusion

Brit Milah has been performed for thousands of years, without causing significant harm, and has enabled Jewish families to pass on their faith and identity to their sons. Iceland should not seek to criminalise such behaviour. Rather, it should recognise that, for Jews, to deny them the right to perform Brit Milah infringes not only Jewish religious practice in general but also the interlinked rights of their male children. We are well aware that banning circumcision in Iceland would also harm the fundamental rights of the Muslim community there. Brit Milah – male circumcision – is not only a concern for the Jewish community in the United Kingdom and around the world but for Muslims and the Muslim community in Iceland as well.

We strongly encourage you to take our grave concerns into account and to withdraw your legislative initiative to ban male circumcision.

Best regards,

Jonathan Arkush

President

Board of Deputies of British Jews

Almenn hegningarlög
(bann við umskurði drengja)

114. mál, 148. löggjafarþing 2017–2018.

Dear Esteemed Madam or Sir,

I have read with interest about the proposed circumcision ban in Iceland. The law, ethics, and policy of male and female genital cutting are my main academic areas of expertise, and I thought I might provide a few resources that may be helpful in your governmental deliberations. I am Research Fellow at the Uehiro Centre for Practical Ethics at the University of Oxford and Associate Director of the Yale-Hastings Program in Ethics and Health Policy at Yale University and The Hastings Center.

First, I am attaching an analysis of a recent court decision in England, *in the matter of B and G*, which classified male circumcision as a 'significant harm' but then tried to rescue the distinciton between it and female genital cutting by appealing to alleged health benefits and a distinction between religion and 'mere' culture. Since this will be a common objection to the proposed Icelandic law, I hope you will find this analysis especially helpful. In the essay, recently published in the *Medical Law Review* by Oxford University Press, I argue that the supposed distinctions concerning health and religion are not grounded in fact, but rather stereotypes about the two forms of genital cutting. That therefore, I conclude, if non-therapeutic female genital cutting is unlawful, then so must be non-therapeutic male genital cutting. This argument is explored further in the attached second essay, "In Defence of Genital Autonomy for Children," published by the *Journal of Medical Ethics*.

Third, I am attaching an in-press chapter on female and male genital cutting for Cambridge University Press, showing, again, that the current legal situation whereby the one is entirely criminalized and the other not is incoherent. The fourth essay is a point-by-point comparison of the supposed differences between female and male genital cutting and shows that these are, again, not grounded in reality but based on stereotypes.

Now, against this view, and as an effort to shore up 'secular' support for male circumcision, many religious leaders will (as noted) appeal to health benefits, which only one pediatric society in the world, the American Academy of Pediatrics (AAP), has argued to outweigh the risks, in their now-expired 2012 policy. The attached next two essays are critical analyses of the AAP findings on health benefits, and show that their policy was politically motivated, whereas the majority view of European health authorities that circumcision cannot be justified on medical grounds is better justified.

Finally, I am attaching two essays concerning the demonstrable harms of circumcision, arguing, in brief, that since the foreskin itself has value (it has been shown to be the most touch-sensitive tissue of the penis by objective measures), its sheer removal is a harm, even if there are no additional surgical complications.

If you prefer more popular, accessible discussions of these ideas, I have a posting with the *Journal of Medical Ethics* blog exploring the problems with appealing to medicine to arbitrate the morality of childhood genital cutting, whether for males or females: http://blogs.bmj.com/medical-ethics/2017/08/15/does-female-genital-mutilation-have-health-benefits-the-problem-with-medicalizing-morality/

And here is a short policy report I wrote for the European Parliament with my colleage Dr. Rebecca Steinfeld, a prominent Jewish opponent of male and female genital cutting who advocates instead "brit shalom" (covenant without cutting): http://euromind.global/en/brian-d-earp-and-rebecca-steinfeld/

I hope these resources are useful as you consider the issue. I am happy to send more papers or to consult on any of these matters in greater detail if that would be of use.

Warmly,
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February 21, 2018

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REASON AND PARADOX IN MEDICAL AND FAMILY LAW: SHAPING CHILDREN'S BODIES

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ABSTRACT

Legal outcomes often depend on the adjudication of what may appear to be straightforward distinctions. In this article, we consider two such distinctions that appear in medical and family law deliberations: the distinction between religion and culture and between therapeutic and non-therapeutic. These distinctions can impact what constitutes 'reasonable parenting' or a child's 'best interests' and thus the limitations that may be placed on parental actions. Such distinctions are often imagined to be asocial facts, there for the judge to discover. We challenge this view, however, by examining the controversial case of *B and G* [2015]. In this case, Sir James Munby stated that the cutting of both male and female children's genitals for non-therapeutic reasons constituted 'significant harm' for the purposes of the Children Act 1989. He went on to conclude, however, that while it can never be reasonable parenting to inflict any form of non-therapeutic genital cutting on a female child, such cutting on male children was currently tolerated. We argue that the distinctions between religion/culture and therapeutic/non-therapeutic upon which Munby LJ relied in making this judgement cannot in fact ground categorically differential legal treatment of female and male children. We analyse these distinctions from a systems theoretical perspective—specifically with reference to local paradoxes—to call into question the current legal position. Our analysis suggests that conventional distinctions drawn between religion/culture and the therapeutic/non-therapeutic in other legal contexts require much greater scrutiny than they are usually afforded.

KEYWORDS: Children, Genital cutting, Religion, Shaping surgeries, Systems theory

I. INTRODUCTION

Legal reasoning often coheres around the determination of what can appear to be binary distinctions. For example, the adjudication of whether an act was lawful or

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unlawful may depend upon an assessment of whether it was reasonable/unreasonable, proportionate/disproportionate, careless/reckless, and so forth. In terms of criminal and civil law standards that delimit acceptable parental action, consideration of whether a practice is religious or cultural or whether an intervention is therapeutic or non-therapeutic may be similarly determinative. Practices described as religious or therapeutic in nature are typically afforded greater protection from interference by the state than those that are described as non-therapeutic or 'merely' cultural. Neither of these distinctions is straightforward, however. As we shall demonstrate, rather than being ahistorical or apolitical in nature, dominant understandings of which practices do or do not deserve the labels 'religious' or 'therapeutic' are shaped by competing value claims and by overlapping, often evolving contingencies of culture, power, gender, race, and social class. As Alice Ludvig notes, law's 'dichotomies are not "neutral"; they have been the means of fixing meaning in ways that secure power relations and inequalities in and of themselves'.[1]

One particularly contentious area in which these binary distinctions are commonly drawn concerns the cutting of children's genitals. When such cutting is done to female children, it is often said to be a non-religious cultural practice, and one which, moreover, has no therapeutic benefit: if legal protection is to be granted, therefore, it should be to the girl and her unmodified genitals, rather than to those who might wish to cut them. When such cutting is done to male children, by contrast, it is commonly said to be a religious practice, and one with at least potential therapeutic benefit:[2] therefore, it must not be restricted—much less forbidden—by law. Accordingly, protection in this instance is afforded to the parents, or to the person or persons designated by the parents to cut the boy's genitals.

To interrogate these distinctions we turn to the English High Court decision of *B and G* [2015], in which Sir James Munby, President of the Family Division, considered the current disparity in legal responses to male and female genital cutting (MGC, FGC).[3] Potentially marking a shift in judicial thinking, Munby LJ found that both practices can constitute 'significant harm'.[4] Yet as Carol Smart has noted, 'harm' is not 'a transcendental notion which is automatically knowable and recognizable at any moment in history by any member of a culture'.[5] Rather, it is a culture- and context-sensitive notion, which can be shaped by differing perceptions, assumptions, and values, and by conscious or unconscious stereotypes about the object(s) of evaluation. Accordingly, one of our aims in this article is to shed light on such factors as they bear on judgements about harm to children's bodies—particularly insofar as these judgements diverge as a function of the child's sex or gender.

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1 A Ludvig, 'Differences between Women? Intersecting Voices in a Female Narrative' (2006) 13(3) European Journal of Women's Studies 245, 249.

2 Expert opinion is sharply divided. R Collier, 'Ugly, Messy and Nasty Debate Surrounds Circumcision' (2012) 184(1) Canadian Medical Association Journal E25; BD Earp, 'Addressing Polarisation in Science' (2015) 41(9) Journal of Medical Ethics 782.

3 *Re B and G (children) (care proceedings)* [2015] EWFC 3.

4 ibid, para 37.

5 C Smart, 'A History of Ambivalence and Conflict in the Discursive Construction of the "Child Victim" of Child Abuse' (1999) 8(3) Social & Legal Studies 391, 392.

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In the ruling by Munby LJ, such divergence re-emerged soon after the initial, apparently sex and gender neutral, judgement about 'significant harm'. In other words, Munby LJ sought to 'rescue' law's current position, which treats females and males differently, in the manner we have just described: by contrasting religion with culture and the therapeutic with the non-therapeutic as a way of distinguishing the two types of cutting. Although these distinctions are generally accepted in law, and used to evaluate a number of contested practices, we shall argue that in the case of childhood genital cutting, at least, they are not valid.[6] Appealing to them, therefore, reveals deep contradictions in conventional legal reasoning.

To explain these contradictions we draw on systems theory. Approaching law as an autopoietic or self-creating system (self-creating in the sense that it constitutes itself from its own systemic elements), one can begin to see how contradictions and even paradoxes are an intrinsic feature of legal change. Rather than seeing such paradoxes as a weakness of law, systems theoretical approaches take them to be a defining and generative feature—arising from the need for law to maintain credibility and legitimacy whilst negotiating its internal tensions. Our focus is on the local paradoxes underpinning Munby LJ's ruling—'local' in the sense employed by Oren Perez to include 'doctrinal weaknesses and inconsistencies'.[7] These inconsistencies, we argue, stem from a differential appraisal of children's bodies that cannot be justified on the basis of an empirically defensible or conceptually lucid account of the harms to which they are exposed in having their genitals cut. Instead, such an appraisal rests more heavily on harm judgements that track questionable assumptions not only about sex and gender, as we have intimated, but also racial identity and ethnic affiliation.

In what follows we show that there are substantial overlaps in both the physical consequences and symbolic meanings of male and female genital cutting, when the full spectrum of such practices is considered and like compared with like. Moreover, these consequences and meanings transcend boundaries of health, religion, and culture, undermining the usefulness of these categories for justifying sex-based distinctions. Drawing on a children's rights perspective, we suggest that considerations of bodily

6 In this article, we focus on MGC and FGC. Nevertheless, we acknowledge that some of our arguments also apply to genital 'normalising' surgeries on children born with intersex conditions. Space precludes us from extending our analysis here, but we would highlight the following critical assessments, some of which explore commonalities among male, female, and intersex genital cutting practices: N Ehrenreich, 'Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of Cultural Practices' (2005) 40 Harvard Civil Rights-Civil Liberties Law Review 71; M Fox and M Thomson, 'Cutting It: Surgical Interventions and the Sexing of Children' (2005) 12 Cardozo Journal of Law & Gender 82; I Morland, 'Intimate Violations: Intersex and the Ethics of Bodily Integrity' (2008) 18(3) Feminism & Psychology 425; M Fox and M Thomson, 'Sexing the Cherry: Fixing Masculinity' in N Sullivan and S Murray (eds), *Queer(ing) Somatechnics: Critical Engagements with Bodily (Trans) Formations* (Ashgate, 2009) 107–26; JS Svoboda, 'Promoting Genital Autonomy by Exploring Commonalities Between Male, Female, Intersex, and Cosmetic Female Genital Cutting' (2013) 3(2) Global Discourse 237; M Travis, 'Accommodating Intersexuality in European Union Anti-Discrimination Law' (2014) 21 European Law Journal 180; F Ammaturo, 'Intersexuality and the "Right to Bodily Integrity": Critical Reflections on Female Genital Cutting, Circumcision and Intersex "Normalising Surgeries" in Europe' (2016) 25(5) Social & Legal Studies 591; M Newbold, 'When Parents Choose Gender: Intersex, Children, and the Law' (2016) 24(4) Medical Law Review 474.

7 See O Perez, 'Law in the Air: A Prologue to the World of Legal Paradoxes' in O Perez and G Teubner (eds), *Paradoxes and Inconsistencies in the Law* (Hart 2006) 3, 22–26.

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integrity and self-determination provide a more compelling basis for assessing the permissibility of genital cutting, regardless of the individual's sex or gender.[8]

In so doing, we acknowledge the growing body of academic commentary arguing that neither religion nor culture can justify substantial intrusions into the bodies of children or other non-consenting persons, particularly when such intrusions result in a permanent alteration that the individual may later reasonably regard as a harm. With ritual genital cutting attracting increased legal and regulatory attention in a number of European jurisdictions and at the supra-national level,[9] and with commonplace assumptions about such cutting drawing heightened scrutiny from across disciplines, such an analysis is timely and essential.

However, the implications of our analysis are not limited to the genital cutting debate. Successful claims to religious or therapeutic status can have a legitimising effect in family and medical law in the context of other contested practices. Given the primacy of bodily integrity within the cluster of rights that law seeks to protect and promote,[10] our discussion bears most directly on other potentially harmful childhood body-shaping interventions where the designation therapeutic/non-therapeutic is disputed. Such interventions include sterilization, 'normalising' surgery on children born with intersex conditions, 'virginity restoration' (ie hymenorrhaphy), limb lengthening, growth attenuation, and so forth. To frame our analysis, we begin with an outline of *B and G*, followed by a discussion of some of the empirical and conceptual confusions that we claim underlie and undermine its conclusion.

A. *B and G*

B and G concerned care proceedings brought in the case of two children, B (a 4-year-old boy) and G (a 3-year-old girl). The central questions raised by the case were: (i) whether G had been subject to FGC; (ii) if she had, did this amount to significant harm; and (iii) what then were the implications for her and her brother. It was agreed in the process of the hearing that if G had been subject to FGC, it was Type IV, using the typology set out by the World Health Organization (WHO).[11] Type IV is defined

8 A full discussion of children's rights, and related debates over the status of parental rights, would take us too far afield. But the perspective of the child, and the notion of children's rights to bodily integrity, self-determination, and an open future, are central to this debate. See, eg, M Fox and M Thomson, 'Reconsidering "Best Interests": Male Circumcision and the Rights of the Child' in G Denniston and others (eds), *Circumcision and Human Rights* (Springer 2009) 15. See further, B Shell-Duncan, 'From Health to Human Rights: Female Genital Cutting and the Politics of Intervention' (2008) 110(2) American Anthropologist 225; DL DeLaet, 'Framing Male Circumcision as a Human Rights Issue?' (2009) 8(4) Journal of Human Rights 405; R Darby, 'The Child's Right to an Open Future: Is the Principle Applicable to Non-therapeutic Circumcision?' (2013) 39(7) Journal of Medical Ethics 463; RS Van Howe, 'Infant Circumcision: The Last Stand for The Dead Dogma of Parental (Sovereignal) Rights' (2013) 39(7) Journal of Medical Ethics 475.

9 SR Munzer, 'Secularization, Anti-Minority Sentiment, and Cultural Norms in the German Circumcision Controversy' (2015) 37(2) University of Pennsylvania Journal of International Law 503; JS Svoboda, 'Growing World Consensus to Leave Circumcision Decision to the Affected Individual' (2015) 15(2) American Journal of Bioethics 46.

10 M Fox and M Thomson, 'Bodily Integrity, Embodiment and the Regulation of Parental Choice' (2017) Journal of Law & Society (forthcoming).

11 Note that the WHO uses the term 'FGM' for Female Genital 'Mutilation', which is also the term employed by Munby LJ. However, among scholars of genital cutting this term is highly controversial, having been

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as 'all other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization'.[12]

Given significant problems with the expert evidence, it was found that the local authority had not proven its case. That is, there was no evidence that G had in fact been subjected to FGC. Nevertheless, Munby LJ moved on to address Type IV, which, he argued, raised an issue 'which cannot be shirked' and which took him to the question of 'male circumcision'.[13] In explaining the court's position, Munby LJ stated that whilst WHO Types I, II, and III FGC are 'more invasive than male circumcision',[14] some practices falling under Type IV FGC, such as pricking of the clitoral hood, are 'on any view much less invasive than male circumcision'.[15] Further, he acknowledged that Type Ia, cutting/removal of the clitoral hood or prepuce, 'is physiologically somewhat analogous to male circumcision'.[16]

In making these observations, Munby LJ aligned judicial thinking with an emerging consensus concerning clear similarities between male and female genital cutting when the full range of practices falling under those labels is considered.[17] His ruling, therefore, challenges the dominant view in both the legal and popular imaginations that such practices are fundamentally distinct. Looking to earlier case law, for example, Munby LJ's judgment departs from that of Baroness Hale in *Secretary of State for the Home Office v K* [2006][18] in which she asserted that FGC 'procedures vary from community to community but cannot in any way be compared to the removal of a boy's foreskin'.[19] Baroness Hale goes on to cite the UNICEF *Innocenti Digest*:

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criticised on numerous grounds, including its lack of value-neutrality: see B Shell-Duncan and Y Hernlund (eds), *Female "Circumcision" in Africa: Culture, Controversy, and Change* (Lynne Rienner Publishers 2000); DS Davis, 'Male and Female Genital Alteration: A Collision Course with the Law?' (2001) 11 Health Matrix 487. Increasingly, FGC is the preferred term, which we employ here except when quoting others.

12 The WHO typology is: **Type I**—Partial/total removal of clitoris and/or prepuce. **Type Ia**, removal of clitoral hood/prepuce only; **Type Ib**, removal of clitoris with prepuce. **Type II**—Partial/total removal of clitoris and labia minora, with/without excision of labia majora. **Type III**—Narrowing of vaginal orifice with creation of seal by cutting/appositioning labia minora and/or labia majora, with/without excision of clitoris. **Type IV**—defined above. WHO, 'Female Genital Mutilation: Fact Sheet' (World Health Organization, February 2016) <http://www.who.int/mediacentre/factsheets/fs241/en/> accessed 4 January 2017.

13 *Re B and G* (n 3) 58.

14 ibid 60.

15 ibid.

16 ibid. The procedures are analogous in that both alter/remove a genital prepuce; however, the penile prepuce is considerably larger: ~30–50 cm^2 in the mature organ. BD Earp, 'Do the Benefits of Male Circumcision Outweigh the Risks?' (2015) 3 Frontiers in Pediatrics 18.

17 Davis (n 11) 487; M Fox and M Thomson, 'A Covenant with the Status Quo? Male Circumcision and the New BMA Guidance to Doctors' (2005) 31(8) Journal of Medical Ethics 463; K Bell, 'Genital Cutting and Western Discourses on Sexuality' (2005) 19(2) Medical Anthropology Quarterly 125; DeLaet (n 8); M Dustin, 'Female Genital Mutilation/Cutting in the UK—Challenging the Inconsistencies' (2010) 17(1) European Journal of Women's Studies 7; M van den Brink and J Tigchelaar, 'Shaping Genitals, Shaping Perceptions: A Frame Analysis of Male and Female Circumcision' (2012) 30 Netherlands Quarterly of Human Rights 417; Svoboda (n 6); BD Earp, 'Female Genital Mutilation and Male Circumcision: Toward an Autonomy-based Ethical Framework' (2015) 5(1) Medicolegal and Bioethics 89.

18 *Secretary of State for the Home Office v K* [2006] UKHL 46.

19 ibid, 91. See also Lord Justice Moore-Bick in *SS (Malaysia) v Secretary of State for the Home Department* [2013] EWCA Civ 888. That is not to say that the potential harm of MGC has not been recognised by the judiciary. See, for example, Wall J's judgement in *Re J (child's religious upbringing and circumcision)* [1999] 2 FLR 678—noting that circumcision is potentially traumatic and may cause unnecessary pain and suffering.

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> In the case of girls and women, the phenomenon is a manifestation of deep-rooted gender inequality that assigns them to an inferior position in society and has profound physical and social consequences. This is not the case for male circumcision, which may help to prevent the transmission of HIV/AIDS.[20]

Hale LJ's statement is indicative of the dominant Western understanding of male and female genital cutting practices. Yet, this understanding is mistaken in several respects. Before turning to the systems theoretical approach we use to address how law in this area has developed and may continue to change, we first highlight some of the key misunderstandings that underpin the prevailing view.

B. Making Distinctions

Theodore Bennett writes that male and female genital cutting 'are discursively conceptualized and legally treated as entirely different, even oppositional, practices'.[21] This is in tension, however, with the fact that both the degree of invasiveness of the interventions themselves, as well as the underlying motivations, root causes, rationales, and associated symbolic meanings are at times quite similar, the same, or even reversed, when comparing like cases.[22] For example, the notion that FGC is always associated with or a consequence of sexist and patriarchal norms, representing a lower status for women and girls, has been described by one expert as a 'gross oversimplification';[23] while at the same time, the patriarchal origins of MGC in some societies (eg within Judaism) has been noted many times.[24]

Specifics will help justify these claims. While it is true that in certain geographical contexts, particularly in parts of northeast Africa, FGC has become associated with pre-existing cultural and religious norms that emphasise female chastity and sexual purity in some groups, this association is not universal.[25] For example, with regard to the FGC-practicing Kono ethnic group of Sierra Leone—the country of origin of the applicant in *Secretary of State for the Home Office v K*—'there is no cultural obsession with feminine chastity, virginity, or women's sexual fidelity . . . because the role of the biological father is considered marginal and peripheral to the central matricentric unit'.[26] In Kono society, as in numerous other African ethnic groups, the FGC ceremony is organised and carried out entirely by women, while the analogous ceremony

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20 ibid, 93.

21 T Bennett, *Cuts and Criminality: Body Alteration in Legal Discourse* (Ashgate Publishing 2015) 68.

22 H Lightfoot-Klein, 'Similarities in Attitudes and Misconceptions about Male and Female Sexual Mutilations' in GC Denniston and others (eds), *Sexual Mutilations* (Springer 1997); van den Brink and Tigchelaar (n 17) 417.

23 L Wade, 'Learning from "Female Genital Mutilation": Lessons from 30 Years of Academic Discourse' (2012) 12(1) Ethnicities 26. See also AL Obiora, 'Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign against Female Circumcision' (1997) 47 Case Western Reserve Law Review 275.

24 MS Kimmel, 'The Kindest Un-cut' (2001) 16(3) Tikkun 43; SD Cohen, *Why aren't Jewish Women Circumcised? Gender & Covenant in Judaism* (University of California Press 2005) 560–78.

25 FS Ahmadu, 'Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision' in B Shell-Duncan and Y Hernlund (eds), *Female "Circumcision"* (n 11); J Abdulcadir and others, 'Seven Things to Know about Female Genital Surgeries in Africa' (2012) 42(6) The Hastings Center Report 19.

26 Ahmadu, ibid 285.

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for boys is managed entirely by men: in both cases, the primary intention is not to reduce the initiates' sexual pleasure (nor to reify a lower status for the females),[27] but is rather to confer on both sexes a community-recognised status as mature adults, earned through their participation in a symbolically complex, morally transformative, and, in some cases, deliberately painful rite of passage.[28]

Strikingly, the anthropological record reveals few or no FGC-practicing societies that do not also practice MGC, often in parallel and under similar conditions.[29] As John Caldwell and colleagues have argued, the failure of Anglo-American law, and of Western attitudes more generally, 'to relate the two types of circumcision is curious ... because they have probably been regarded by most Africans as being related for aeons'.[30] To return to *Secretary of State for the Home Office v K,* it is worth noting that Bingham LJ is quick to draw a sharp distinction between MGC and FGC based on allegedly differing symbolic meanings. With respect to FGC, he argues,

> The contrast with male circumcision is obvious: where performed for ritualistic rather than health reasons, male circumcision may be seen as symbolizing the dominance of the male. FGM may ensure a young woman's acceptance in ... society, but she is accepted on the basis of her institutionalised inferiority.[31]

This analysis is, in certain respects, too easy. To begin, Lord Bingham's assessment of Sierra Leonean society is inconsistent with that of anthropologists who specialise in the region, such as Fuambai Ahmadu, a Sierra Leonean-American who has written extensively about female and male initiation ceremonies among the Kono ethnic group in that context. According to Ahmadu,

> Kono culture promulgates a dual-sex ideology, which is manifested in political and social organization, sexual division of labor, and, notably, the presence of powerful female and male secret societies. The existence and power of Bundu, the women's secret sodality, suggest positive links between excision, women's religious ideology, their power in domestic relations, and their high profile in the 'public' arena.[32]

There are certainly normative gender roles in Kono society, as there are in all societies. However, it is far from evident that the role(s) for Kono females is associated with a 'lower' status, much less a kind of 'institutionalized inferiority' as Lord Bingham asserts. Ahmadu cautions that 'Scholars must be wary of imposing Western religious,

27 See, eg SM James and CC Robertson (eds), *Genital Cutting and Transnational Sisterhood* (University of Illinois Press 2005).

28 B Shell-Duncan and Y Hernlund (eds), *Female "Circumcision"* (n 11); HD Lyons, 'Genital Cutting: The Past and Present of a Polythetic Category' (2007) 53(4) Africa Today 3.

29 Abdulcadir and others (n 25); RA Shweder 'The Goose and the Gander: The Genital Wars' (2013) 3(2) Global Discourse 348.

30 JC Caldwell and others, 'Male and Female Circumcision in Africa from a Regional to a Specific Nigerian Examination' (1997) 44(8) Social Science and Medicine 1181.

31 *Home Office* (n 18) 31.

32 Ahmadu (n 25) 285.

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philosophical, and intellectual assumptions that tend to place enormous emphasis on masculinity and its symbols in the creation of culture itself', leading to the automatic conclusion that the male roles must be of higher status.[33] To the contrary, according to Ahmadu, women in Kono culture occupy a complementary role to men that is just as valued in the local ontology. Making the more general point with reference to other FGC-practicing groups, Christine Walley notes that whilst the anthropological record supports the view that gender inequality is widespread:

> the cultural and historical particulars of how gender relations are constructed differently in different places, and the alternate sources of power and authority that women often hold, are ignored in these generalized assumptions about the oppression of third-world women.[34]

Indeed, such generalised assumptions may, themselves, be seen as expressions of patriarchy, as Arianne Shahvisi has recently argued: 'An extension of . . . patriarchy is the widespread idea that Europeans must protect women of colour from the "barbarism" of men of colour. It is from this misled belief that [Western] hypocrisy around FGM stems'. As she illustrates:

> UK law codifies the idea that adult women of particular cultures are not as capable of making their own decisions as are other women, let alone as capable as men. For, if a woman requests a labiaplasty (say) from a private cosmetic surgeon in the UK, her ethnicity will likely be used to determine her consent status, and in turn whether or not the procedure can occur legally. The current law [therefore] enforces differential access to [genital-altering] procedures on the basis of race.[35]

Turning to MGC and patriarchy, there are indeed some contexts in which the genital cutting of males is more directly associated with their elevated status, and thus with a lowered status for females. In Jewish ritual practice, for instance, only males are entitled to have their genitals cut as part of a perceived divine covenant. Shaye D. Cohen, the Littauer Professor of Hebrew Literature and Philosophy at Harvard University, argues that of all the rituals from which women are excluded by rabbinic culture, 'the exclusion from circumcision is at once the most obvious and the most problematic'. As he explains, 'the fundamental inferiority, marginality and Otherness of women were so self-evident [throughout Jewish history] that the presence of a covenantal mark on the bodies of men, and its absence from the bodies of women, seemed natural and inevitable'.[36] Contemporary Jews, Cohen argues, 'especially those sensitive to gender issues . . . might wish to argue that male circumcision needs to be abolished or

33 ibid.

34 CJ Walley, 'Searching for "Voices": Feminism, Anthropology, and the Global Debate over Female Genital Operations' (1997) 12(3) Cultural Anthropology 405, 420.

35 A Shahvisi, 'Why UK Doctors Should be Troubled by Female Genital Mutilation Legislation' (2017) Clinical Ethics (forthcoming).

36 SD Cohen, 'Why aren't Jewish Women Circumcised?' (1997) 9(3) Gender & History 560, 574.

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de-emphasized as a ritual marker precisely because it has functioned within history to discriminate invidiously against women'.[37]

The lesson from these examples—just two of many more that could be raised—is that the non-physical 'meanings' of MGC and FGC differ from group to group, such that there is no single overarching symbolic framework that can quarantine the practices from one another on the basis of sex or gender.[38] When this lesson is combined with the 'overlaps' in physical consequences between the two procedures (depending on type) as recognised by Munby LJ from the bench for the first time, a puzzle is raised as to why they have conventionally been seen, at least in Western discourse, as being fundamentally distinct.

There are a number of solutions to this puzzle, with cultural familiarity being among the most significant.[39] Put simply, the Western world's familiarity with Jewish circumcision since antiquity has contrasted with its long-standing 'ignorance of female circumcision . . . the discovery [of which] during the eighteenth century was met with a combination of incredulity, fascination, and horror'.[40] In more recent times, it was not until the 1970s that African FGC practices were brought into the popular consciousness (often without any reference to their coincident male counterparts, some of which were more physically harmful), primarily through the work of activists following Fran Hosken who interpreted such cutting as evidence of global domination of women by men.[41] But as Walley notes, in their 'depiction of female genital operations for an international audience, the practices became largely severed from their sociocultural context'. Thus, despite the fact that male and female cutting were performed side by side in many of the African ethnic groups whose cultural traditions were being written about, in the 'Western-oriented literature opposing such practices there was an exclusive focus on the tormenting of girls, if not solely by men, then by a monolithic patriarchy'.[42]

This dichotomous discourse continues today. When FGC is raised in public conversation, it is usually the most severe forms in the least sanitary conditions that are emphasised (the young girl in a remote African village being cut and infibulated by a village elder), with limited mention of the more 'mild' forms of FGC, such as ritual nicking of the clitoral prepuce as is carried out by health professionals in some Muslim-majority countries including Malaysia.[43] However, when male circumcision is the focus of public discourse, it is most often described in its least invasive forms, and in sanitary conditions such as a hospital setting (common in the United States), with limited awareness of the more extreme and unsanitary forms of MGC that are carried out in other contexts (eg ritual circumcision among the Xhosa of South Africa, where

37 ibid, 561.

38 L Leonard, 'Interpreting Female Genital Cutting: Moving Beyond the Impasse' (2000) 11(1) Annual Review of Sex Research 158.

39 N Sullivan, 'The Price to Pay for our Common Good: Genital Modification and the Somatechnologies of Cultural (In)difference' (2007) 17(3) Social Semiotics 395.

40 R Darby, 'Moral Hypocrisy or Intellectual Inconsistency?' (2016) 26(2) Kennedy Institute of Ethics Journal 155, 156.

41 Bell (n 17).

42 Walley (n 34) 418.

43 See, AK Rashid and others, 'The Practice of Female Genital Mutilation among the Rural Malays in North Malaysia' (2010) 9(1) Internet Journal of Third World Medicine 1.

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more than 400 boys died between 2008 and 2014 due to complications associated with their initiations).[44] Such thinking both stems from, and perpetuates, a gendered opposition that does not reflect the full reality. As anthropologist Zachary Androus has argued:

> The fact of the matter is that what's done to some girls [in some cultures] is worse than what's done to some boys, and what's done to some boys [in some cultures] is worse than what's done to some girls. By collapsing all of the many different types of procedures performed into a single set for each sex, categories are created that do not accurately describe any situation that actually occurs anywhere in the world.[45]

Consistent with this observation is Munby LJ's discussion of the 'curious situation' facing the court. Noting the Muslim identity of the family, he reasoned that it was likely that B either was or would in due course be circumcised. Yet:

> G's FGM Type IV (had it been proved) would have been relied upon . . . as justifying the adoption of *both* children, even though on any objective view it might be thought that G would have [been] subjected to a process much less invasive, no more traumatic (if, indeed, as traumatic) and with no greater long-term consequences, whether physical, emotional or psychological, than the process to which B has been or will be subjected.[46]

Having made these observations, Munby LJ turned to the specifics of the legal case before him. Section 31 of the Children Act 1989 provides that before the state can intervene, the local authority must first prove 'significant harm'. In accepting that all forms of FGC constitute 'significant harm' for the purposes of care proceedings, Munby LJ then asserts that:

> Given the comparison between what is involved in male circumcision and FGM Type IV, to dispute that the more invasive procedure involves the significant harm involved in the less invasive procedure would seem almost irrational. In my judgement, if Type IV amounts to significant harm . . . then the same must be so of male circumcision.[47]

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44 M Douglas and A Nyembezi, 'Challenges Facing Traditional Male Circumcision in the Eastern Cape' (*Human Sciences Research Council*, 2015) <http://www.hsrc.ac.za/uploads/pageContent/6391/Presentation%20-%20Challenges%20facing%20traditional%20male%20circumcision%20in%20the%20Eastern%20Cape.pdf> accessed 4 January 2017; LL Gonzalez, 'South Africa: Over Half a Million Initiates Maimed under the Knife' (*All Africa*, 20 June 2014) <http://allafrica.com/stories/201406251112.html> accessed 4 January 2017.

45 ZT Androus, 'The US, FGM, and Global Rights to Bodily Integrity' (Rothermere American Institute: US and Global Human Rights, University of Oxford, November 2004) <http://www.zacharyandrous.com/The%20US%20FGM%20and%20Global%20HR.pdf> accessed 16 June 2016, 3.

46 *Re B and G* (n 3) 62–63.

47 ibid 69.

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C. Justifying Distinctions

This assertion is significant. It is the first time in English law that MGC has been described as a 'significant harm'. Nevertheless, since this is the threshold test for care proceedings, if 'significant harm' is identified, the question then becomes whether it was a result of parental care that fell below what it would be 'reasonable to expect' of a parent. It is here that Munby LJ identifies a 'clear distinction' between female and male genital cutting:

> There are, after all, at least two important distinctions between the two. FGM has no basis in any religion; male circumcision is often performed for religious reasons. FGM has no medical justification and confers no health benefits; male circumcision is seen by some (although opinions are divided) as providing hygienic or prophylactic benefits.[48]

In other words, Munby LJ rationalises the legal distinction between male and female genital cutting in terms of 'reasonable parenting' by pointing to purported differences between religion and culture, and between the therapeutic and non-therapeutic. In resorting to these distinctions, Munby LJ's ruling is, in one sense, a conservative judgement. But there is a certain nuance in his choice of language which hints at a more progressive view. This nuance concerns the question of harm and why the law would respond differently to the children in front of him if both had their genitals cut:

> The explanation, it must be, is simply that in 2015 the law . . . is still prepared to tolerate non-therapeutic male circumcision . . . while no longer being willing to tolerate FGM in any of its forms. Certainly current judicial thinking seems to be that there is no equivalence between the two.[49]

The language is tentative and contingent, both temporally and legally. In terms of legal contingency, his final ruling is on the 'narrow' legal question of the reach of section 31. In terms of temporality, Munby LJ states that 'in 2015' and in the light of 'current judicial thinking' law is '*still prepared to tolerate* non-therapeutic'[50] cutting of male children's genitals. One way to read this hedge is as follows: 'for now, at this time, we still let this happen'. Assuming that is a fair reading, the suggestion seems to be that the situation is untenable. Continuing to use *B and G* to frame our analysis, in the next section we turn to a systems theoretical approach to explain the processes of legal change. This approach foregrounds the importance of scrutinising distinctions that serve to underpin the legitimacy of current social and legal arrangements.

II. RATIONALITY, IRRATIONALITY, AND THE LEGAL METHOD

From Munby LJ's tentative language one may infer an implicit understanding of how law changes over time. This understanding has a teleological dimension according to which society and law are purposefully developing towards a progressive and logical

48 ibid 72.

49 ibid 64–65.

50 ibid 64 (emphasis added).

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end: here, the protection of all children, regardless of sex or gender, from significant bodily harm. As John Harrington has written more generally of beliefs about change in medical law, the 'goals of universality and freedom are taken to be immanent . . . [t]he law will work itself clear of impediments to reason and liberty'.[51]

Systems theoretical approaches provide an alternative model of legal change. Such approaches position law as a recursive practice that is *operationally* closed to its environment.[52] As such, the legal system makes and remakes itself from its own normative resources (court judgements, for example rely on statutory provision and precedent cases), while its wider environment is constituted by other self-referential social systems (science, medicine, politics, and so forth) as well as the natural world.[53] This combination of systemic closure and self-reference establishes that 'a decision on lawfulness cannot be replaced by one on truth, profitability or therapeutic benefit and remain a *legal* decision'.[54]

A systems theoretical understanding of law recognises that there is no foundational justification for the distinction between law and non-law. The question of 'how can we rightly or wrongly differentiate the right and the wrong'[55] is the foundational paradox that results from this initial distinction—the essentially arbitrary (or violent) drawing of a line that designates one side as system (*the law*) and the other as environment. Hence law, esteemed in classic jurisprudence as the negation of violence—the Hobbesian contract—'in fact proceeds from it'.[56] The reproduction of the distinction between law and non-law in every subsequent legal operation has the effect of embedding contingency throughout the legal system.[57] This means that law is 'binding, but provisional; normative, but arbitrary'.[58]

Paradox is not only a defining feature of law, but is also generative of it. For as an autopoietic system, law 'cannot but find justification in [its] own circularity and cannot but produce regularities . . . that govern the transformation of their own irregularities'.[59] This circularity can be seen both in the foundational sense just outlined, but also in the form of 'local' paradoxes—those 'decisional paradoxes of daily legal

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51 J Harrington, 'Of Paradox and Plausibility: The Dynamic of Change in Medical Law' (2014) 22(3) Medical Law Review 305, 305. Nevertheless, Munby LJ also acknowledges less 'logical' modes of legal change, quoting Holmes J (from *The Common Law*, 1881): 'The life of the law has not been logic; it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious, even the prejudices which judges share with their fellow-men, have had a good deal more to do than the syllogism in determining the rules by which men should be governed'. This does not seem to satisfy Munby LJ, however: 'the curiosity' before him 'remains'. *Re B and G* (n 3) 64.

52 Whilst it is operationally, or normatively, closed, it is 'cognitively' open, drawing on expertise and knowledge claims from other systems such as medicine, as we go on to acknowledge.

53 See N Luhmann, 'Operational Closure and Structural Coupling: The Differentiation of the Legal System' (1991–92) 13 Cardozo Law Review 1419, 1420.

54 Harrington (n 51) 309 (emphasis added).

55 N Luhmann, 'The Third Question: The Creative Use of Paradoxes in Law and Legal History' (1988) 15(2) Journal of Law & Society 153, 154.

56 Harrington (n 51) 310.

57 G Teubner, '"And God Laughed": Indeterminacy, Self-Reference, and Paradox in Law' (1990) 7 Stanford Literature Review 15, 26.

58 Harrington (n 51) 310.

59 G Teubner, 'How The Law Thinks: Towards A Constructivist Epistemology of Law' (1989) 23(5) Law & Society Review 727, 736.

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practice'.[60] These arise as law addresses contingency in its daily operations and responds to dilemmas and pressures that are generated by social and political change. Included among these paradoxes are inconsistencies, contradictions, and weaknesses in legal reasoning.[61]

In managing such local paradoxes, law relies on processes of *distinction* and *displacement*. In the context of medical and family law, distinctions can be structured around categories such as age, reasonableness, parent, risk, and—as in the present case—the religious and therapeutic. The legitimacy or plausibility of such distinctions may then be supported by the displacement of the reasoning, and at times decision-making, into a different social field (such as medicine) relevant to the claimed distinction. Harrington illustrates this process with the example of the law governing the capacity of minors to consent to contraceptive treatment, an example that helpfully (for our purposes) straddles family and medical law:

> A distinction is drawn between over-16s and under-16s: the former are presumed competent, the latter must prove that they are. But . . . the actual decision on competence in the case of under-16s is displaced to the clinical judgement of the doctor. The underlying contingency of legal decision-making in this field will be effectively concealed for as long as this regime of distinction and displacement holds good.[62]

Rather than a process of logical development, therefore, we have a dynamic of legal change that is ordered through processes of distinction and displacement. A local paradox will be 'solved' by a process that relies on (increasingly fine) distinctions and—at times—the mobilisation of knowledge claims or decision-making from another social field. Paradoxes cannot be truly eliminated, however. Instead, they can only be bypassed by the drawing of further system-internal distinctions,[63] or by displacement into the environment. The task of making such strategies plausible is one that belongs necessarily to the judge.[64]

This understanding of the basis for legal reasoning can help us make sense of Munby LJ's judgement in *B and G*, as well as the wider discursive field within which it sits. The inconsistent treatment of MGC and FGC has typically been managed by drawing distinctions on the basis of harm. So, FGC is constructed as always harmful no matter how slight the intervention nor how sterile the equipment used, whereas MGC is constructed as always a benign parental choice, no matter how much of the foreskin is excised or the means by which this takes place.[65] Yet, this distinction

60 G Teubner, 'Dealing with Paradoxes of Law: Derrida, Luhmann, Wiethölter' in O Perez, G Teubner (eds), *Paradoxes and Inconsistencies in the Law* (Hart Publishing 2006) 50.

61 Perez (n 7) 22–26.

62 Harrington (n 51) 311.

63 See J Hendry and C King, 'How Far is Too Far? Theorising Non-conviction-based Asset Forfeiture' (2015) 11(4) International Journal of Law in Context 398, 404.

64 Harrington (n 51) 306.

65 Indeed, in the latter case, the risk of harm is typically reduced to and equated with the risk of 'surgical complications', R Darby, 'Risks, Benefits, Complications and Harms' (2015) 25(1) Kennedy Institute of Ethics Journal 1; BD Earp, 'Infant Circumcision and Adult Penile Sensitivity' (2016) 7(4) Trends in Urology & Men's Health 17. Even more peculiarly, in the case of MGC but not FGC, the risk of harm is often

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strains credulity. Because law's distinctions and displacements must be perceived as reasonable for it to maintain its credibility, a tension is created that must be resolved.

Whilst much of the immediate commentary on *B and G* interprets it as reasserting the distinction between male and female forms of genital cutting,[66] or actively fails to engage with Munby LJ's reasoning (at times uncritically restating the assumptions he challenges),[67] we see the case as providing the potential for a shift in judicial thinking. Munby LJ no longer accepts the blanket harm distinction that has been automatically asserted in previous rulings, such as *Secretary of State for the Home Office v K*. It is no longer plausible due to the simple fact that there are legally prohibited forms of FGC that are on any view less physically harmful than even the most mild yet legally tolerated forms of MGC. According to Munby LJ, therefore, both male and female children suffer 'significant harm' in the eyes of the law.

Munby LJ's reconsideration of harm acts as a (momentary) 'reparadoxification': his statement foregrounds the inconsistent logic of the current legal position. How, then, is this paradox managed? In the case of *B and G*, it is managed by drawing distinctions based on, and displacing responsibility into, the domains of religion and medicine. However, the stability of this solution is open to question. As Teubner argues, partial or temporary management of inconsistencies along one dimension 'promises no solution of the crisis, but at most its . . . postponement, concealment, [and] repression. It is only a matter of time before the crisis breaks out again'.[68] One possibility, therefore, is that, just as the prior distinction relying on (gendered) understandings of harm has lost its plausibility—at least to Munby LJ—so too will the new distinctions relying on religion and medicine. In this context, 'scholarly and other critiques may function as "irritations" provoking the legal system to reconsider' its temporary and partial solutions.[69] In the following sections, we undertake such an analysis by questioning the plausibility of Munby LJ's distinctions and displacements—that is, his attempted 'deparadoxifications'—before returning to the implications of this assessment for legal change.

III. THE THERAPEUTIC/NON-THERAPEUTIC DISTINCTION

We begin with the distinction drawn between the therapeutic and the non-therapeutic. To understand the relationships among gender, genital cutting, and medicine, it is useful to consider some of the historical factors that led to the adoption of

articulated in terms of *failure* to cut male children—eg the child will be harmed due to being teased for having unmodified genitals or face other social disadvantages. When similar points are raised concerning 'uncircumcised' females, however, what is proposed is a change to social norms, not their genitals. BD Earp and R Darby, 'Circumcision, Sexual Experience, and Harm' (2017) University of Pennsylvania Journal of International Law (in press).

66 See, for example, G Morris, 'What Can be Learnt from the First FGM Case?' (*lexisnexis*, 4 February 2015) <http://blogs.lexisnexis.co.uk/family/what-can-be-learnt-from-the-first-fgm-case/> accessed 16 June 2016; R English, 'Male Circumcision can be Part of "Reasonable Parenting", but No Form of FGM is Acceptable – Family Court' (*UK Human Rights Blog*, 18 January 2015) <https://ukhumanrightsblog.com/2015/01/18/male-circumcision-can-be-part-of-reasonable-parenting-but-no-form-of-fgm-is-acceptable-family-court/> accessed 25 September 2016.

67 See, for example, RD McAlister, 'A Dangerous Muddying of the Waters?' (2016) 24(2) Medical Law Review 259.

68 Teubner (n 61) 48.

69 J Harrington, *Towards A Rhetoric of Medical Law* (Routledge Glasshouse 2017) 26.

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MGC by Anglophone doctors in the 19th century. After providing this brief historical context, we identify problems with the frequent assertion that MGC is therapeutic whilst FGC has no health benefits.

Male circumcision emerged at a time of medical experimentation on the genitals of both sexes. Male and female genitals were subject to exploratory cutting, cauterising, and other interventions aimed at 'curing' a number of related Victorian scourges including hysteria, masturbation, degeneracy, insanity, and neurasthenia.[70] At the centre of this experimentation was a desire to manage sexuality and fears of sexual excess in both sexes. Thus FGC was embraced in a number of European countries and the United States, although it was treated with scepticism in the UK by most doctors (with a handful of notable exceptions).[71] Whilst medicine's experimentation with clitoridectomies and other 'clinical' interventions aimed at the vulva was fairly short lived,[72] the 1890s saw male circumcision become routine in Anglophone nations.[73] The entrenchment of MGC at that time has been explained in terms of cultural anxieties regarding hygiene, masturbation, and sexually transmitted diseases,[74] which saw the foreskin become 'the most vilified normal anatomical structure of the body'.[75]

Cultural anxieties concerning masturbation were particularly influential and focused on the individual child (who risked enfeeblement, paralysing lethargy, and perhaps insanity),[76] the family (threatened by men more interested in 'self-pleasure' than procreation),[77] and the ruling classes (a weakened ruling class 'stock' was seen as threatened by working class and immigrant populations who were perceived to be stronger and reproducing at a greater rate).[78] As Michel Foucault notes in *The History of Sexuality*, 'precocious sexuality was presented from the eighteenth century to the end of the nineteenth as an epidemic menace that risked compromising not only the future health of adults but the future of the entire society and species'.[79] Against this backdrop, MGC was believed to militate against masturbation as it reduced the incidence of adhesions and irritations which would otherwise lead to the penis being touched, thus encouraging 'self-abuse'.[80] Some advocates of circumcision believed that the anti-masturbation effects were bolstered by the pain of circumcision, which

70 GP Miller, 'Circumcision: Cultural-legal Analysis' (2002) 9 Virginia Journal of Social Policy and the Law 497; M Thomson, *Endowed: Regulating the Male Sexed Body* (Routledge 2008).

71 R Darby, *A Surgical Temptation: The Demonization of the Foreskin and the Rise of Circumcision in Britain* (Chicago University Press 2005) 143. The best-known advocate of 'female circumcision' in the UK was the prominent doctor Isaac Baker Brown. IB Brown, *On the Curability of Certain Forms of Insanity, Epilepsy, Catalepsy and Hysteria in Females* (Robert Hardwicke 1866).

72 However, note that FGC was available as a 'medical' procedure on some health insurance plans—chiefly as a treatment for such conditions as 'hysteria'—in the US until the 1970s. SB Rodriguez, *Female Circumcision and Clitoridectomy in the United States* (University of Rochester Press 2014).

73 Darby (n 72) 143.

74 R Darby, 'Circumcision as a Prevention of Masturbation: A Review of the Historiography' (2003) 36 Journal of Social History 737.

75 CJ Cold and JR Taylor, 'The Prepuce' (1999) 83 BJU International 34.

76 Thomson (n 71).

77 S Garlick, 'The Biopolitics of Masturbation: Masculinity, Complexity, and Security' (2014) 20(2) Body & Society 44.

78 Thomson (n 71).

79 M Foucault, *The History of Sexuality* (Penguin 1990) 146.

80 Miller (n 71) 527.

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would create an association in the mind of the child between touching the penis and pain.[81]

This early adoption of MGC as an individual and population level health intervention has circulated in different guises since this period. Whilst claims that now appear outlandish (that MGC will cure asthma, gout, alcoholism, malnutrition, eczema, and so forth)[82] have diminished, certain associations have persisted. Early pro-circumcision, anti-masturbation narratives were often linked not just with claims about hygiene, but also claims regarding sexually transmitted diseases. As a result, circumcision became an intended prophylaxis against (incurable) syphilis and was later mobilised against gonorrhoea.[83]

In contemporary terms, MGC continues to be promoted by some medical figures, primarily situated in the United States, on the basis that it may reduce the risk of urinary tract infections (UTIs), some sexually transmitted infections, and penile cancer, among other diseases. With respect to UTIs, boys with normally developing anatomy have an approximately 1% risk of infection in the first few years of life regardless of circumcision status, and these can be cured with antibiotics as they are for girls. As Benatar and Benatar explain, 'UTI does not occur in 99.85% of circumcised infant males and in 98.5% of un-circumcised infant boys'.[84] Accordingly, it would take more than 100 circumcisions to prevent a single UTI.[85] As for penile cancer, this is rare in developed countries, such that it would take between 909 and 322,000 circumcisions to prevent a single case.[86] This leaves primarily the claimed risk-reduction concerning sexually transmitted infections, which are preventable without surgery, often curable with antibiotics, and, if not curable, at least manageable with medications.

Notwithstanding these caveats, circumcision has recently been proposed as a public health response to HIV/AIDS, focused in the context of Sub-Saharan Africa. Here, evidence from three Randomized Control Trials suggests a partial protective effect of adult, voluntary circumcision against female-to-male transmission of HIV in areas with high base rates of such transmission and low baseline circumcision prevalence.[87] The scientific validity and ethics of these trials have been hotly debated.[88] More importantly, however, the relevance of these findings to circumcision of infants or young children, especially in more developed countries with different epidemiological environments and patterns of HIV transmission, is unknown. The balance of

81 See, for example, AW Johnson, 'On an Injurious Habit Occasionally Met with in Infancy and Early Childhood' (1860) 7 Lancet 344.

82 Miller (n 71) 527.

83 M Fox and M Thomson, 'HIV/AIDS and Male Circumcision: Discourses of Race and Masculinity' in M Fineman and M Thomson (eds), *Masculinity, Feminism and Law* (Ashgate 2013) 97–113.

84 M Benatar and D Benatar, 'Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision' (2003) 3 American Journal of Bioethics 35, 40.

85 AAP, 'Male Circumcision' (2012) 130 Pediatrics e756.

86 ibid.

87 See Fox and Thomson (n 84) 798; M Fox and M Thomson, 'The New Politics of Male Circumcision: HIV/AIDS, Health Law and Social Justice' (2012) 32(2) Legal Studies 255.

88 See discussion in M Frisch and BD Earp, 'Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries' (2016) 19 Global Public Health 1.

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opinion among global health authorities is that there is little or no such relevance.[89] Nevertheless, as has been evident throughout the history of medicalised MGC, the purported benefits have become entrenched in public, including legal, discourse.

In this context, it is worth considering the putative benefits of circumcision in relation to other modes of health promotion. To begin, it is likely that removing tissue from most locations on a child's body would reduce the future risk of medical problems affecting that tissue or introduced to other parts of the body through it. Yet as Eike-Henner Kluge argues, if this logic were accepted more generally, 'all sorts of medical conditions would be implicated' and we would find ourselves 'operating nonstop on just about every part of the human body'.[90] So, routinely removing parts of the paediatric vulva, such as the labia minora, for instance, might come to be seen as a sensible means of reducing the future risk of vulvar cancer in female individuals (according to this framework). Yet it is currently impermissible to collect the data that would be needed to support such an intervention, since neonatal or early-childhood labiaplasty is illegal in Western countries.

The question, therefore, is not whether certain health benefits may in fact follow from simply removing the tissue or body part in question, but whether those benefits are sufficient to outweigh the costs and harms of the intervention (physical, monetary, and moral) in light of alternative modes of prevention that are less risky and less invasive, as well as more effective and less ethically contentious.[91] Given this analysis, the plausibility of the distinction based on 'health benefits' can be challenged from at least two directions. The first direction involves critiquing the studies that purport to show health benefits in the male case, and/or arguing that even if these benefits do exist, they are not sufficient to outweigh the costs and harms. This is a common strategy, and it reflects the dominant view of health professionals who have considered the matter outside the United States.[92]

The second direction for challenging the distinction is less common, and relies on the fact that the apparent difference between male and female forms of genital cutting with respect to health benefits may in large part be a *consequence* of the current legal situation, rather than a valid prior justification for it. Specifically, as alluded to above, due to the fact that all forms of FGC are prohibited by law in Western countries, it is not possible to conduct an adequately controlled scientific study to determine whether a minor, sterilised form of the procedure in childhood would in fact confer some kind or degree of health benefit. And yet the vulva, compared to the penis, provides if anything an even more hospitable environment to bacteria, yeasts, viruses, and so forth, such that removing moist folds of tissue (with a sterile surgical instrument) might very well reduce the risk of associated problems.

89 JA Bossio and others, 'A Review of the Current State of the Male Circumcision Literature' (2014) 11(12) Journal of Sexual Medicine 2847; see also Appendix 2, RACP, 'Circumcision of Infant Males' *(Royal Australasian College of Physicians*, 2010) <https://www.racp.edu.au/docs/default-source/advocacy-library/circumcision-of-infant-males.pdf> accessed 20 March 2017.

90 EH Kluge, 'Dr. Kluge Responds' (1994) 150(10) Canadian Medical Association Journal 1542.

91 Frisch and Earp (n 89).

92 ibid. See also M Frisch and others, 'Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision' (2013) 131(4) Pediatrics 796; RACP (n 90).

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We do not advocate that this be done. We are simply pointing out that the claimed lack of health benefits for childhood FGC is based on a near-exclusive focus on its most invasive and least hygienic forms, and on a paucity of research into any possible health advantages that might be associated with its more minor and most hygienic forms. As the medical historian Robert Darby has pointed out, official bodies working against FGC including the WHO 'have condemned medicalization of the procedure and funded massive research programs into the harm of the surgery'. He sees it as ironic that:

> [the] WHO also frames male circumcision as a public health issue - but from the opposite starting point. Instead of a research program to study the possible harms of circumcision, it funds research into [its] benefits . . . In neither case, however, is the research open-ended: in relation to women the search is for damage, in relation to men it is for benefits; and since the initial assumptions influence the outcomes, these results are duly found.[93]

Even so, as we have suggested, the health benefits that have been attributed to male circumcision, particularly as it is performed in childhood, and particularly in the Western context that is most relevant to the legal reasoning employed by Munby LJ and others, are generally agreed to be modest at best. This conclusion is further strengthened when the claimed benefits are weighed against the countervailing risks and other drawbacks of circumcision and the fact that they are generally achievable by other, less invasive, more autonomy-respecting means (ie safer sex practices and basic hygiene).[94]

IV. CULTURE VERSUS RELIGION

What about the plausibility of the distinction based on religion? According to Munby LJ, 'FGM has no basis in any religion [whereas] male circumcision is often performed for religious reasons'.[95] This is a common view. As Margherita Brusa and Y. Michael Barilan note, this distinction between cultural and religious motivations is widespread in the popular imagination:

> It is implied that 'religious' [ie, male] circumcision deserves protection and even assistance on the grounds of respect for people's faiths and own perception of divine commandments, whereas 'cultural' [ie, female] circumcision is more like a habit that deserves less tolerance.[96]

This view is problematic for at least two reasons, both of which challenge Munby LJ's attempted resolution of the paradox concerning harm. First, there is a good argument to be made that, within Islam at least, the religious justification for FGC is no weaker, on textual grounds, than it is for MGC, as we shall detail.[97] And second, even if a

93 Darby (n 40) 157.
94 See Frisch and others (n 93).
95 *Re B and G* (n 3) 55.
96 M Brusa and YM Barilan, 'Cultural Circumcision in EU Public Hospitals' (2009) 23(8) Bioethics 470, 471.
97 M Johnson, 'Male Genital Mutilation: Beyond the Tolerable?' (2010) 10(2) Ethnicities 181.

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practice were *only* cultural in nature, this would not entail that it was any less deserving of moral or legal respect. Indeed, whilst human rights were not raised in the court, international human rights provisions protect both religion and culture.[98] Moreover, case law both domestically and in the European Court of Human Rights has stressed equal protection and provided an expansive definition of culture or belief. In terms of European jurisprudence on belief, what is required for legal protection is that a belief attains 'a certain level of cogency, seriousness, cohesion and importance'.[99] In fact, in the month that followed *B and G*, the UK Employment Appeals Tribunal held that what is required is that a belief is 'fundamental or integral to a person's individuality and daily life'.[100] As such, the cultural or religious origins of a belief or sense of obligation do not determine the level of its legal protection.

To return to our first point, although FGC is often associated with Islamic culture, no mention of FGC is found in the Qur'an: this is often taken as evidence that the practice is not religious.[101] However, just as in Judaism and Christianity where 'binding religious obligations can arise from oral teachings and extrabiblical sources (eg, rabbinic teachings, papal encyclicals), Islam looks to other sources to interpret and supplement Koranic teachings',[102] such as the Hadith, the prophetic sayings of the prophet Mohammed. Accordingly, as Alex Myers notes:

> [I]n Sunni Islam, the dominant branch of Islam, two of the four schools of jurisprudence, Shafi'i and Hanbali, consider Type 1 female circumcision to be obligatory, while the other two schools, Maliki and Hanafi, recommend the practice. *The scriptural support for this is no weaker than that for male circumcision*—both are derived from the secondary source of Islamic law . . . the Hadith . . . and neither is to be found in the Qur'an.[103]

To assert that because it is not in the Qur'an it is not part of the religion is, as Dena Davis notes, 'as nonsensical as telling a Roman Catholic that because there is no prohibition against abortion in the Bible she cannot claim to be opposed to abortion on religious grounds'.[104] Arora and Jacobs similarly argue that outsiders to a religious tradition 'cannot infer the practices of a religious system from a literal reading of its canonical texts'. So, for example, 'It is no more possible to define Islam within the four corners of the Quran than to define Christianity (which includes traditions ranging from Presbyterian to Pentecostal to Greek Orthodoxy) solely from a reading of the

98 Whilst our analysis focuses on the distinction drawn between religion and culture, we are aware of arguments that courts have implicitly drawn further distinctions between different religions, in the sense of being more willing to challenge the legitimacy of the practices of some religions (notably Islam) more than others. See L Peroni, 'Religion and Culture in the Discourse of the European Court of Human Rights' (2014) 10(2) International Journal of Law in Context 195.

99 *Campbell and Cosans v UK* App no 7511/76, 22 March 1983.

100 *General Municipal and Boilermakers Union v Henderson* [2015] UKEAT 0073_14_1303, 62.

101 Davis (n 11) 532.

102 ibid.

103 A Myers, 'Neonatal Male Circumcision, If Not Already Commonplace, would be Plainly Unacceptable by Modern Ethical Standards' (2015) 15 (2) American Journal of Bioethics 54, 55 (emphasis added).

104 Davis (n 11) 532; KS Arora and AJ Jacobs, 'Female Genital Alteration: A Compromise Solution' (2016) 42(3) Journal of Medical Ethics 148, 151.

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Bible'. Rather, 'the content of religious belief and practice are guided by interpretive texts and traditions'.[105]

With respect to genital cutting practices in particular, Brusa and Barilan explain that the claimed distinction between the religious and the cultural is also historically unfounded: 'Research on the historical development of [both male and female] circumcision demonstrates very intricate links bridging religion, institutions of social power and metamorphoses in meaning and practice over time and space'. In practice as well as conceptually, then, religion and culture are not abstract, independent entities that maintain stable logical relationships with each other.[106] Supportive of this view is the work of Francis Raday, who argues that the schematic separation of culture and religion 'does not accurately represent the way in which traditionalist cultures and religion actually interact . . . [as] there appears to be a correlation between certain cultural practices and the religious environments in which they thrive'.[107] But even if religion and culture were conceptually distinct, independent entities, there would be little reason to think that a cultural practice was less worthy of legal protection than a religious one. Importantly, in a context in which we are looking at how law treats male and female individuals differently, Brusa and Barilan suggest that the distinction between religion and culture reflects biases in both class and gender. As they point out, the religiously educated (disproportionately men) locate and justify their practices in theological terms, while those less versed in official theological teachings (disproportionately women), may explain their equally valued goals in 'cultural' terms that are perceived to be less authoritative. The authors state:

> [W]e do not see a reason for trying to rank the value of circumcision to Senegalese Christians relative to those of tribal Africans or observant Muslims. In the same vein, we do not suppose that the few religious sentiments of a secular person, even an atheist, deserve less consideration than the religious values of the most piously orthodox, or of one who follows the ways of an ethnic group without adherence to any creed whatsoever.[108]

Davis makes a related point, asking her readers to compare two scenarios which she populates with a series of 'matched' couples. In the first scenario, she refers to a deeply religious Muslim couple who believe that they are religiously obligated to cut their daughter's genitals. In respect of this, they are willing to accept a medicalised ritual 'nick' to meet this obligation. Davis matches this couple with a similarly religious Jewish couple who wish to have their son cut in a religious ceremony. In these circumstances, and sitting comfortably with Munby LJ's initial reasoning, Davis argues that it is difficult to reconcile why the first couple's actions would be illegal and the second's not. Further, 'If we imagine that the Muslim girl's experience will be a tiny nick with proper pain control in a hospital context, while the Jewish boy's experience will be a

105 Arora and Jacobs, ibid 151.

106 Brusa and Barilan (n 97).

107 F Raday, 'Culture, Religion, and Gender' (2003) 1(4) International Journal of Constitutional Law 663, 675–76.

108 Brusa and Barilan (n 97) 472.

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somewhat larger operation by a nonmedical practitioner without adequate pain control, the justification becomes even more difficult'.[109]

In Davis's second scenario, a Jewish couple is planning a circumcision performed by a physician in a surgical setting. Whilst the couple state that they will not educate him religiously and do not know if he will ever join a synagogue, they believe that to leave him uncut is 'unthinkable'. To leave him uncut 'will make him look odd to his Jewish friends, may have a negative effect on his ability to marry a Jewish girl, and will bring down the wrath of their parents'.[110] Davis matches this couple with a sub-Saharan African couple vague about their religious beliefs but who feel that to leave their daughter uncut will be in some sense un-Islamic. Further: 'they have good reason to fear that their daughter, if left uncircumcised, will be laughed at, perhaps ostracized, and have a very difficult time marrying within their culture'. As she concludes, and as we are inclined to agree, it is difficult to locate a sound justification for respecting the first couple's 'mix of beliefs and custom, but not the second'.[111]

V. LEGAL IRRITANTS AND CHANGE

In the preceding sections, we have challenged the validity, coherence, and consistency of the distinctions that are often used to justify differential treatment of MGC and FGC. In doing this we identify certain 'irritants', questioning the sustainability of the current legal position.[112] Until recently, the conventional distinctions have relied on forms of knowledge that have been relatively secure from such irritation by activists and academics. Religion and medicine have both functioned as 'black boxes', absorbing inconsistencies, contradictions, and challenge.[113] There is now significant dissent in terms of health-based claims, and changes in medicine more generally—including evidence-based practice and clinical guidelines—have further dented this black box. Religion, by contrast, remains more secure although the identification of 'harm' threatens this status: in other contexts, Western law does not allow parents to harm their children *simply* because it is called for or sanctioned by some religion.[114] The religious black box is also threatened by a growing body of scholarship that challenges the distinction between religion and culture, as well as by work that seeks to foreground the lack of homogeneity in religious practice. In terms of the latter, one might draw attention to the adoption by some Jewish communities of the *brit shalom* welcoming ceremony (which is gender neutral and which does not involve any genital cutting) as an alternative to the traditional *brit milah*.[115] Legal change may thus continue, as these

109 Davis (n 11) 565.

110 ibid.

111 ibid 566.

112 See G Teubner, 'Legal Irritants: Good Faith in British Law or How Unifying Law Ends Up in New Divergencies' (1998) 61 Modern Law Review 11.

113 Harrington (n 51) 305.

114 Indeed, harm has been posited as delimiting the special treatment that religion is afforded by law. See R Plant, 'Religion, Identity and Freedom of Expression' (2011) 17(1) Res Publica 7.

115 See N Bivas, 'Choosing Brit Shalom Over Brit Milah' (*Beyond the Bris*, 24 April 2012) <www.beyondthebris.com/2012/04/choosing-brit-shalom-over-brit-milah.html> accessed 4 January 2017; MD Reiss 'Brit Shalom Information' (*Britshalom.info*, 2016) <http://www.britshalom.info/> accessed 4 January 2017.

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black boxes are opened and additional light is cast on the complexity of what is 'usually taken to be simple and inevitable'.[116]

Viewed through the lens of children's rights, the standing of *B and G* is ambiguous. Whilst Munby LJ identifies MGC as causing significant harm, this is nevertheless done in the specific context of section 31—and the harm is then characterised as arising from parental behaviour that in 2015 the law 'is still prepared to tolerate'. This limited reading played out in the case of *Re L and B (children) (Specific Issues: Temporary Leave to Remove from the Jurisdiction; Circumcision)*[117] that was heard just over a year after *B and G*. The case involved a dispute between separated parents regarding the care and upbringing of two boys aged 6 and 4. This case concerned, *inter alia*, an application by the father to have the two boys circumcised in accordance with the Muslim faith in which the children were being raised. The mother objected to the cutting of the boys and argued that this should be left for the boys themselves to decide when they were competent to make the decisions. In assessing the legal position regarding circumcision, Roberts J provides a detailed account of *Re J* [1999],[118] *Re S* [2004],[119] and the judgement that has served as the basis of our analysis. In addressing *B and G*, Roberts J observed that according to Munby LJ, '"reasonable" parenting is treated as permitting male circumcision'.[120] In other words, in the first case since *B and G* we see that Munby LJ's careful consideration of MGC has been reduced to its conservative conclusion.

There are three points to note, however. First, Roberts J declined to make the order allowing the father to circumcise the two boys. She claimed that she was 'simply deferring that decision to the point where each of the boys themselves will make their individual choices once they have maturity and insight to appreciate the consequences and longer term effects of the decisions which they reach'.[121] This claim is consistent with the earlier post-separation cases of *Re J* and *Re S* and moves us towards a consensus in such cases and in the academic literature. This consensus recognises that children have a right to bodily integrity and to participate in important decision-making that affects them.[122]

Secondly, whilst we see a rather minimal (if legally correct) response to Munby LJ's wider reasoning, the potential impact of his statement regarding the comparability of harms is nevertheless still great: it is an authoritative statement by one of the UK's leading judges. The legal and cultural life of judicial statements can be unpredictable and designating MGC as causing 'significant harm' may have effects beyond the confines of the case and the specific consideration of section 31. Yet whether this happens will rely, to a large extent, on the response of activists and academics. As we have

116 Harrington (n 51) 319.

117 [2016] EWHC 849 (Fam).

118 *Re J (child's religious upbringing and circumcision)* [1999] 2 FLR 678.

119 *Re S (Specific Issue Order: Religion: Circumcision)* [2004] EWHC 1282 (Fam).

120 [2016] EWHC 849 (Fam) (n 118) [52].

121 ibid 143.

122 The right of children to participate in decision-making that affects them has long been recognised in health care law and practice, see: M Donnelly and U Kilkelly, 'Child-friendly Health Care: Delivering on the Right to be Heard' (2011) 19(1) Medical Law Review 27–54. For a discussion of the conflict between parental rights and the child's right to bodily integrity in the context of non-therapeutic procedures see, B Lyon, 'Obliging Children' (2011) 19(1) Medical Law Review 55–85 and '"The Good that is Interred in Their Bones": Are There Property Rights in the Child?' (2011) 19(3) Medical Law Review 372.

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emphasised, these groups may provide critiques that function as irritations, 'provoking the legal system to reconsider and abandon' the inadequate solutions it proposes to the paradoxes it creates.[123] Here Munby LJ's less than wholehearted turn to the religion/culture and therapeutic/non-therapeutic distinctions provides a renewed focus for these activists and academics.

Finally, there is one more paradox that remains to be addressed. Following the line of cases *Re J, Re S,* and *Re L and B* there is authority for stating that in post-separation families where there is disagreement about the cutting of a male child's genitals, the decision is likely to be deferred until the boy is old enough to make this decision for himself. This deferral recognises the harm, pain and risks involved, as well as the child's right to make decisions regarding his own body and permanent marks of religious affiliation.[124] The paradox here is that the law only recognises the child as having these rights when the parents disagree. Where the parents agree, these rights are not protected.

VI. CONCLUSONS

Many scholars now view the non-consensual, medically unnecessary surgical alteration of male, female, and indeed intersex children's genitals as morally impermissible, and a growing minority endorses efforts to eliminate these practices. In this article, we have challenged the differential treatment of genital cutting on the basis of gender, highlighting recent changes in understandings of harm that echo the way in which other harms experienced by children have become knowable at different times.[125] Further, we have interrogated two distinctions that are often uncritically asserted to justify the current legal position, and we have found that they do not withstand scrutiny. Our analysis has relevance to other parental actions where claims to therapeutic benefit or religious observance are used to justify choices that may violate children's rights. Specifically, the analysis presented here should provoke greater scrutiny of the cultural and historical particularities of such distinctions and demarcations. Whilst our analysis is most relevant to body-shaping surgeries where the designation therapeutic/non-therapeutic is contested, it is also relevant to other parental decision-making in non-medical contexts where fundamental rights, such as the right to education, may be violated.

The ultimate afterlife of *B and G* cannot be anticipated with certainty. It might be that the potential significance of Munby LJ's approach to harm is lost as subsequent cases sideline his nuanced analysis, as occurred with *L and B.*[126] Alternatively, it might be that the judgement inspires movement towards a point at which male and female forms of non-therapeutic genital alteration are no longer discussed in separate discourses, whether from a legal or moral perspective. This alternative future is possible when we consider law according to a systems theoretical approach that foregrounds

123 Harrington (n 51) 313.

124 These rights were recognised in a controversial case in Cologne in 2012: Landgericht Koln (Cologne District Court), Judgment on May 7 [2012] No 151 Ns 169/11. For discussions of this case and the response of the German government, see GB Levey, 'Thinking about Infant Male Circumcision after the Cologne Court Decision' (2013) 3 Global Discourse 326; Munzer (n 9); Earp and Darby (n 65).

125 Smart (n 5) 391.

126 See (n 118).

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its contingent management of local paradoxes and the generative potential of challenging its inconsistencies:

> [P]aradoxes are far from being simply technical problems, quietly impelling legal evolution. Rather they constitute points of entry for political struggle in law and, thus, a focus for multiple strategies to establish and re-establish the terms and arrangements of social life.[127]

In this article, we have identified 'points of entry' for those who regard the law as it currently stands as falling short of protecting and equally valuing all children's right to bodily integrity.[128] Society must now consider how tolerant it is willing to be of practices which permanently shape children's bodies in the service of culture or religion, before the child can make his or her own determination.

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127 Harrington (n 51) 323–24.

128 See, M Fox and M Thomson, 'Older Minors and Circumcision: Questioning the Limits of Religious Actions' (2008) 9 Medical Law International 283; Earp (n 15); BD Earp, 'Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on "FGM"' (2016) 26(2) Kennedy Institute of Ethics Journal 105; BD Earp, 'In Defense of Genital Autonomy for Children' (2016) 41(3) Journal of Medical Ethics 158; Fox and Thomson (n 10).

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In defence of genital autonomy for children

Brian D Earp

ABSTRACT

Arora and Jacobs (2016) assume that liberal societies should tolerate non-therapeutic infant male circumcision, and argue that it follows from this that they should similarly tolerate—or even encourage—what the authors regard as '*de minimis*' forms of female genital mutilation (as defined by the World Health Organization). In this commentary, I argue that many serious problems would be likely to follow from a policy of increased tolerance for female genital mutilation, and that it may therefore be time to consider a less tolerant attitude toward non-therapeutic infant male circumcision. Ultimately, I suggest that children of whatever sex or gender should be free from having healthy parts of their most intimate sexual organs either damaged or removed, before they can understand what is at stake in such an intervention and agree to it themselves.

INTRODUCTION

In their target article, Arora and Jacobs[1] contend, among other things, that if non-therapeutic infant male circumcision should be widely tolerated, then so should some forms what the WHO calls 'female genital mutilation' (or FGM).[2] [i] Indeed, there are numerous substantial overlaps, both physical and symbolic, between these two types of genital alteration that are not very widely appreciated;[3–10] accordingly, I have prepared an online supplementary appendix[ii] in which I outline some of the main morally relevant features that they share. For now, however, let us consider only the conditional argument put forward by the authors, namely that: 'a liberal society that tolerates expression of culture and/or religion in the manner of male circumcision should also permit certain *de minimis* [female genital altering] procedures'.[1]

I offer a different perspective. Rather than proceeding from the premise that non-therapeutic, non-consensual male genital alteration (MGA) is clearly permissible (and should therefore be widely tolerated in liberal societies) to the conclusion that purportedly '*de minimis*' forms of non-therapeutic, non-consensual female genital alteration (FGA) should also be permitted, I will instead move in the opposite direction. My strategy will be to highlight some of the downsides that seem likely to follow from an increased tolerance for FGA in Western societies, and use this as a premise from which to argue that it may be time to consider a less tolerant position towards MGA. Please note that I will not be arguing in favour of a 'ban' on MGA (for reasons I go into elsewhere)[11–13] but rather for its being strongly discouraged, perhaps through some form of regulation (akin to the proposal by Ben-Yami in an earlier issue of this journal).[14]

SOME PROBLEMS WITH INCREASING TOLERANCE FOR FGA IN WESTERN SOCIETIES

Here are some problems that seem likely to follow from a more tolerant position towards FGA.

Legal problems

FGA, including its 'minor' forms, is currently illegal in the vast majority of liberal societies (I will focus on so-called Western countries, such as the USA, Canada, Australia and the countries of Europe).[15 16] To change this situation, at least according to one plausible interpretation, it would require that the laws regarding physical assault on a minor be rewritten, potentially creating widespread disturbances and inconsistencies throughout their respective legal systems. This is because, as some scholars have argued, cutting into a child's genitals without a medical diagnosis, and without its informed consent, meets the formal definition of criminal assault under the legal codes of most of these societies.[4 17–20] (Please note that this view assumes that parental 'proxy' consent is invalid for such procedures, for which arguments have been given elsewhere.)[20–22] Indeed, in its move to ban FGA in 1997, the US Congress stated 'that it 'infringes upon the guarantees of rights secured by Federal and State law, both statutory and constitutional'. That is to say, [non-therapeutic] female genital cutting [without consent] *was already unlawful*' prior to the enactment of specific legislation.[23]

A further issue, as Blackstone noted more than 200 years ago, is that 'the law cannot draw [a] line between different degrees of violence'[24] [p. 270]. What this means is that if any particular act of violence—such as the cutting of a child's body in the absence of medical necessity, perhaps especially with the effect of damaging or removing functional tissue—is legally permitted, then fraught decisions have to be made 'as to where within the continuum of violence the limits are to be fixed'[25] [p. 129]. This, in turn, could open the door for interested parties to argue, for any proposed act of cutting, that it is not 'violent enough' to warrant the placement of limitations on parental decision making.[4] More on this will be said in a subsequent section.

An additional problem is that changing the law would remove at least one important tool that reformers from within the affected communities can appeal to, in their quest to end the spectrum of FGA practices. Specifically, many women from established immigrant groups report that they do not wish to continue subjecting their daughters to FGA (for an excellent review of the evidence concerning 'cultural change after migration' with respect to this issue, see the work of Johnsdotter and Essén)[26] but they may face pressure from fellow group members.[27] This can make it difficult for any one parent or family to unilaterally challenge, much less abandon, the tradition: as Mackie has argued, it is a collective action problem.[28 29] What a legal prohibition allows, then, is for reformers from within these groups to be able to point to the law and say, 'I have no choice but to keep my daughter's genitals intact', effectively resolving the social dilemma.[27 30]

Finally, as Ludbrook argues, 'the law is an important symbol and if [it] allows parents, carers and teachers to [so much as hit their] children', much less cut into a physically and symbolically sensitive part of their bodies, 'it is sending a message to

[i] The terminology here is notoriously contentious: see, for example, Davis[3] for an in-depth discussion. I will simply follow Arora and Jacobs in using 'female genital alteration' (FGA) for the remainder of this essay.

[ii] Available at http://dx.doi.org/10.1136/medethics-2015-103030. Please note that this appendix also includes a more detailed response to many of Arora and Jacobs's more problematic claims, focusing on those that I did not have the room to address in the main text of this commentary.

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these people and to the community generally that children are not entitled to the same right to bodily integrity as adults'[25] [p. 129].

Against this view, Arora and Jacobs argue that (what they regard as) '*de minimis*' forms of FGA 'do not constitute a human rights violation' with respect to bodily integrity, because they have 'no more effect than other accepted procedures performed on minors for esthetic enhancement'.[1] In previous writings, they have listed mole removal and cosmetic orthodontia as examples of such procedures.[31] But as I have suggested elsewhere:

> 'the genitals (in particular) might plausibly be seen as having a special, even unique psychosexual significance compared to other parts of the body, which could make their un-consented alteration more likely to be experienced (later on) as a harm. [This] could help to explain why there is an active 'genital autonomy' movement in the United States, Europe, and elsewhere—fueled by women, men, and intersex people who are extremely resentful about their childhood genital surgeries—but not an anti-orthodontics movement or an anti-mole removal movement'[32] [p. 45].

More could be said about this disagreement. For a thoughtful analysis of the right to bodily integrity as it applies to preautonomous individuals, see the essay by Ungar-Sargon in a recent issue of this journal.[33] See also the work of Darby on a child's 'right to an open future'.[34] For an extended articulation of my own views concerning the ethics of ostensible 'enhancement' procedures in children, see the references here.[5 12 35 36 iii]

Regulatory problems

Another problem with the authors' proposal has to do with monitoring and regulation. As Arora and Jacobs concede, their suggestion might 'open the door' for 'more invasive procedures [to be carried out] under the guise of *de minimis* procedures',[1] thereby increasing the overall level of harm. In response to a similar policy proposal by the American Academy of Pediatrics (AAP) in 2010 (see later discussion), the Somali-born writer and activist Hirsi Ali asked: 'how could we tell that parents who want to ensure that their daughter will be a virgin on her wedding night will not have her (legally) nicked [on one day] and then a few months later (illegally) infibulated?'[37] Indeed, as Leye and colleagues point out, 'in some communities, traditional circumcisers will 'redo' girls if they notice that only an incision has been made'[38] [p. 368].

The authors' response to this type of objection is that 'given the widespread nature currently' of the more invasive procedures, 'if even a few girls undergo a *de minimis* procedure instead of a more invasive one due to this strategy then the strategy is appropriate'.[1] However, they do not provide any evidence that the more invasive procedures are in fact 'widespread' in Western countries, specifically, which is the legal setting most relevant to their arguments (and readership); in fact the recent survey by Johnsdotter and Essén stands in direct contrast with this scenario.[26] Moreover, if permitting 'minor' forms of FGA actually had the effect of lending a 'cloak of respectability' to all FGA procedures—a possibility that Arora and Jacobs themselves raise, but do not adequately consider—then the more invasive forms might very well increase in number, leading (again) to greater harm overall. Since the authors do not provide any persuasive evidence in favour of their own predicted outcome as opposed to this plausible alternative, it is unclear why we should endorse their policy proposal, even on consequentialist grounds.

A related problem is more practical in nature. How would the actual cutting sessions be monitored (and by whom) to make sure that only the 'right amount' of tissue was being incised, damaged, or removed? Arora and Jacobs admit that this is a problem with their proposal. But instead of addressing it, they simply divert attention to other problematic practices. As they write: 'The concern regarding amount of tissue being removed is … not unique to FGA, but is similar to male circumcision as well as cosmetic surgeries on adults'.[1]

They are right to raise the example of male circumcision. At least one underdocumented risk of this procedure, especially when carried out in infancy, is the removal of too much tissue—sometimes causing painful erections when the child grows up.[39–42] To put it simply, there is no 'dotted line' showing where to cut around an infant's diminutive penis, just as there is no determinate location where the foreskin ends and where the rest of the penis begins. This uncertainty in terms of where to cut, and the associated risk of cutting away too much, arguably speaks in favour of deferring the surgery until the organ has reached its full size. Then, the individual whose genital integrity is at stake can indicate exactly how much tissue - if any -[iv] he would like to have removed, and he can do so under conditions of informed consent.

A similar analysis applies to FGA procedures. In fact, this parallel leads us directly to the other diversion mentioned by the authors, namely, 'cosmetic surgeries on adults'. The key word is 'adults'. If an *adult female* wishes to undergo a genital surgery (to choose the most pertinent example) for cosmetic, cultural, religious or other reasons, there is indeed, as Arora and Jacobs point out, a non-trivial risk that too much tissue will be removed, or that the surgery will yield unsatisfactory results in any number of other ways. But this would be mitigated by the fact that the surgery was undertaken voluntarily. In other words, the primary (moral) difference between consensual genital surgery, and both FGA and MGA carried out on children, is that an adult can assess the relevant risks in light of her own goals and values, and determine whether they are 'worth it' to her, all things considered.[35 43] A child has no such recourse.

Speaking generally, then, the suggestion of harm tolerance when it comes to interventions into children's bodies is untenable. In part, this is due to 'the difficulty it presents in terms of specifying an appropriate threshold for harm that could be measured in an objective way'[4] [p. 98]. As Van Howe notes, the meaning of 'harm', in practice, therefore, will inevitably be left up to the interpretational vagaries of each provider, perhaps in consultation with the child's parents.[44] This vagueness creates a problem: 'there are practitioners, especially in cultures where female circumcision is common, who fervently believe that more invasive forms of female circumcision'—that is, forms that even Arora and Jacobs reject—'do not pose risks of physical or psychological harm'[44] [p. 167]. In fact, these providers could easily make selective appeals to studies from the medical literature that appear to show health-based benefits for FGA,[4] as well as an absence of serious harms,[45] much as some supporters of MGA are prone to do.[46 47] When the many purported cultural benefits of FGA

[iii] Of particular relevance is the essay, 'Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on 'FGM',' in press at the *Kennedy Institute of Ethics Journal*. The accepted manuscript is available online ahead of print here: https://www.academia.edu/10197867/Between_moral_relativism_and_moral_hypocrisy_Reframing_the_debate_on_FGM_.

[iv] The overwhelming majority of men who grow up with intact genitalia do not go on to pursue circumcision later on.

are factored in, Van Howe continues, 'practitioners could easily convince themselves that any harm is more than offset by the many perceived benefits'[44] [p. 167].

Medical problems

Potential problems concerning clinical and surgical matters have been raised by Leye and colleagues. They write: 'it is difficult to avoid damaging the clitoris when performing a ['*de minimis*'] incision, especially in genitalia that are not fully developed'. Moreover, 'complications (such as shock, infections, sepsis, and bleeding) are difficult to avoid [entirely], even with [such a minor] incision'[38] [p. 368]. Thus, as Goldman has stated, the assumption that '*de minimis*' interventions into a child's vulva really are essentially harmless is 'debatable'. As he goes on to write: even if it could be shown that the harm is, in some sense, 'relatively minor, it is still harm. Certainly, there is physical harm or risk of physical harm any time a cutting instrument contacts sensitive genital tissue'.[48] He concludes, then, that the 'burden of proof' is on those who argue that the risk of harm is trivial.

How Arora and Jacobs could meet this burden is unclear. First, as they note, it is currently illegal in Western societies to perform FGA procedures in children, so it is impossible to collect the very data that would be needed to make their case. But let us just assume that the ban were lifted. How long would it be reasonable to allow for such procedures to be performed in the absence of high-quality long-term follow-up data (concerning such vital issues as the effects of these procedures on, eg, sexual function, sensation and satisfaction) before it became possible to show that they had, in fact, been more harmful than Arora and Jacobs guessed that they would be?

An example should elucidate the danger. Consider 'procedures resembling elective labiaplasty as performed in Western nations', which Arora and Jacobs use to illustrate category 2 of their proposed typology. This refers to interventions that 'create morphological changes, but are not expected to have an adverse effect on reproduction or on the sexual satisfaction of the woman or her partner'.[1]

Arora and Jacobs argue that such procedures should be considered permissible in young girls, so long as they are requested by the parents. Problematically, however, the only available studies assessing reproductive and sexual outcomes associated with this particular intervention stem from surgeries performed on consenting adult women (or older adolescents); and even then the data are woefully incomplete.[49] But—again—let us just assume that, one day, researchers do produce a robust and convincing benefit-to-risk (or benefit-to-harm)[50] profile for non-therapeutic labiaplasty or similar procedures carried out on adults. Even so, we could not be sure that the profile would apply to children.[32] For one thing, sexual outcomes, in particular, are highly subjective;[51] and the women who undergo procedures akin to labiaplasty and subsequently report on their effects are unlikely to be representative of the general female population. This is because, overwhelmingly, they will have pursued their elective genital surgeries precisely because they were unsatisfied with their labia/vulva in some way, and wanted a change. In the case of a young girl, however, we cannot know, in advance, how she will (later) regard her own vulva—she might value her genitals in their intact state very highly—and so we are not in a position to judge how their modification would affect her sexual experience.

Sexual problems

Against this view, it might be argued that if genital tissue is excised early enough, a girl will not 'know what she is missing' when she reaches an older age. Similar arguments are raised in support of performing male circumcision as early as possible. But this does not guarantee a 'harmless' outcome. On the contrary, such an intervention could just as easily lead to feelings of loss or resentment—whether or not the surgery itself was consciously remembered. After all, a woman might reasonably wonder what sex, masturbation, and so on would have been like had her vulva been left intact, and feel angry that she was not given the chance to find out. In line with this perspective, there are indeed many documented reports of women (as well as men and intersex people) who had their genitals modified for non-therapeutic reasons in early childhood, who do in fact experience anger and resentment. These feelings, in turn, have the potential to impact negatively on sexual experience, quite apart from any 'purely' physical effects that would ensue from the loss of sensitive tissue (see Box 1).[22 27 52–56]

The lesson here is that classification of childhood genital surgeries based on 'predicted' effects on sexuality is a mistake. Since everyone's genitals are unique (including the specific distribution of nerve endings, how sensitive the tissue is in different parts, and so on), and since people have different attitudes towards intact versus modified genitals, as well as

Box 1 What are the likely effects of procedures resembling labiaplasty on a woman's sexual experience?

As Runacres and Wood note, 'the labia minora are highly innervated along the entire free edge, and are involved in the process of engorgement during sexual arousal. It follows therefore that labiaplasty has the potential to remove tissue that contributes to sensory sexual arousal'. In fact, 'the labia minora are second only to the clitoris for both sensation and sensitivity and are more sensitive than the vaginal introitus'.[49] In addition, the labia can be orally and manually manipulated, which may yield particular sensations that would be physiologically impossible if the tissue were removed—an outcome that Arora and Jacobs seem to regard as irrelevant. Whether such an outcome is on balance negative, of course, cannot be 'scientifically' determined; rather, it depends on an individual's sexual preferences. For example, for those for whom the ability to fondle, etc., the labia is an important part of their sexual activity, the surgical reduction or elimination of this tissue would indeed be expected to 'have an adverse effect on … sexual satisfaction'. The upshot is that everyone is different. Thus, as Johnsdotter has argued, there is no consistent relationship between type or degree of genital cutting—whether in females, males or intersex people—and subjective sexual pleasure later on. Hence: 'the current academic focus on the role of genitalia in understanding sexual pleasure is a dead end. While genitalia usually are central to sexual activity, and can be seen as a prerequisite for sexual intercourse, it is a misapprehension to see the state of them (cut or uncut) as determinative of the individual's experience of the sexual encounter. Consequently, ongoing debates on enhancing or detrimental effects of circumcision practices often miss the point, since they are based in too narrow a theoretical framework of sexual pleasure'[59] [p. 262]. See online supplementary appendix for further discussion.

different sexual preferences that can range rather widely, it is not ethically useful to make bland, medicalised statements about expected sexual satisfaction considered as an 'average' effect of some intervention. This is especially the case given that such an outcome is typically measured by reductive 'scientific' surveys involving numbered scales or similar, often failing to control for socially desirable responding.[32 57]

Indeed, Arora and Jacobs's willingness to rely on such statements in their endorsement of both male[31] and female[1] forms of non-therapeutic genital alteration, rather than proceeding cautiously and recognising the limitations—or even nonexistence—of the pertinent data,[32] is worrying. When a child's genitals are on the line, along with the prospect of diminishing his or her future sexual function and/or satisfaction (the latter of which is a highly subjective notion), we should be extremely careful about making assumptions of no harm when the available data are so weak and contentious.

Cultural problems

A further problem is that Arora and Jacobs's proposal is culturally incoherent. On the one hand, they decry 'culturally insensitive' laws and language that seek to eliminate female genital 'mutilation'. But on the other hand, they offer a made-up, 'medicalised' ritual of their own design, without explaining how this would satisfy the real-life cultural impulses of the families who endorse FGA. As they themselves state, 'We are … not suggesting that people whose beliefs or sense of propriety leads them to perform these procedures on their children would necessarily accept alterations to their practices to conform to the authors' views of what is acceptable'.[1] Indeed—why would they? As Hirsi Ali has written: 'To understand this problem, we need to begin with parental motives. The 'nicking' option is regarded as a necessary cleansing ritual … the clitoris is considered to be an impure part of the girl-child and bleeding it is believed to make her pure and free of evil spirits'. Problematically, however, for girls in at least some communities, the point of FGA is 'to ensure their virginity … and to curb their libido to guarantee sexual fidelity after marriage'. Thus, when FGA is intended 'to ensure chastity before marriage and to curb female libido … the nick option [would not be] sufficient' from a cultural perspective.[37]

Political problems

Finally, there is almost no chance that Arora and Jacobs's suggestion will actually be taken up by lawmakers: it is a political non-starter. This can be inferred from the debacle that ensued in 2010, when the AAP issued a policy similar to the one proposed by the authors, in the name of 'cultural sensitivity'. As Arora and Jacobs discuss, it was summarily retracted (just 1 month later) after it was met with fierce opposition and even outrage.[58] Opponents of the AAP policy included survivors of FGA such as Ayaan Hirsi Ali[37] and Soraya Mire;[58–60] members of its own ranks;[44 61 62] distinguished doctors from other countries;[63] US lawmakers;[64] and organisations such as Equality Now, an international advocacy network fighting to end female genital cutting.[65 v] In fact, I expect that Arora and Jacobs's own proposal (as well as perhaps the *Journal of Medical Ethics*, for publishing it) will be met with a similar outcry. While their article constitutes an interesting (if unoriginal)[3] academic exercise, Western societies have, for the most part, reached the seemingly irreversible conclusion that sharp objects should not be taken to the vulvas of little girls, unless it is to save their life or health.[11] Importantly, many immigrant communities in these same societies—derived from populations where FGA has traditionally been performed—have reached the same conclusion, and have willingly given up the practice.[26] It would be sobering for those who have struggled towards this end to see such progress reversed.

There are numerous other problems with Arora and Jacobs's proposal, including misleading (or inaccurate) citations concerning key empirical assertions, but I do not have the space to cover them all in detail in this response. Instead, I refer the reader once again to the online supplementary appendix accompanying this article, in which I discuss these and other matters (see http://dx.doi.org/10.1136/medethics-2015-103030).

[v]Similar patterns have played out in other countries. For example, as Leye *et al*[38] [p. 367] report (internal references omitted): 'In 1992, two researchers in the Netherlands submitted a report to the Dutch Ministry of Health in which they proposed that as a step toward the total eradication of the practice, incisions of the clitoris be allowed in cases where the parents or family wanted to circumcise a girl. This kind of incision was considered as a nonmutilating form of 'female circumcision', as FGM is commonly referred to in the Netherlands. This report's recommendation provoked a public debate about the issue that resulted in the total rejection of any form of FGM and, moreover, the rejection of any attempts to differentiate between mutilating and nonmutilating forms of 'female circumcision''.

CONCLUSION

In summary, if Western societies were to change their laws in order to allow for more 'minor' forms of FGA, this would likely result in: (a) disturbances and inconsistencies throughout their legal systems, possibly requiring new definitions of bodily assault and opening the door for inadvertent legal protection of a wide range of potentially harmful practices (typically carried out on children, who cannot adequately defend themselves); (b) removal of an important tool that reformers from within the affected communities rely on to solve the 'collective action' problem introduced by FGA; (c) regulatory challenges in tracking and monitoring FGA cutting sessions to ensure that they were not being used as opportunities for more invasive procedures; (d) exposure of young girls to an unknown amount of surgical risk in the absence of medical need, thereby placing doctors in an untenable position with respect to their professional duties; (e) accusations of cultural insensitivity, on account of outsiders having invented a 'compromise' intervention to be carried out in a medicalised setting, with the aim of replacing the traditional rituals that carry meaning for the relevant communities; and (f) widespread outrage among women who consider themselves victims and/or survivors of FGA as well as their allies, and other forms of political backlash.

In light of these considerations, let us return to Arora and Jacobs's major conditional argument, namely, that 'a liberal society that tolerates expression of culture and/or religion in the manner of male circumcision should also permit certain *de minimis* [female genital altering] procedures'.[1] I have tried to show that such permissiveness would result in a fiasco, making this suggestion (for all intents and purposes) a *reductio ad absurdum*. Accordingly, there is a growing trend among scholars of genital cutting, particularly in the fields of bioethics and law, of arguing that it is time to consider a less lenient position towards MGA (whether by banning it with a possible exception for sincere religious belief, or by regulating it in other ways), rather than a more lenient position towards FGA.[8 9 17 43 66–68] As Arora and Jacobs themselves point out,

> 'We acknowledge that issues of cultural sensitivity and gender discrimination in

> the disparate treatment of male circumcision and FGA could also be treated by proscribing both, instead of the position for which we are advocating. In fact, many have criticised male circumcision as a human rights violation due to the lack of autonomous decision-making and the irreversible nature of the procedure'.[1]

Whether it is in fact a fundamental human rights violation, or rather a morally objectionable practice on other grounds, 'it is clear that the current *laissez faire* attitude towards MGA that is typical of Western societies—and in particular the United States—can no longer be maintained without facing serious scrutiny. FGA and MGA are both highly problematic practices, with far more overlap between them (both physically and symbolically) than is commonly understood: they should not be discussed, therefore, in hermetically sealed moral discourses'.[4] My own perspective is that the most promising way forward would be to argue for an 'autonomy-based' ethical framework,[4 9] whereby 'Children of whatever [sex or] gender should not have healthy parts of their most intimate sexual organs removed, before such a time as they can understand what is at stake in such a surgery and agree to it themselves'.[69]

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Abstract

In this chapter, we contrast legal and ethical perspectives on two forms of nontherapeutic female genital cutting: those commonly known as "female genital mutilation" and those commonly known as "female genital cosmetic surgeries." We begin by questioning the usefulness of these categories—and the presumed distinctions upon which they rest—stressing the shared features of the two sets of practices. Taking UK legislation as a case study, we show that there are troubling inconsistencies in the way in which female genital cutting is understood in Western contexts. Specifically: (a) all nontherapeutic genital alterations to female minors are criminalised, typically with harsh penalties for transgressing the law, while even more invasive nontherapeutic genital alterations to male and intersex minors are permitted and almost entirely unregulated; and (b) genital alterations of adult women regarded as "cosmetic" in nature are treated as legal, while in some jurisdictions, anatomically identical procedures classified as "mutilation" are illegal. This chapter highlights these and other inconsistencies, speculates as to why they arise in Western contexts, and explores the scope for more consistent and constructive attitudes and legislation.

Key words: female genital mutilation, female genital cosmetic surgery, intersex surgery, male circumcision, genital autonomy

1. Introduction

Nontherapeutic female genital cutting (FGC) typically conjures associations of gender oppression and child abuse in the Western imagination. More commonly described as "female genital mutilation" or "FGM," such cutting has been roundly condemned and legislated against [1]. Yet FGM/C is not exclusively a practice of the "Other" as is often assumed. In Western countries, the demand for a range of surgical procedures collectively known as female genital cosmetic surgeries (FGCS) is rising [2], as women—and, increasingly, teenage girls [3]—pursue a perceived aesthetic ideal identified with "designer vaginas," including petite clitoral hoods, non-protruding labia, and pre-pubescent hairlessness, apparently modelled upon

exemplars from pornography [4]. Moreover, some forms of medically unnecessary "cosmetic" or "normalizing" surgery performed on intersex children before an age of consent—such as "feminizing" cliteroplasty to reduce the size of healthy, albeit larger than average clitorises [5]—are consistent with Western legal definitions of "female genital mutilation," but are largely accepted and still regularly performed [6].

A word on terminology. Since "mutilation" is a value-laden term, indicating intentional disfigurement or damage, we consider that its use (a) fails to accurately reflect the motivations of communities within which the class of relevant practices is common (no loving parent seeks to "mutilate" their child), and (b) tends to prefigure the debate, introducing moral biases that are not imposed on analogous forms of nontherapeutic genital cutting that are more familiar in Western contexts, such as FGCS or male circumcision (see Box 1), both of which are typically picked out by more neutral descriptors. We therefore favour the terms "female genital cutting" (FGC), "female genital cosmetic surgery" (FGCS), and, where applicable, "male genital cutting" (MGC) or male circumcision, and we will use these terms throughout the chapter. Where it is necessary to use the term "FGM," for example, when referencing the activist/advocacy literature devoted to the elimination of such practices, it will appear in scare quotes to draw attention to its disfavoured status among scholars of genital cutting [7, 8, 9].

In section two, we describe the different varieties of female genital cutting, focussing on the differences and commonalities between (a) purportedly "mutilating" forms of FGC and (b) Western-style FGCS. Section three interrogates the law in the UK (and other Western contexts) in relation to each class of procedure. Section four highlights the inconsistencies arising from the differential legislative approaches, while section five explores some of the problematic assumptions that underwrite these inconsistencies. Section six concludes.

2. Varieties of genital cutting

According to the World Health Organization (WHO), "female genital mutilation" refers to any procedure "involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" [10]. The term therefore covers a loose assemblage of different interventions, carried out by different groups for different reasons in different settings, ranging from a "prick" to the clitoral hood (which does not remove tissue and is thus less invasive than male circumcision—see Box 1) to the excision of the external clitoris followed by suturing of the vaginal opening (known as infibulation). These interventions may occur in a hospital setting or a rural village; they may be carried out by a

Box 1. Comparison to male genital cutting (MGC).

Nontherapeutic MGC ranges from ritual pricking (e.g., *hatafat dam brit*), to piercing, scraping the inside of the urethra, bloodletting, shaft scarring, and/or foreskin slitting (among, e.g., various ethnic groups in Papua New Guinea) [11], to circumcision as it is traditionally performed on male newborns in Judaism and generally in the United States (tearing of the membrane that fuses the immature foreskin to the head of the penis followed by excision of the majority of the foreskin) [12], to *metzitzah b'peh* (the same followed by direct oral suction of the wound, risking herpes infection, performed on more than 3,000 babies in New York City each year among some ultra-Orthodox Jews) [7], to non-sterilized, un-anaesthetized circumcisions performed in the bush during rites of passage in Eastern and Southern Africa [13], to highly traumatic mass cutting of pre-teen boys carried out on school tables in the Philippines (*tuli*) [14], to forced circumcision of men following political conflict in various countries [15], to subincision (slicing open the underside of the penis lengthwise, often through to the urethra) in Aboriginal Australia [16], to involuntary castration (now rare but occasionally documented among the *hijras* of India). The extent of the cutting, the tools used, the skill of the practitioner, the age of the initiate, and so on, vary widely across circumstances, leading to a heterogeneous risk profile both within and across types. There is also considerable variation in associated social and symbolic meanings (e.g., sealing a divine covenant, punishing an enemy, mimicking menstruation, proving oneself as a man, basis for marriageability, perceived hygiene, ritual purification, conformity to peer pressure, etc.) as well as physical context (e.g., sometimes medicalised, often not), depending on the group in question.

The most common form of male genital cutting is circumcision. Male circumcision involves the partial or total removal of the foreskin of the penis—an elastic sleeve of erogenous tissue that normally covers and protects the glans—occasionally to address a medical problem, but most often for ethnoreligious or cultural reasons [17]. In Western countries the surgery is typically performed on healthy newborn babies or young male children as part of a medicalized birth custom, as in the United States [18], or in the context of a religious ritual, for example, among practicing Muslims and Jews. Such non-therapeutic circumcision of infant males is legal throughout the Global North, with few restrictions or exceptions [19].

Supporters of circumcision tend to view the procedure as relatively harmless—except in the case of "botched" operations—possibly due to a lack of awareness of the anatomical properties of the excised tissue (if the tissue itself has value, its sheer removal is a harm) [20]. Increasingly, men who were circumcised in infancy or early childhood, that is, before they were old enough to give or withhold their informed consent, are voicing distress and opposition to the surgery, often citing a lack of personal choice concerning an irreversible alteration to their most private sexual anatomy [21]. In addition to this perceived violation of their genital autonomy, there are also inherent (or highly probable) effects of early circumcision that some such men regard as deleterious. These include the presence of scar tissue and associated discoloration, inability to engage in sexual acts requiring foreskin motility [22], elimination of the parts of the penis most sensitive to light touch [23], and irritation and possible altered sensitivity of the glans.

Common side effects include meatal stenosis (pathological narrowing of the urethral opening) [24], bleeding, infections, and incomplete skin removal requiring revision surgery. Additional side effects of unknown frequency include painful erections due to excessive skin removal, partial or complete amputation of the organ due to surgical error, urinary problems, fistulae, skin bridges, and cysts [25]. Finally, death is a possible outcome: in the United States, early deaths following circumcision in clinical settings occur at a rate of approximately 1 for every 50,000 circumcisions [26]. In rural settings, such as among the Xhosa of South Africa, deaths as well as penile amputations are far more common: between 2008 and 2014, more than half a million Xhosa boys were hospitalized due to botched circumcisions in the Eastern Cape alone, while between 2006 and 2010 there were 269 recorded deaths among this group and 146 penile amputations [27, 28].

In settings where circumcision is relatively common, such as the United States, prophylactic health benefits are often cited in support of the practice [29]. However the evidence is contested and is primarily associated with adult, voluntary circumcision in Sub-Saharan Africa, not newborn circumcision in economically developed regions with advanced healthcare systems [30]. In any case, the claimed health benefits can also be achieved non-surgically through, e.g., safe sex practices and basic hygiene. Accordingly, the vast majority of international health authorities to have issued formal statements on the health benefits and risks associated with newborn and early childhood male circumcision have concluded that the benefits do not outweigh the risks [31]. Even if they did, however, removing healthy tissue as prophylaxis without consent is not automatically morally acceptable. Consider that performing non-consensual mastectomies on adolescent girls with high-risk genetic profiles in order to guard against future breast cancer would not be tolerated. Similarly neonatal labiaplasty, though it might conceivably reduce the risk of certain labial cancers or other such problems, is not seriously entertained as a means of health promotion [32]. Although prophylactic tonsillectomies were once common, they are no longer regularly performed; moreover, the tonsils, in contrast to the genitals, are not a visually prominent, psycho-sexually significant external organ. Among ethicists and legal scholars, it is now increasingly argued that male infants and young boys, just like female infants and young girls, have a strong interest in having their genital integrity preserved until they are old enough to make an informed, personal decision [33].

medical practitioner or a medically untrained ritual provider; they may be performed with sterile instruments and anesthesia or with a septic tool and no pain control whatsoever [34]. As noted, we will use "female genital cutting" (FGC) to refer to all such nontherapeutic procedures—nontherapeutic in the sense that they are imposed on healthy genitalia and are not intended to treat a recognized disease nor are required to preserve or restore functionality (sexual, reproductive, urinary, or otherwise). In practice, FGC almost always involves the clinically unnecessary modification of vulvar tissue in order to adhere to perceived religious or cultural norms or ideals.

Table 1 shows the extent of the similarities between the set of practices described by the WHO as "FGM" and those more commonly described as FGCS. As has been noted elsewhere [35], genital cutting procedures are diverse, falling on a wide spectrum of severity, in part because the motivations for the procedures—both conscious and unconscious, historical and contemporary—are likewise diverse. Some groups, for example, are openly committed to tempering the sexual desires of women, as is apparent in many contexts throughout in Egypt, where clitoridectomy (partial or total removal of the external clitoris) is common [36]. In other contexts, the procedure marks a transition from childhood to adulthood and may have little to do with reducing sexual desire or exerting sexual control [37]. In still others, such as among the Muslim Malay population of Southern Thailand, both boys and girls are subjected to genital cutting as a form of ritual purification as well as to symbolize full acceptance into the Islamic community. For their part, the boys have their foreskins removed in a public ceremony between the ages of 7 and 12, while the girls experience a "prick" to the clitoral hood shortly after birth [38, 39]. Similar cutting occurs among the Dawoodi Bohra sect of Shia Islam, whose followers are concentrated in Gujarat, India, and Karachi, Pakistan: the boys are circumcised, and the girls—in the typical case—have part of their clitoral hood cut or removed in a practice known *khanta*, with stated reasons for both kinds of cutting ranging from "religious purposes" to "physical hygiene and cleanliness" [40].

The WHO collects all such (female) practices together under the banner of "FGM" [41]. Although some nuance is introduced through seemingly arbitrary divisions into types and sub-types, the WHO typology is not able to ground a principled distinction between (typically African, Middle Eastern, or Southeast Asian) so-called "mutilations" and (chiefly European and North American) so-called "cosmetic" genital procedures. In the second column of Table 1, we present a parallel typology of practices which are standard within FGCSs. The table is organised to exhibit the commonalities between the component practices.

Table 1: Comparing "FGM" and FGCS.

	"FGM"	*FGCS*
Procedures and typology	Type I: **Alterations of the clitoris**, within which type 1a is the partial or total removal of the clitoral hood, and type 1b is the partial or total removal of the clitoral hood and the (external portion of the)* clitoris.	**Alterations of the clitoris,** including clitoral reshaping [42], clitoral unhooding [43], and clitoridectomy or cliteroplasty [44] (also common in "intersex" surgeries) [5, 6].
	Type II: **Alterations of the labia**, within which type IIa is the partial or total removal of the labia minora, type IIb is the partial or total removal of the labia minora and/or the (external)* clitoris, and type IIc is the partial or total removal of the labia minora, labia majora, and (external)* clitoris.	**Alterations of the labia**, including trimming of the labia minora and/or majora, also known as "labiaplasty" [42, 43].
	Type III: **Alterations of the vaginal opening,** within which type IIIa is the partial or total removal and appositioning of the labia minora, and type IIIb is the partial or total removal and appositioning of the labia majora, both as ways of narrowing the vaginal opening.	**Alterations of the vaginal opening,** typified by narrowing of the vaginal opening, variously known as "vaginal tightening," "vaginal rejuvenation" [45], or "hymen repair" [46].
	Type IV: **Miscellaneous,** including piercing, pricking, scraping, and cauterization.	**Miscellaneous**, including piercing [47], tattooing [48], and liposuction [49].
Example high-prevalence geographies	Depending on the procedure: Somalia, Sierra Leone, Guinea, Djibouti, Egypt, Mali, Sudan, Senegal, Eritrea, Ethiopia, Mauritania, Liberia, Burkina Faso, Gambia, Guinea Bissau, Kenya, Nigeria, Chad, Cote d'Ivoire, and concomitant diaspora communities [50].	North America, Australia, Europe [51].
Actor	Traditional practitioner, midwife, clinical worker or paramedic, surgeon.	Surgeon, tattoo artist, body piercer.
Age at which performed	Depending on the procedure/community: Typically around puberty, but ranging from infancy to adulthood [32].	Typically in adulthood, but increasingly on adolescent girls [3]; intersex surgeries (e.g., cliteroplasty) more common in infancy, but ranging through adolescence and adulthood [52]
Legal status in the UK and similar regimes	Unlawful	Lawful

* **NOTE:** The WHO wrongly equates the external portion of the clitoris (i.e., the part that protrudes outside the body) with the entire clitoris, thereby diminishing the anatomical and sexual significance of the latter. Most of the clitoris, including the majority of its erectile tissues and structures necessary for orgasm, is underneath the superficial skin layer of the body—like an iceberg—and therefore cannot be removed without major surgery (which does not occur in any recognized form of "FGM"). This fact may explain why sexual pleasure and orgasm are reported at higher than expected rates in women who have experienced various forms of genital cutting [53].

Table 1 shows that for each component of the "FGM" typology, there is a close analogue within the FGCS typology. Alterations of the clitoris, labia, and vaginal opening are observed in both sets of practices, with considerable variation both between and across cases as to the degree of tissue damage or removal. Instead of using umbrella terms such as "FGM" or FGCS, then, it is likely to be more illuminating in most cases to be specific. Thus, one should refer to (1) particular procedures (e.g., labiaplasty, cliteridectomy, hoodectomy, infibulation); (2) the extent of the procedure, along with the means by which it is carried out—i.e., with which instruments and how skilfully—and the associated risk/benefit profile (both medical and non-medical); and (3) the relevant context: physical, psychological, and social/symbolic. As it stands, the terms "FGM" and FGCS are proposed as stable categories not on the basis of the acts that actually fall within them, but instead by the perceived *reasons* for undertaking those acts (e.g., "non-medical reasons," "to oppress women," and so on).

That said, there are some differences between the two categories. The first is that the practices known as "FGM" are generally not performed in a safe, regulated medical setting (although they are increasingly being performed in medicalized settings in the communities in which they are common and customary) [54], while those within the FGCS typology are usually performed by trained professionals in medical or similar facilities (although there are growing concerns about a lack of regulation) [55].

A second potential difference concerns the age at which the cutting is typically performed—i.e., usually minor girls for "FGM," usually adult women for FGCS—but there is overlap here is well. First, in many African societies, female and male genital cutting ceremonies constitute the very ritual by which adult status is conferred in the community, which complicates the question of consent as well as adult/child designations [56]. And second, staying just within the USA, UK, and other Western contexts, nontherapeutic genital cutting—e.g., cosmetic labiaplasty—is increasingly performed on female children and adolescents well before the age of legal majority [57].

The final difference is their status in law: in Western countries "FGM" of any type is illegal (in the UK and Australia, this is true regardless of the age at which it is performed), while in these same countries, FGCS is treated as legal despite technically meeting the same criteria [58].

3. The status of the law

In this chapter, we take UK law as a case study. However, similar laws apply throughout the Western world [59], where increased migration of FGC-prevalent communities, coupled with a growing focus on FGC as a contested site of political attention, have led to pressure to address FGC either in dedicated legislation, or under existing laws.

In England, Wales, and Northern Ireland, the FGM Act 2003 holds that "to excise, infibulate, or otherwise mutilate any part of a girl's labia minora, majora or clitoris" is an offense with a maximum sentence of fourteen years [60]. The legislation has two puzzling features. First, it stipulates that "Girl includes woman" and therefore equates the consent capacities of adult women to those of children. Second, the legislation contains a caveat to permit genital alterations where they are deemed necessary to the "mental health" of a person, while noting that it is "immaterial" for purpose of making such assessments whether the person requesting the alteration "or any other person believes that the operation is required as a matter of custom or ritual."

These rather confusing qualifications were evidently inserted to ring-fence access to FGCS, by portraying such procedures as necessary to the mental health of some women (as judged by their cosmetic surgeons), while preventing "traditional" FGC, which is more readily interpreted as being performed for reasons that qualify as customary or ritualistic, from slipping through under the mental health clause. Dustin [61] suggests that the cosmetic surgery lobby may have played a key role in securing the future of FGCS when the legislation was being drafted.

Yet one could argue that FGCS *also* qualifies as being motivated by custom or ritual. As noted by Crouch and colleagues, it is "difficult to see how FGCS could be anything other than cultural" [62]. For as Edwards argues, "any woman's choice to have a procedure on her genitals cannot be separated from the culture in which this decision is made" [63]. Highly restrictive aesthetic ideals, widespread anatomical ignorance about the range of "normal" appearances for the vulva, marketing campaigns designed to prey on bodily insecurities, and normatively questionable social pressures undoubtedly threaten "mental health" and thus play a role in motivating requests for FGCS [64]. In short, "the rationale [for cutting] cannot be separated from cultural associations" regardless of the culture in which it occurs [63].

Similarly, it is plausible that there may be potentially severe adverse consequences to the mental health of a person who is "denied" FGC if she lives within an FGC-prevalent

community, identifies with the practice, regards modified vulvae as normal or beautiful (or unmodified vulvae as abnormal or ugly) [7, 9, 56, 86], and so on. But if, as it seems reasonable to argue, problematic cultural norms or expectations are ultimately to blame for any such psychological anguish—such that the norms and expectations, rather than female bodies, should be changed [46]—they are certainly no less to blame for women's "mental health" issues in the majority culture, used to justify FGCS.

Perhaps the difference in law can be grounded in the fact that FGCS is medically safer than FGC? One might indeed contend that the first is safer under current legislation, since it is usually performed in clinical contexts, while the latter must be performed "underground" in Western countries because it is unlawful. Yet the division is not so tidy. First, in communities where FGC is common, the cutting is often performed in medical settings prior to immigration: according to the WHO, in some FGC-prevalent countries, "one-third or more of women had their daughter subjected to the practice by a trained health professional" [10]. By contrast, Western-style "cosmetic" genital piercing, a legal form of FGCS, typically takes place in a non-clinical environment such as a tattoo parlour and is only minimally regulated [55].

Moreover, depending on the type of cutting, medical training does not guarantee superior skill: for example, in some communities, FGC—similar to MGC performed by a Jewish *mohel*—is carried out by a highly-experienced circumciser for whom the cutting is her primary occupation. Thus, medicalization *per se* does not eliminate, nor even necessarily reduce, the risk of complications, as the WHO also notes [10] (but see [65]).

Accordingly, many of the complications and risks are similar for FGC and FGCS where the type (as indicated in Table 1) matches. Even where FGCS of various types are performed by a licensed surgeon, the following complications are commonly noted: infection, healing problems, adhesion, dyspareunia, bleeding, and effects on sexual pleasure [66]. These are strongly redolent of the sorts of complications that are often described as following from many instances FGC, though of course, non-clinical environments and instruments, where applicable, may render these complications more likely and more severe [67].

Finally, as noted earlier, the presumed difference between FGC and FGCS in terms of the age at which the cutting takes place is not sufficient to ground such divergent laws: some FGC procedures, such as re-infibulation, are requested by adult women [68], while some FGCS procedures are performed on adolescent girls. Nevertheless, in all Western contexts, "FGM"

is unlawful, while FGCS procedures are presumed to be lawful. The "mental health" caveat within UK law in particular exemplifies the difficulty in outlawing one set of procedures while protecting access to a set of procedures that is identical or nearly identical in physical terms. The difference, in the eyes of the law, then seems to rest on certain stereotypes concerning the "reason" for which the procedure is undertaken, a matter we will take up in the following sections.

4. Interrogating inconsistencies

All three of FGCS, FGC, and MGC involve the non-therapeutic modification or removal of healthy, erotogenic tissue. Whilst there is a lively debate about the average (net) effects of these practices on health [29, 30, 31, 69] and sexual pleasure [22, 30, 70, 86], what is often lost in such discussions is that no one is an embodied statistical average: genital cutting affects different individuals differently, depending upon the type and extent of cutting, whether and what kind of pain control is used, the age at which it is performed, the skill of the practitioner, one's mind-set going into the cutting—or later reflecting upon it or its effects—and so on [71]. Given such vast individual differences, arguably the more pressing question for ethicists working within a Western medicolegal context is whether the person in question can consent to the procedure and thereby exercise bodily autonomy, often characterized as a (human) right [72].

As noted, the capacity of adult women to "choose" FGC or FGCS is sometimes disputed, often along racial lines, a discussion to which we will return below. But the question of consent is perhaps most salient in the case of children. Supporters of childhood genital cutting note that infants and young children are pre-autonomous and therefore incapable of either giving or withholding their informed consent, not only to genital cutting, but to any significant parental action that affects them [73]. Therefore, they suggest, it is up to the parents to decide whether to cut the child's genitals. But such cutting is typically irreversible: depriving a child of the opportunity to remain genitally intact is also to deprive the eventual adult of the same opportunity. Plainly, a child's temporary lack of capacity to make certain informed, mature decisions about the state or condition of their own body does not create a "blank cheque" for parents to authorize whatever permanent body alterations they may choose [74].

Granting this point, some authors argue that the permissibility of a given act of childhood genital cutting—usually presumed to fall somewhere beneath an arbitrary and unspecified threshold of harm [75]—depends on the *reason* for its performance, that is, the conscious or

unconscious motive(s) of the parents or wider community [73]. Some motives, at least for certain kinds of nontherapeutic childhood genital cutting, appear to be regarded as acceptable in Western societies, while other motives are regarded as unacceptable.

For example, discussants who oppose even "minor" forms of FGC carried out prior to an age of consent (for example, ritual nicking), while at the same tolerating or even advocating more physically invasive forms of MGC carried out prior to an age of consent (chiefly, infant male circumcision), tend to base their arguments on the premise that male circumcision is a religious requirement, at least for some groups, while FGC is not. The argument then proceeds to claim that if there is a "religious" motive for childhood genital cutting, then the cutting can be justified, whether morally or legally.

However, the premise is false, so the argument is unsound. First, FGC is very often regarded by its supporters as an explicitly Islamic practice with the same or similar scriptural standing as male circumcision within that religion [7, 65]. Whilst it is true that FGC, like MGC, is not mentioned in Koranic scripture, both are noted in the Hadith, a record of the teachings of the Prophet Muhammed. On this basis, some Muslim authorities argue that FGC is in fact obligatory (though this view is far from universal) [76]. Certainly, in Judaism and Christianity, it is widely held that "binding" religious obligations can stem from extra-biblical sources, such as rabbinic commentaries or papal encyclicals: the notion that a practice can only be "religious" if it is grounded in a literal reading of a group's primary scripture is absurd [65].

Second, male circumcision is often performed for "cultural," rather than specifically religious, reasons, and yet it is broadly tolerated even in those cases. Christians in Africa, for instance, often practice infant male circumcision not because they view it as an explicit requirement of their own religion, but rather because the practice is widespread in the communities alongside which they live [77]. In the US, circumcision of newborn boys is mostly performed in accordance with perceived social and aesthetic norms by those who place no religious stake in the surgery whatsoever, with statements such as "the boy should look like his father" held up as common explanations [18, 78]. Even many Jews who circumcise are atheists or otherwise non-religious, yet choose to continue the tradition for various reasons including a sense of shared history or ethnic identity [79]. In a similar vein, a study in Australia showed that three times as many parents opted to have their newborn son circumcised to continue a "family tradition" than to fulfil a perceived religious obligation [80].

This leads to a dilemma. If male circumcision should be permitted generally and for any reason because in *some* groups it is regarded as an explicitly religious practice, then relatively more mild forms of FGC that are regarded by *some* groups as religiously required should be given equal consideration, and should also be tolerated for all groups regardless of the reason. Indeed, some prominent defenders of ritual male circumcision, aware of the existing double standard (see Box 2), have recently begun to argue that "mild" forms of FGC should in fact be tolerated in Western law, presumably to ensure that the legal status of male circumcision remains unquestioned [65, 81]. Alternatively, one might argue that male circumcision should only be permitted when it is done for explicitly religious reasons (which would exclude most US American circumcisions, and might also exclude non-religious Jewish and Islamic circumcisions that would otherwise be done for "cultural" reasons), in which case, by analogy, only groups that regard FGC as religiously required would be permitted to perform the cutting, and all others disallowed. Finally, one could argue that *neither* male nor female nontherapeutic childhood genital cutting should be permitted, regardless of the religious motives of the parents [82].

Whichever option one favours, the common emphasis in this discourse on "religion" versus "culture" is telling. The apparent assumption is that religious norms are categorically different from, and more important than, "merely" cultural norms. However, it is not obvious that there is a firm line—whether in practice or conceptually—between what is religious and what is cultural [77], nor is it obvious that one should be elevated above the other as "legitimate" grounds for cutting the genitals of a child [83].

Box 2. Double standards: a case study

This apparent double standard is playing out as we write this chapter. Four members of the Dawoodi Bohra, a small Muslim sect with members in Detroit, Michigan, and other US cities, have recently been indicted on charges of "Female Genital Mutilation" – the first such case under federal law in the United States [84]. As even opponents of the practice from within the community acknowledge [40], the form of cutting typically practiced by the Bohra on their daughters, namely, pricking or excision of a portion of the foreskin ("hood") of the external clitoris—often by a doctor in a clinical setting, as in the Detroit case being prosecuted—is significantly less physically invasive than the form of cutting practiced by the very same community on their sons, namely, complete removal of the penile foreskin ("circumcision"). The two forms of cutting may be done at similar ages, for similar reasons; both are regarded as a religious obligation by the Bohra based on similar readings of the same passages of Muslim scripture (in this case, the Hadith – the sayings of the Prophet Mohammed); and both are referred to with the same word, *khatna*. Yet, though the male procedure is more severe, only the female procedure has triggered criminal proceedings under federal law [69].

Even more peculiar, the false dichotomy is inconsistently applied. For example, it is often argued that (adult) FGCS is more acceptable than (adult) FGC because the former are *not* motivated by a strong cultural imperative [85]. That is, FGCS is presented as a procedure which is *chosen* by those who request it, which makes it at least plausibly permissible, whereas FGC is presented as an *obligation* for those who request it (by virtue of being a ritual or custom) which then renders it impermissible because it is presumably not "freely" chosen. But if common defences for male circumcision are to be accepted, one could equally hold that since FGC is "mandated" by strong religious or cultural pressures in some groups, it is something that Western societies ought to tolerate, whereas since FGCS is a not mandated in a similar way, it should not be granted this shortcut to tolerance. Either way, the status quo is incoherent.

Simply put, the reasoning employed in defence of pre-consensual male circumcision and against pre-consensual FGC is sharply at odds with the reasoning employed in defence of adult FGCS and against adult FGC. In the case of motivations for ritual male circumcision, it is commonly argued that the strength of the associated background norm, whether religious or "merely" cultural, is a reason for respecting or tolerating the practice, despite the fact that young male children and especially newborn boys are manifestly incapable of providing their own consent. Yet in the case of FGC, the strength of what is in some communities an equally robust and often highly similar background norm is seen as consent-undermining, not only for female minors but also mature adult women—irrespective of their agency or autonomy as might be demonstrated in other contexts.

On one side, then, we have MGC, one form of which is of great religious significance to some groups, while for others it is "merely" cultural but is not necessarily any less valued. Although it is typically performed on the most intimate part of a child's body before consent can possibly be given or withheld, it is widely accepted and is permitted by Western law. On the other side, we have FGCS, a set of procedures that have primarily aesthetic value for a small—if growing—number of individuals and are of no religious significance to anyone. They are typically performed on adults who are presumed to be competent to provide their own consent but are also increasingly performed on younger girls with the permission (or at the insistence) of their parents. They, too, are relatively uncontroversial and are permitted by Western law. Then in the middle we have FGC, an anatomically overlapping set of procedures performed at various ages, sometimes on adults or older adolescents who are typically presumed, in this case, to be *non*-competent to provide consent, but most often on younger girls with the permission (or at the insistence) of their parents. Certain forms are of great religious

significance to some groups *and* have aesthetic value for those who embrace them [86, 87], but all forms are seen as entirely unacceptable, and no form is permitted by Western law.

5. Explaining the inconsistencies

Perhaps the difference in attitudes and legislation toward male versus female forms of ritual genital cutting—and between FGC and FGCS—stem not from the religious or cultural significance of one or the other, but from other differences. One common candidate for such a distinction is that FGC—but not FGCS—is performed for reasons that are purely or primarily misogynistic, aiming to curb the sexual lives of girls and women, while male circumcision has no such limiting intention towards boys. As noted recently in the *African Journal of Reproductive Health* [88]:

> Female circumcision has been presented somewhat stereotypically as a practice in which men control female sexuality and female reproduction. The manner in which women have been depicted as victims of a brutal male practice has created sharp reactions, not the least from circumcised women. They have not commonly perceived themselves as victims of a violent male practice but have seen female circumcision as a female custom that is necessary to maintain order [and] to make or create true women.

Consistent with this view, in nearly every culture where FGC occurs it is organized and carried out exclusively by women, with men being barred from participation and often far more likely to report a desire for abandonment of the practice than their female counterparts. Moreover, there is no known community that practices FGC without also practicing MGC, often in parallel and for similar reasons: girls are nowhere being singled out for cutting [9, 56, 89]. By contrast, there are many groups that practice MGC without practicing FGC, such as within Judaism, some but not other sects of Islam, and generally in the USA: in those cases, boys *are* singled out for cutting, while girls are strictly protected. Nevertheless, where the two practices do co-occur, prevailing motivations are often close conjugates: ostensible health benefits, aesthetics, religious adherence, hygiene, symbolic entry into adulthood, enhancing one's expected sex appeal, reduction of promiscuity, and feminization or masculinization of the genitals [90].

Depending on the community in question, any number (or combination) of these and other motivations may apply simultaneously across the gender divide [77]. And while sexual control is sometimes a motivating factor, as we shall discuss, this rationale is not confined to the female rites. In the context of hazing ceremonies, for example, it has been proposed that MGC may be a means by which older males exert sexual dominance over adolescent boys, saying in

essence: "We can hurt your penis now, so just think what we can do if you misuse it against us—a warning, if only in symbolic form, of possible castration" [91].

Moreover, in some groups, MGC is explicitly intended to reduce a male's capacity for sexual pleasure. Among the Nso people in Cameroon, for example, one recognized purpose of circumcision is to "tame and moderate the sexual instinct" of men [92]. In addition, the widespread popularity of circumcision in the United States traces directly to historical attempts to curtail masturbation in male children as a form of sexual discipline and "moral hygiene" [93, 94]. And even today, Western-funded campaigns to circumcise millions of African boys and men as a "surgical solution" to the spread of HIV are premised in part on the belief that such men cannot be trusted to control their own sexual behavior (hence the "need" for surgery):

> Lurking just below the surface in many HIV discussions—especially of HIV in sub-Saharan Africa—is the perception that people in certain countries or regions are more promiscuous, more callous, less empathic, or less moral. Some imply that people living with HIV should abstain from or minimise sexual activity, including reproductive desires.

Thus, some authors have warned that the aggressive Western "marketing" of male circumcision in such contexts risks reinforcing colonial-era stereotypes about the "sexually promiscuous African male" [95].

None of this detracts from the fact that FGC has, in many cases, become tightly bound up in the regulation of female sexuality, among so many other methods by which such regulation is pursued globally (including FGCS, as we shall argue in a moment). Thus, in some communities, for example in parts of the Sudan, the prizing of female chastity and the subjection of girls and women to the presumed sexual and aesthetic preferences of men are among the primary motivations for FGC [96, 97]. In other communities, "the belief that girls with intact genitalia will be stubborn, promiscuous, or unable to control their sexual desires," or that "genital cutting is necessary [to] prove virginity" may be widespread [20]. In still others, the motives are not primarily anti-sexual, for either the females or males [37].

Such variation is only to be expected. As noted by the non-partisan Public Policy Advisory Network on Female Genital Surgeries in Africa, "the vast majority of the world's societies can be described as patriarchal, and most either do not modify the genitals of either sex or modify the genitals of males only. There are almost no patriarchal societies with customary genital surgeries for females only" [9]. Finally, motivations may even differ from family to family. The temptation to universalise over a given motivation should therefore be resisted:

the variety of reasons for—and types of—both FGC and MGC across their disparate geographical regions of prevalence frustrate such reductive explanations [9, 37].

Nor should FGCS be permitted to evade critique on this front. Such "cosmetic" procedures are, by all accounts, largely motivated by a desire for genitals that are perceived to be (a) aesthetically appealing according to restrictive norms propagated within pornography and aided by trends toward total pubic hair removal (which render the genitals more visible), and (b) "enhanced" in terms of sexual function, which often amounts to the creation of a "tight receptacle for penile penetration" [4]. If there are motivations for FGCS that do not derive from these two main sources, they have not been as well-reported. To the extent that both the global pornography industry, and the instrumentalisation of female genitals for penile penetration, are reflections or instantiations of misogyny, it may well be that the motives for FGCS are more universalisable than those for FGC, with as much or more to answer for on this point.

If not health reasons, religious motivations, or misogyny, what is it that makes FGC sufficiently distinct from its close cousins, FGCS and childhood male circumcision, so as to warrant such extreme legislative differences? One possible answer lies beyond medicine or ethics, and instead focusses on the way in which FGC is positioned *politically* within Western discourses. Some scholars argue as follows: While male circumcision is more common than FGC within Islam, and there are more circumcised men globally who are Muslim than Jewish, FGC has found itself associated with Islam in ways that have caused the practice to inherit the fears and anxieties created by Islamophobic trends across the Western world [98]. The strength of this association is likely encouraged by the widespread belief that FGC is always performed for sexist or "patriarchal" reasons, which has contributed to, and meshed with, the vilification of Islam as an inherently misogynistic religion. This framing allows fear of the "Other" to adopt the more beneficent mask of concern for the welfare of women and girls.

Moreover, unlike the stereotypically imagined recipients of male circumcision (chiefly, Jewish or US American boys) and FGCS (chiefly, white/Western women), FGC is mentally associated almost exclusively with women-of-colour from the Global South. In accordance with the discourses of historical colonial "civilising missions" and more recent examples of military imperialism, these women are portrayed as lacking autonomy, and as subjugated to the will of their men-folk, thereby impelling Western intervention [99]. The intervention comes in the form of draconian legislation whose primary function is to reassure the public that the

perceived "civilizational threat" is held at bay, and that the perceived misogyny of *foreign* cultures will not be tolerated.

Meanwhile, because the force of this legislation derives from political rather than ethical narratives, and therefore concentrates on charges of "barbarism" rather than violations of bodily autonomy *per se*, male infants as well as intersex children are left unprotected. Further, because these political considerations replace more nuanced inflections within feminist theory and anthropology, cultural norms around female bodies are not brought into the same narrative, leaving FGCS largely free of critique.

In the shadows of these moral lacunae are the women and girls of FGC-prevalent communities, whose diverse needs and perspectives are often lost in the focus on criminality and realpolitik. Unsurprisingly, attitudes towards FGC are as varied as its typology and geographical distribution [20]. Whilst in many regions, a growing minority of women strongly oppose the practice to which they were subjected as children, the more general pattern is that the majority of women within populations of prevalence who have themselves been cut report their continuing support for the practice [100]. Of course, ethics and morality do not reduce to a tally of votes, and beliefs and values can change. But if campaigns to eliminate FGC are ever to be successful, they must take seriously—not condescend toward—the women who do value their cutting traditions, and who regard their modified vulvae as normal or enhanced as opposed to mutilated or otherwise harmed. Meeting such women on their own terms, rather than automatically discounting their perspective or dismissing them as victims of false consciousness, would be a good place to start.

In line with this, despite the variation in typology and culture between regions of prevalence, successful abandonment campaigns share several core features. Amongst them: centring affected women, engaging local religious or cultural leaders, accommodating the interdependence of communities and their decision-making, showing appropriate respect for cultures and reinforcing their positive aspects, and focussing on local values and aspirations [100, 101]. In other words, initiatives which positively engage communities and allow abandonment to be led from within are most likely to be successful. Blanket criminalisation based on double-standards, by contrast, is unlikely to foster an atmosphere of cooperation and mutual understanding. Such a realization has recently led to calls for legal reform—on practical grounds—even among steadfast anti-FGC advocates [102].

6. Conclusion

The prevailing view that there is a categorically valid, morally significant difference between the set of acts described as "FGM" and those known as FGCS is inconsistent with the available evidence concerning both the range of physical interventions constituting such practices, and the cultural and individual motivations behind them. On closer inspection, it is clear that the categories are functional, rather than "scientific"; they are defined not by the acts they contain (since the physical realities of these acts have considerable overlap), but by the perceived rationales for which they are sought. FGCS acts are sought for purportedly aesthetic reasons (which are themselves rooted in wider cultural norms that deserve scrutiny); FGC acts are sought to adhere to religious or cultural norms (which similarly should be subjected to critique), within which aesthetics is often also a consideration. Even the "rationale" demarcation is thus evidently blurry.

The more closely one studies the two sets of practices, especially in light of further overlaps with MGC, the greater the apparent similarities between them. Yet acts understood to constitute "FGM" are criminal, while those within the FGCS category are not. As discussed, one reason for this discrepancy is that the stereotypical reasons for seeking "FGM" are perceived to be indefensible, while the reasons for seeking FGCS are regarded as less problematic. Moreover, "FGM" is believed to be primarily (but is not always actually) performed upon children, who cannot give consent, while FGCS is believed to be primarily (but is not always actually) sought by adults, who (contestably) can. But even if such presumed distinctions were more strongly rooted in reality, they would be undermined by the fact that religious or cultural male circumcision—which is more physically invasive than at least some prohibited forms of FGC—is legal almost everywhere, often unregulated, and primarily performed upon infants and newborns who are least capable of consenting.

Given such inconsistencies, it is increasingly being argued that the laws concerning genital alteration are not based in "objective" or universally valid distinctions, but are rather heavily shaped by certain social and political discourses regarding race and gender [83]. This creates a confusing situation for medical professionals, whose work requires a clear understanding of the differences between the two practices, yet the (largely unexplained) division offered by the law is not derivable from, nor consistent with, the tenets of medical ethics [103].

Changes to legislation around genital alteration in Western contexts could be approached in several ways. Some would argue that, in liberal, multicultural societies, it is important to permit

pluralism in the law in order to accommodate the practices of minority ethnic and religious groups, even if those practices involve irreversible modifications to the bodies of children. On that view, one might argue that the law around FGC (perhaps with certain typological restrictions) should be brought into line with its parallel practice, MGC [65]. Others would contend that the only defensible distinction is that between those who have the capacity to consent, and those who do not, and that if pluralism in the law should be upheld, it should be reserved for the bodies of adults [82]. Such a view motivates changes to the law according to which non-therapeutic genital alterations are unlawful for all children, and lawful for all adults [33, 61]. This would allow genital surgeries to be chosen, if desired, on the basis of one's own mature preferences and values, regardless of race or gender, and to be offered within regulated clinical conditions with due attention to possible complications and follow-up care.

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REVIEW

Female genital mutilation and male circumcision: toward an autonomy-based ethical framework

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Abstract: The non-therapeutic alteration of children's genitals is typically discussed in two separate ethical discourses: one for girls, in which such alteration is conventionally referred to as "female genital mutilation" (or FGM), and one for boys, in which it is conventionally referred to as "male circumcision." The former is typically regarded as objectionable or even barbaric; the latter, benign or beneficial. In this paper, however, I call into question the moral and empirical basis for such a distinction, and I argue that it is untenable. As an alternative, I propose an ethical framework for evaluating such alterations that is based upon considerations of bodily autonomy and informed consent, rather than sex or gender.

Keywords: FGM, circumcision, gender, sexuality, autonomy, consent

"The cutting of healthy genital organs for non-medical reasons is at its essence a basic violation of girls' and women's right to physical integrity. This is true regardless of the degree of cutting or the extent of the complications that may or may not ensue."

–Anika Rahman and Nahid Toubia[1]

"Most illogical is the use of the term 'male genital mutilation' to refer to male circumcision … in an attempt to equate the latter with female genital mutilation, with which it has little in common, either anatomically or health-wise."

–Brian J Morris[2]

Introduction

The non-therapeutic surgical alteration of children's genitals is treated very differently in Western societies, depending upon the sex or gender[a] of the child whose genitals are altered. When such alteration is done to females, it is often branded "female genital mutilation" (or FGM) and is typically deemed to be wholly impermissible. FGM is illegal in many developed countries, is punishable by lengthy prison sentences and/or hefty fines,[9] and is proscribed by the United Nations.[10,11] When such alteration is done to males, by contrast, it is usually given the label "male circumcision" – and is conventionally regarded as being benign or beneficial.[12] In almost no jurisdiction is such

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[a]The relationship between sex and gender, as well as how each should be defined, is notoriously complex;[3] I will not be able to explore that thicket in this essay. In a similar vein, although the genital alteration of so-called intersex individuals has drawn considerable critical attention,[4–7] I will have to set aside that issue as well. For a hint of my views, however, see the essay by Carmack, Notini, and Earp (in press).[8]

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alteration prohibited (in many it is not even regulated);[13,14] and in some it is actively promoted, for example, as a form of partial prophylaxis against certain diseases.[b]

Why such divergent treatment? As one prominent ethicist has noted, "these two practices, dramatically separated in the public imagination, actually have significant areas of overlap."[21] For example, both types of intervention involve the incision (and usually, though not always, the excision) of healthy, erogenous tissue.[11,22,23] Both concern an individual's "private parts," yet are done without the person's own consent. And neither involves the treatment of disease, nor the correction of an acknowledged deformity.[24] *Prima facie*, then, at least according to this way of thinking, a similar medical-ethical analysis – based on conventional bioethical principles – would seem to apply to both.

Yet this is not the predominant opinion expressed in Western popular discourse, nor in much of the scholarly literature. In these domains, as well as in many others, the two types of intervention are rarely discussed in the same context.[25] Moreover, when they are characterized as being potentially comparable, the reaction is often incredulous. For example, when the anthropologist Kirsten Bell put forward such a comparison in her university lectures, the response from her students was "immediate and hostile":

> "How dare I mention these two entirely different operations in the same breath! How dare I compare the innocuous and beneficial removal of the foreskin with the extreme mutilations enacted against females in other societies!"[26]

One recurrent claim is that FGM is analogous to "castration" or a "total penectomy," such that any sort of comparison between it and male circumcision is entirely inappropriate.[27] This perspective alludes to a harm-based argument for the (distinctive) impermissibility of female forms of genital alteration. On this sort of view, the sheer level of harm entailed by FGM passes a threshold of intolerability that is not passed by male circumcision. FGM is also seen as lacking in any benefit (as the World Health Organization states: FGM has "no health benefits, [and] only [causes] harm"),[28] whereas potential health-based benefits are not infrequently raised in support of male circumcision.[29–30]

In the first section of this essay, I call into question the claims upon which these distinctions are typically premised. Specifically, I show that at least certain forms of FGM (or female genital alteration [FGA]),[21] including forms that are legally prohibited in Western societies, are demonstrably less harmful than the most prevalent forms of male circumcision. I also show that certain forms of male circumcision (or male genital alteration [MGA]), including forms that are common in parts of Africa and elsewhere, can be at least as harmful as the most extreme forms of FGA as practiced in any context. I will also question the claims that have been made on the point of health benefits, with respect to both types of genital alteration.

The harm-based argument, then, does not turn out to be sufficient to draw a strict moral distinction between male and female forms of genital cutting practices. The consequence of this conclusion can be stated as a conditional: if the degree of harm vs benefit commonly attributed to male circumcision is seen as being compatible with its permissibility in Western societies, then forms of female genital cutting that result in a similar degree of harm vs benefit must also be considered permissible on these grounds.[c] Yet many would resist this conclusion. Indeed, the official position of such influential bodies as the World Health Organization and the United Nations is that *any* kind of medically unnecessary, non-consensual alteration of the female genitalia – no matter how minor the incision, no matter what type of tissue is or is not removed, no matter how slim the degree of risk, and no matter how sterile the equipment used – is by definition an impermissible "mutilation."[11]

Granting this view for now (although it is not uncontroversial),[11,21] perhaps we can find some other moral basis on which to ground a gender or sex-based distinction. The philosopher Joseph Mazor has recently advanced an intuitive-sounding possibility:

> There is an important *moral* difference [between male and female forms of genital alteration] that does not have to do with the physical effects of the operation[s]. Namely, in some … of the cultures in which female genital cutting is practiced, the practice reflects deeply-rooted attitudes about the lower status of women. Thus, even if male and female genital cutting were perfectly identical in terms of net health benefits and effects on sexual pleasure, the

[b]Such promotion is largely driven by a core group of (primarily) US-based researchers[15] who have succeeded in influencing the policies of not only of the American Academy of Pediatrics[16] and the US Centers for Disease Control and Prevention,[17,18] but also the World Health Organization.[19] For further analysis of the health benefits arguments in favor of male circumcision, see my essay, "Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines" in the journal *Frontiers in Pediatrics*.[20] See also the relevant sections below.

[c]And conversely, if the degree of net harm commonly attributed to FGA is seen as being incompatible with its permissibility in Western societies, then forms of MGA that result in a similar (or greater) degree of net harm must also be considered impermissible on these grounds.

> relationship in some cultures between female genital cutting and a failure to respect women as moral equals would give an additional reason to object to female circumcision.[31] (emphasis added)

This line of thought, which I will refer to as the "symbolic meanings" argument, will be the focus of the second section of my paper. In this section, I argue that Mazor's proposed distinction, while potentially appealing on a first-pass assessment, is ultimately untenable. First, as Mazor himself concedes, male and female forms of genital alteration are carried out for different reasons, and reflect different norms and attitudes, in different cultural contexts. In some cases, the "symbolic meanings" of these respective alterations are in fact quite similar. Indeed, contrary to common wisdom, non-therapeutic FGA is not always associated with, nor a reflection of, sexist and patriarchal norms; nor are the norms associated with male genital cutting always as morally innocent as is typically assumed.

Accordingly, even if one were to grant that the moral permissibility of each type of genital cutting – stipulated to be equally (physically) harmful for the sake of this analysis – hinged on the attitudes or norms that they "reflected," it would still be necessary to distinguish between such attitudes and norms on a context-specific basis, and possibly even case-by-case. Apart from the practical difficulties that would be incurred by such a task, there are a number of epistemological difficulties as well.

As I conclude, therefore, the Western habit of drawing a stark moral distinction between male and female forms of non-therapeutic, non-consensual genital alteration may be impossible to maintain on principled grounds – or if not impossible, certainly much more difficult than is commonly assumed. In the final section of this paper, I provide a very brief sketch of an ethical framework that could be used to evaluate such alterations in a more consistent and principled way. Instead of being based on considerations of sex or gender, my proposed framework will be based on considerations of bodily autonomy and informed consent.

Male and female forms of genital alteration: the question of harm

That FGA is harmful to women and girls – and certainly much more harmful than MGA – is a truism in Western societies. This is the harm-based argument to which I alluded earlier, and I have already suggested that it cannot succeed. To see why this is the case, it is necessary to begin with a widely-accepted definition of FGM (if I may now revert to the conventional terminology for the sake of this discussion) so that we can understand what is at stake in such a procedure, followed by an analysis of male circumcision. The World Health Organization gives us the following typology:[32]

FGM Type 1 – This refers to the partial or total removal of the clitoral glans (the part of the clitoris that is visible to the naked eye) and/or the clitoral prepuce ("hood"). This is sometimes called a "clitoridectomy,"[28] although such a designation is misleading: the external clitoral glans is not always removed in this type of FGM, and in some versions of the procedure–such as with so-called "hoodectomies"–it is deliberately left untouched.[33] There are two major sub-types. *Type 1(a)* is the partial or total removal of just the clitoral prepuce (ie, the fold of skin that covers the clitoral glans, much as the penile prepuce covers the penile glans in boys; in fact, the two structures are embryonically homologous).[34d] *Type 1(b)* is the same as *Type 1(a)*, but includes the partial or total removal of the external clitoral glans. Note that two-thirds or more of the entire clitoris (including most of its erectile tissue) is internal to the body envelope,[35] and is therefore not removed by this type, or any type, of FGM.

FGM Type 2 – This refers to the partial or total removal of the external clitoral glans and/or the clitoral hood (in the senses described above), and/or the labia minora, with or without removal of the labia majora. This form of FGM is sometimes termed "excision." *Type 2(a)* is the "trimming" or removal of the labia minora only; this is also known as labiaplasty when it is performed in a Western context by a professional surgeon (in which case it is usually intended as a form of cosmetic "enhancement").[33] In this context, such an intervention is not typically regarded as being a form of "mutilation," even though it formally fits the WHO definition. Moreover, even though such "enhancement" is most often carried out on consenting adult women in this cultural context, it is also sometimes performed on minors, apparently with the permission of their parents.[11,36] There are two further subtypes of *FGM Type 2*, involving combinations of the above interventions.

FGM Type 3 – This refers to a narrowing of the vaginal orifice with the creation of a seal by cutting and repositioning the labia minora and/or the labia majora, with or without excision of the external clitoris. This is the most extreme type of FGM, although it is also one of the rarest, occurring

[d]Note that, on some interpretations, FGM Type 1(a) is the strict anatomical equivalent of male circumcision, since both procedures constitute the removal of the genital prepuce. However, such comparisons are not quite exact: in the male version of the procedure, many more square centimeters of erogenous tissue are removed due to the larger size of the penile prepuce.

in approximately 10% of cases.[11,37] When the "seal" is left in place, there is only a very small hole to allow for the passage of urine and menstrual blood, and sexual intercourse is rendered essentially impossible. This type of FGM is commonly called "infibulation" or "pharaonic circumcision" and has two additional subtypes.

FGM Type 4 – This refers to "all other harmful procedures to the female genitalia for non-medical purposes" and includes such interventions as pricking, nicking, piercing, stretching, scraping, and cauterization.[32] Counterintuitively for this final category – which one might expect to be even "worse" than the ones before it – several of the interventions just mentioned are among the least severe forms of FGM. Piercing, for example, is another instance of a procedure – along with labiaplasty (*FGM Type 2*) and "clitoral unhooding"[33] (*FGM Type 1*) – that is popular in Western countries for "non-medical purposes," and can be performed hygienically under appropriate conditions.[11,38–40]

The harms of FGM/A

Several points can now be emphasized. First, "FGM" is not just one thing. Instead, there are many ways to nick, scratch, or cut off parts of a girl's vulva, ranging from (at the lowest end of the harm spectrum) an anaesthetized prick on the clitoral hood, as is common in Malaysia and in some other Muslim communities,[11,41] to (at the highest end of the spectrum) the excision of the outer clitoris with a shard of glass, and the suturing of the labia with thorns.[42] It should be clear that these different forms of intervention are likely to result in different degrees of harm, with different effects on sexual function and satisfaction, different chances of developing an infection, and so on, among the other possible adverse consequences that may be associated with these procedures.[43] But as Carla Obermeyer has observed:

> It is rarely pointed out that the frequency and severity of complications are a function of the extent and circumstances of the operation, and it is not usually recognized that much of [our] information comes from studies of the Sudan, where most women, [in contrast to the majority of other contexts] are infibulated. The ill-health and death that these practices are thought to cause are difficult to reconcile with the reality of their persistence in so many societies, and raises the question of a possible discrepancy between our "knowledge" of their harmful effects and the behavior of millions of women and their families.[44]

A further point to consider is that many of the risks and harms that are associated with FGM – such as pain, infection, and hemorrhage – could be substantially reduced, if not eliminated, by transitioning toward the less invasive forms of the procedure, coupled with an increased focus on "medicalization."[45,46] In light of this recognition, more minor forms of female genital alteration are indeed being performed in hospital settings in an increasing number of communities worldwide, on the model of routine male circumcision as performed in the United States.[47] This trend has not been welcomed, however, by those who oppose FGM regardless of implementation or type,[11,47,48] and it has been explicitly condemned by both the World Health Organization and the United Nations.[11]

What about effects on sexuality?[44] While a popular assumption is that any form of FGM deprives women of all sexual feeling, "[r]esearch by gynecologists and others has demonstrated that a high percentage of women who have had genital surgery have rich sexual lives, including desire, arousal, orgasm, and satisfaction, and their frequency of sexual activity is not reduced."[49] Indeed, in one study,[50] up to 86% of women–some of whom had undergone even "extreme" forms of FGM–reported the ability to orgasm, and "the majority of the interviewed women (90.51%) reported that sex gives them pleasure." These counterintuitive findings might be explained by the fact, noted earlier, that much of the clitoris is actually underneath the skin layer and is therefore not removed by even the most invasive types of FGM.[e] Of course, there are other parts of the vulva/vagina to consider as well, whose stimulation can likewise contribute to sexual pleasure. All told, the degree and quality of subjective sexual feeling is likely to vary considerably depending upon the type of FGM, as well as from person to person: the number and distribution of nerve endings, etc – and hence the sexual responsiveness of each person's genitals – is unique. Therefore FGM and other forms of genital modification will affect different people differently.[51]

On the other side of the ledger, there is a great deal of evidence[f] that FGM can be harmful to sexual function

[e]As Catania et al. report: "It is … important to remember that in infibulated women, some fundamental structures for the orgasm have not been excised. The women interviewed by [some researchers] achieve orgasm by stimulating the vagina and consider the clitoris as something extra. In reality they refer to the visible (external) part of the clitoris which is [only] the 'tip of the iceberg' of the whole structure, strictly connected to the vagina."[50]

[f]However, see Obermeyer[55] for an important discussion of the methodological difficulties inherent in these types of studies, as well as the need to distinguish between more vs less invasive forms of FGM/A when reporting on its effects on sexuality. See also, eg, Meston et al.[56] for evidence of a lack of ability to orgasm among some women with intact genitalia, further complicating the relationship between ability-to-orgasm and the presence or absence of an external clitoral glans.

and experience, especially when one considers the more extreme forms.[52–54] Women in some studies have reported feeling "cold" during sex, deriving "no satisfaction" from intercourse, and "having pain during sex."[57] As Sara Johnsdotter has pointed out,[51] the relationship between the amount of genital tissue removed from any individual and her felt satisfaction during sexual intercourse is complex (as well as difficult to study in a controlled, scientific manner), so FGM–of whatever degree of severity–will lead to different psychologically-mediated outcomes, depending upon the beliefs, attitudes, and other internal states of the affected individual.[50,51] As I have argued elsewhere:

> While many African women feel *enhanced* by having modified genitals – feeling more beautiful, 'cleaner,' more 'smooth' and 'neat' – increasing numbers of them are aware of just how controversial their local customs have become on the world stage. Many of them are learning about how other cultures and societies regard the innervation and functions of the clitoris. Some of them are dating outside of their cultural groups [and finding] out that 'cut' genitals are *not* considered beautiful by the prevailing group in such contexts, and so on. Accordingly, they may feel humiliated, deprived, diminished – and yes, 'mutilated.' There is even [some] evidence of women seeking reconstructive surgery of their genitals to try to reclaim what was 'taken from them' when they were too young to fully understand what was happening.[11]

In the final analysis, it is clear that FGM, and especially its more invasive forms, poses a distinct risk of causing sexual harm, even if this harm may not be experienced in the same way, or to the same degree, by every woman who has been subjected to genital surgery. Moreover, in at least some cases, the harm is quite clearly catastrophic.

The harms of MGA

These same considerations apply to male circumcision. As with FGM/A, circumcision is not a monolith: it isn't just one kind of thing.[g] The original form of circumcision within Judaism, for example, until about 150 AD, was comparatively minor: it involved cutting off the overhanging tip of the foreskin – whatever stretched out over the end of the glans – thus preserving (most of) the foreskin's protective and motile functions, as well as limiting the amount of erogenous tissue removed.[58] The "modern" form adopted by the United States[59] is significantly more invasive: it typically removes between one-third to one-half of the movable skin system of the penis,[60] or about 50 square centimeters of sensitive tissue in the adult organ.[61,62] The operation also eliminates the gliding function of the prepuce (which may help to reduce chafing in the female sexual partner),[h] as well as any and all sexual sensation in the prepuce itself;[23,62] and it exposes the head of the penis to environmental irritation.[23,60] Just as with various forms of non-therapeutic FGA, male circumcision has been associated with numerous sexual difficulties, ranging from reduced sensitivity in the exposed glans, to problems with orgasm, to pain in the receptive female partner.[64–66] Nevertheless, many, if not most, circumcised men report being able to enjoy their sexual experiences, notwithstanding the loss of erotogenic tissue[67,68] (see Box 1 for further discussion).

Just as with FGA, male genital cutting can take many different forms. In Pakistan, traditional Muslim circumcisions are done while the boy is fully conscious, usually between the ages of 3 and 7. As S A Rizvi and colleagues describe, "the child is held in a seated position, with both legs apart." Then, "a probe, a cutter made of wood, and a razor are used [to excise] the prepuce," at which point "ashes of burnt wood are [applied] to establish haemostasis."[72] The operation is performed "with no anaesthesia, no sutures and with unsterilized instruments."[72] In the United States, routine (non-religious) circumcisions are performed in a hospital setting, and take place in the first few days of life. These, too, often involve inadequate (or no) pain control, and have been known to result in serious "botches," including partial amputations of the penis. While such an outcome is typically described as "rare," the true incidence of complications is unknown.[13,16,73] Metzitzah b'peh, done by some ultra-Orthodox Jews, requires the sucking of blood from the circumcision wound, and carries the risk of herpes infection and permanent brain damage.[74] Subincision, performed by some Australian aboriginal groups, involves slicing open the urethral passage on the underside of the penis from the scrotum to the glans, often affecting urination as well as sexual function.[75,76] As Derrick J Pounder states, "the bleeding is staunched with sand, and the edges of the wound may be cauterized … the resultant defect in the urethral wall is kept open [with] pieces of wood, bone,

[g]For a proposed typology, see Svoboda and Darby.[25]

[h]As Scott states: "Upon full erection, there is ample play in the penile skin to allow the glans to glide in and out of the prepuce. During the inward motion of intercourse, the ridged mucosa, positioned now near the mid-penile shaft, glides along and in contact with the vaginal wall. The Meissner's corpuscles [sensitive nerve fibers] in the crests of the ridged mucosa are stimulated by this contact and by the restraint of the frenulum, with which the ridged mucosa is continuous. In the outward motion of intercourse, the prepuce inverts over the distal portion of the penis. The Meissner's corpuscles are again stimulated, this time by contact with the corona glandis."[63]

The literature concerning the sexual effects of male circumcision is hotly contested.[69,70] However, the most recent, comprehensive, and balanced review of the available evidence is due to Jennifer Bossio and her colleagues,[68] who note that: "Adverse self-reported outcomes associated with foreskin removal in adulthood include impaired erectile functioning, orgasm difficulties, decreased masturbatory functioning (loss in pleasure and increase in difficulty), an increase in penile pain, a loss of penile sensitivity with age, and lower subjective ratings of penile sensitivity" (internal references omitted).[68] While "other studies have found no significant differences in self-reported sexual functioning following adult circumcision," it must be remembered that (a) adult vs infant/child circumcision may not necessarily yield equivalent outcomes,[23] and (b) that a lack of statistical significance does not entail a lack of underlying effect.[71] For example, in an oft-cited study purporting to show no adverse effect of circumcision on sexuality, "several questions were too vague to capture possible differences between circumcised and not-yet circumcised participants [such that] non-differential misclassification of sexual [outcomes] probably favored the null hypothesis of no difference, whether an association was truly present or not."[66] Finally, due to the fact the foreskin "can be stretched, rolled back and forth over the glans, and otherwise manipulated during sex and foreplay, [allowing] for a range of sexual functions – along with their concomitant sensations – that are physiologically impossible if this tissue is removed … To say that circumcision has 'little or no effect' on sexual experience [is] to adopt an extremely narrow conception of that term".[23]

Box 1 – What are the effects of male circumcision on sexual function, satisfaction, and sensation?

or clay."[75] Circumcision among the Xhosa in South Africa is traditionally done in the bush as a rite of passage, sometimes with the use of spearheads and dirty knives, and frequently by medically untrained practitioners. Just as with female genital altering rites performed under comparable conditions (and often by the very same groups), these kinds of operations frequently cause hemorrhage, infection, mangling, and loss of the sexual organ.[77] In fact, between 2008 and 2014, more than half a million boys were hospitalized due to botched circumcisions in South Africa alone; more than 400 lost their lives.[78,79] But even when performed in a modern clinical setting, circumcisions are not without their risks and complications. In 2011, nearly a dozen infant boys were treated for "life threatening hemorrhage, shock or sepsis" as a result of their non-therapeutic circumcisions at a single children's hospital in Birmingham, England.[80]

By now it should be clear, as Debra DeLaet (among others) has argued,[81,i] that both male and female forms of genital alteration fall on a wide spectrum, and that the harms they may entail substantially overlap.[21] That this is not commonly understood in the popular discourse is most likely due to the fact that when Westerners hear the term "FGM," they tend to think of the most extreme forms of female genital cutting, done in the least sterilized environments, with the most drastic consequences likeliest to follow (since these are the forms to which they will typically have been exposed, due to their disproportionate representation in the media and in other popular accounts).[49] When people hear the term "male circumcision," by contrast, they are much more likely to think of the *least* severe forms of male genital cutting, done in the most sterilized environments, with the least drastic consequences likeliest to follow, largely because this is the form with which they are culturally familiar.[11,82]

However, as the anthropologist Zachary Androus has noted, this way of thinking is misleading: "The fact of the matter is that what's done to some girls [in some cultures] is worse than what's done to some boys, and what's done to some boys [in some cultures] is worse than what's done to some girls. By collapsing all of the many different types of procedures performed into a single set for each sex, categories are created that do not accurately describe any situation that actually occurs anywhere in the world."[83]

The other side of the coin: the question of benefits

So far, I have discussed the potential harms of male and female genital alterations, but I have not yet considered the question of benefits. MGA, but not FGA, is believed by some medical professionals to confer a number of possible health benefits[j] – most notably, a small reduction in the absolute risk of female-to-male, heterosexually transmitted HIV in areas with high base rates of such infection[16–19,84] – although

[i]As she writes, while "there are sharp differences between infibulation, the most extreme form … of female genital mutilation, and the less invasive form of male circumcision that is most widely practiced … that comparison is not necessarily the most appropriate comparison that can be made. There are extremely invasive forms of male circumcision that are as harsh as infibulation [and while it] is true that these extreme forms of male circumcision are rare … it is also the case that infibulation [is rare]. Indeed, female circumcision as it is commonly practiced can be as limited in terms of the procedures that are performed and their effects as the most widespread type of male circumcision."[81]

[j]For an overview of the scientific and ethical controversy surrounding the question of health benefits in a Western context, see my earlier work on the subject;[20,85] for critiques of US-based support for circumcision specifically. see, eg, Frisch et al.,[86] Svoboda and Van Howe;[87] Garber;[88] Hartmann;[89] Lawson;[90] Booker;[91] Bewley and Stranjord;[92] Guest;[93] Androus;[94] Earp and Darby;[62] Earp;[95] and Bossio et al.[68] Note that replies and counter-replies to some of these critiques have been published; these can be accessed at the relevant journal websites.

the likelihood and the magnitude of such benefits outside of sub-Saharan Africa is the subject of considerable dispute. If these authorities are correct, then the benefits of circumcision might conceivably offset the drawbacks and risks in a way that is not the case for FGA, thereby preserving the moral distinction between them.

An important qualification is in order. First, almost all of the controlled evidence pointing to potential health benefits for MGA has been derived from studies of adult (and hence voluntary) circumcision, rather than from infant/child (and hence involuntary) circumcision.[68] Since "the spread of disease, including sexually transmitted infections, is determined much more by socio-behavioral and situational factors than by strictly anatomical-biological factors, such as the presence or absence of a foreskin … the apparent findings from these studies cannot be simply mapped on [to] circumcisions performed earlier in life, ie, before an age of sexual debut."[20] This distinction is important. From an ethical perspective, few people would argue that fully-informed adult males should not be permitted to undergo elective surgeries on their own genitals, whether in an attempt to achieve partial prophylaxis against disease or for other reasons. This issue of informed consent will feature prominently in our discussion later on.

With respect to neonatal or childhood circumcision, by contrast, the primary health benefit that has been attributed to this version of the surgery is a slight reduction in the absolute risk of urinary tract infections.[86] However, the overall chance of contracting such an infection (in the first year of life) is low–approximately 1%–regardless of one's circumcision status.[96] As Benatar and Benatar explain, "UTI does not occur in 99.85% of circumcised infant males and in 98.5% of uncircumcised infant boys."[97] In the rare event that a child does in fact become infected, UTIs are both "easily diagnosed and treatable, with low morbidity and mortality."[97] A further point to consider is that: according to one recent estimate, about 111 circumcisions would have to be performed to prevent a single case of UTI.[98] Accordingly, "a more conservative, humane, and effective course of treatment would be to prescribe oral antibiotics – if and when an infection does occur. This is just what we do for girls, who get UTIs (after the age of 1) about 10 times more frequently than boys do, with no pre-emptive surgery recommended."[62]

But what if such surgery were recommended? The question cannot be left unanswered. The point here is that we do not actually know whether some minor form of FGA might confer health benefits, because it is illegal – and would be unethical[23,43] – to conduct a study to find this out. Obviously, the more extreme types of FGA will not contribute to good health on balance, but neither will the spearheads-and-dirty-knives versions of MGA performed on boys. What about more mild forms of FGA? As I have noted elsewhere, "the vulva has all sorts of warm, moist places where bacteria or viruses could get trapped, such as underneath the clitoral hood, or among the folds of the labia; so who is to say that removing some of that tissue (with a sterile surgical tool) might not reduce the risk of various diseases?"[82]

As a matter of fact, defenders of FGA in some countries actually do cite such "health benefits" as "a lower risk of vaginal cancer … less nervous anxiety, fewer infections from microbes gathering under the hood of the clitoris, and protection against herpes and genital ulcers."[25] Moreover, at least one study by Western scientists has shown a link between "female circumcision" and reduced transmission of HIV – a result that the authors, both experienced statisticians, characterized as a "significant and perplexing inverse association between reported female circumcision and HIV seropositivity."[99,100] The authors, Rebecca Stallings and Emilian Karugendo, expressed a dire need for further research into the issue. Yet as the medical anthropologist Kirsten Bell has noted (personal communication, January 16, 2015):

> These findings, which were presented at an International AIDS Society conference in 2005, have never been published in a peer-reviewed journal and it is difficult to imagine any agency willing to entertain Stallings and Karugendo's call for further research. Indeed, the topic is self-evidently a non-starter. Regardless of any evidence that might suggest an association, it is impossible to imagine a parallel research agenda [to the one on male circumcision] solidifying around the procedure, irrespective of whether the surgery was conducted in a medical context and [irrespective of] the extent of cutting involved.

The thought experiment can be taken a step further. With respect to causal plausibility, it is often argued that the biological mechanism through which the foreskin in males becomes a vector for HIV transmission (although the details are somewhat contentious)[101,102] is the presence of Langerhans cells in the inner mucosa of the foreskin. What is rarely mentioned in these discussions, however, is that the external female genitalia are also richly endowed with Langerhans cells.[103] If the removal of tissue with Langerhans cells is seen as an acceptable means of reducing HIV transmission, then the excision of portions of the female genitalia (on these grounds) should logically be entertained as well.

The point here is not to suggest that there is in fact good evidence that certain forms of FGA could definitely reduce

the risk of male-to-female transmission of HIV; as it stands, that is not the case. Instead, the point is that regardless of any evidence for such a possibility, serious research into the question is unlikely ever to be considered, simply because such procedures are unacceptable to Western ethical and cultural norms.[104] Bell has highlighted the contradictory policies of international health organizations on this point, "which seek to medicalize male circumcision on the one hand, oppose the medicalization of female circumcision on the other, while simultaneously basing their opposition to female operations on grounds that could legitimately be used to condemn the male operations."[26]

Is there a "symbolic" difference?

The analysis in the preceding section suggests that a benefit vs harm analysis cannot rule out, in a principled fashion, all forms of FGA, while simultaneously tolerating, much less promoting, the most common forms of MGA. This is because the health benefits that have been attributed to male circumcision, at least in a Western context, are relatively minor (in terms of absolute risk reduction); they apply mostly after an age of sexual debut; they can be achieved in much less harmful ways (such as by the adoption of safe sex practices); and – crucially for the sake of the present analysis – we do not actually know that certain minor forms of FGA would not confer the same degree of prophylaxis against disease.[20] In the latter case, however, it seems unlikely that any such surgery would be seen as proportionate to the desired outcome (given alternatives): indeed, it is illegal to pursue the question. With respect to harms, on the other hand, I have tried to show that the adverse effects of both MGA and FGA overlap substantially, and that it is only by focusing on the least harmful forms of the former, and the most harmful forms of the latter, that this fact is not more widely understood.

But there may be a "symbolic" difference to consider as well. This is the view suggested by the philosopher Joseph Mazor, as indicated in the introduction, and it is one that has been advanced by Martha Nussbaum, among many others. "Female genital mutilation is unambiguously linked to customs of male domination,"[105] Nussbaum has written; whereas male circumcision is not ordinarily seen as being linked to such customs, nor perhaps to other problematic norms.[106]

In contrast to this perspective, I suggest that male genital cutting can indeed "be understood as a gendering practice tied to [patriarchal notions of] masculinity" as well as to customs of male domination;[107] and also, following Ahmadu,[108] that female forms of genital cutting are *not* "unambiguously" tied to such customs, as Nussbaum and others seem to assume.

The symbolic meanings of FGA

Let me begin with the latter case. As is increasingly being emphasized by scholars in this area, female genital cutting is performed for different reasons in different social contexts, and is not always associated with a lower status for women and girls, nor with the aim of reducing their sexual pleasure.[49,108] Indeed, such cutting is nearly always carried out by women themselves, who do not typically view their rites as being an expression of patriarchal norms, but rather as conducive to good hygiene, beautifying,[37,109] empowering, and as a rite of passage with high cultural value.[37,108] As Lisa Wade has argued, "attributing [the] persistence [of female genital altering rites] to patriarchy grossly oversimplifies their social, cultural, and economic functions" in the diverse societies in which they are performed.[110]

It has sometimes been argued that women who endorse FGA are victims of "false consciousness" and are thus mistaken about the nature of their own most cherished customs – that they are so oppressed, for example, that they have become unwitting instruments to their own oppression.[111] However, this sort of argument is increasingly being seen as both simplistic and condescending.[11,37,111–114] As Dustin Wax has argued, the supportive voices of women who have actually undergone genital alterations "is almost entirely absent, literally silenced by [a Western] insistence that the horrendousness of the practice precludes any possible positive evaluation."[115]

Of course, popular opinion has only limited value as a guide to the moral status of a given practice. It is quite possible that those women who approve of FGA in their societies possess a comparatively narrow degree of awareness of the key issues, such as the relevant genital anatomy, the ethical controversies surrounding the practice, the way it is perceived in other societies, and so on. (If so, then they would not be altogether different, in this respect, from circumcised men in the United States – including many members of the medical profession – who typically know little to nothing about the anatomy and functions of the foreskin, and who may be unaware that circumcision is rare in other developed nations outside of religious communities).[22,85,116–118] In support of this view, there is some evidence – from Nigeria, for example – that an increase in parental education corresponds to a reduction in the likelihood that the daughter will be "circumcised," although in other contexts, an increase in parental education corresponds, not to the abandonment of FGA, but rather to its medicalization[104] (somewhat akin to MGA in the United States).[59,119]

As Francelle Wax, a Jewish filmmaker and critic of both FGA and MGA has argued (personal communication, January 18, 2015):

> It would be productive to encourage people away from relying on majority opinion to determine what is ethically acceptable (or what people would [endorse] had they not been primed by their culture's norms). As most people are not [inclined to be] norm-questioning … and are hard-wired to rationalize irreparable harm done to them, or harm they caused to another, it is both unsurprising and un-compelling to note that the majority of people from cutting cultures do not object to having been cut [or see the practice as being unproblematic]. People should be encouraged to look to dissenting minorities, not to the masses, to take their cues about what is ethically problematic.

Notwithstanding Wax's important insight, as Ahmadu has argued, there has been an "unjustified conflation" of the varied practices of FGA in the popular discourse, resulting in an overemphasis on the most symbolically problematic form, namely infibulation or pharaonic circumcision.[108] This conflation is unjustified, she suggests, because infibulation is simultaneously the most extreme form of FGA, the rarest, and the form most closely associated with norms of male dominance and sexual control. It is also "associated with a specific region and interpretation of Muslim purdah ideology,"[108] and appears to be concentrated in north-east Africa.

In most other African contexts, by contrast, both FGA and MGA are least superficially egalitarian: they are carried out regardless of the sex or gender of the child, and are intended as a means of conferring adult status within the group.[49,104] Among the Kono of Sierra Leone, for example, "there is no cultural obsession with feminine chastity, virginity, or women's sexual fidelity, perhaps because the role of the biological father is considered marginal and peripheral to the central 'matricentric unit.'"[108] In this context, male and female genital alterations are performed in parallel ceremonies, are not primarily intended to reduce sexual pleasure, and the operations are seen as mirror images of each other.[11,49,104]

Nancy Ehrenreich and Mark Barr provide a general lesson:

> […] the mainstream anti-FG[A] position is premised upon an orientalizing construction of FG[A] societies as primitive, patriarchal, and barbaric, and of female circumcision as a harmful, unnecessary cultural practice based on patriarchal gender norms and ritualistic beliefs. … Lambasting African societies and practices (while failing to critique similar practices in the United States [and Europe]) … essentially implies that North American [and European] understandings of the body are "scientific" (ie, rational, civilized, and based on universally acknowledged expertise), while African understandings are "cultural" (ie, superstitious, un-civilized, and based on false, socially constructed beliefs). [Yet] neither of these depictions is accurate. North American medicine is not free of cultural influence, and FG[A] practices are not bound by culture – at least not in the uniform way imagined by opponents.[4]

The symbolic meanings of MGA

What about the other side of things? The usual claim is that male circumcision is not associated with a lowered status for women, but in Judaism, at least, this is not obviously the case. Indeed, only the males are permitted to "seal the divine covenant" by having their foreskins removed, so the custom is sexist on its face.[21] In his analysis of why Jewish women are not circumcised, Shaye J D Cohen argues that "Jews of antiquity seem not to have been bothered by this question probably because the fundamental Otherness of women was clear to them. Jewish women were Jewish by birth, but their Jewishness was assumed to be inferior to that of Jewish men."[120,121] Thus, as David Benatar has pointed out, "half of the Jewish people lack the physical mark that is widely associated with Jews. One would have thought that egalitarians would want to rectify this oversight."[122] As he goes on to state, "A true egalitarian would think it unfair that a boy is cut while a girl is not [and would] either extend the burden [of circumcision] to girls or remove it from [the] boys."[122] The sociologist Michael Kimmel goes a step further:

> circumcision means … the reproduction of patriarchy. [In the Jewish tradition] Abraham cements his relationship to God by a symbolic genital mutilation of his son. It is on the body of his son that Abraham writes his own beliefs. In a religion marked by the ritual exclusion of women, such a marking not only enables Isaac to be included within the community of men … but he can also lay claim to all the privileges to which being a Jewish male now entitles him. …. To circumcise [one's son, therefore, is] to accept as legitimate 4000 years [of] patriarchal domination of women.[123]

Male circumcision may be related to other problematic norms as well. One connection that has been raised in the literature is with an attempt to exercise control over boys' sexualities.[21,124] While most contemporary Western parents who choose circumcision for their sons do not (very likely) have such a motivation consciously in mind, neither, apparently, do most African parents when they choose "circumcision" for their daughters. Instead, as the renowned anti-FGA activist Hanny Lightfoot-Klein has stated: "The [main]

reasons given for female circumcision in Africa and for routine male circumcision in the United States are essentially the same. Both promise cleanliness and the absence of odors as well as greater attractiveness and acceptability."[125]

Nevertheless, male genital cutting has indeed been used as a form of sexual control, and even punishment, for a very long time.[21,124] The Jewish philosopher Maimonides (b. 1135) argued that diminished sexual sensitivity was part of the point of performing circumcisions (to reduce excessive "lust" as well as "weaken … the organ in question");[126] circumcision was adopted into Western medicine in the Victorian period largely as a means to combat masturbation and other expressions of juvenile sexuality;[127] and forced circumcision of (male) enemies has been used as a means of humiliation since time immemorial: the Luo of Kenya, for example, who do not traditionally circumcise, have been victims of such attacks in recent times, as have numerous other groups, including Christians in Aceh, Indonesia.[128–130]

Here, too, it could be argued that these apparent associations with problematic norms are superficial,[131] outdated, or only apply to a limited number of cases. But this is exactly the point. Neither male nor female forms of genital cutting can be successfully "boiled down" in terms of the attitudes that they supposedly express, and both have been plausibly associated with both (seemingly) unproblematic as well as (seemingly) extremely problematic norms. Yet if these interventions are meant to be distinguishable in terms of their permissibility on account of the differing norms that they are taken to reflect, then they will be very hard to distinguish indeed. As I have noted elsewhere:

> Given that both male and female forms of genital cutting express different cultural norms depending upon the context, and are performed for different reasons in different cultures, and even in different communities or individual families, how shall we assess the permissibility of either? Do we need to interview each set of parents to make sure that their proposed act of cutting is intended as an expression of acceptable norms? If they promise that it isn't about 'sexual control' in their specific case, but rather about 'hygiene' or 'aesthetics' or something less symbolically problematic, should they be permitted to go ahead? But this is bound to fail.[82]

Toward an autonomy-based ethical framework

Let me take stock of where we are. So far, I have been questioning the dominant moral paradigm according to which non-therapeutic genital alterations performed on children are treated fundamentally differently, depending upon the sex or gender of the child whose genitals are altered. I have tried to show that such differential treatment cannot be maintained on unambiguous and principled grounds, neither on the basis of a harm-based analysis, nor on the basis of differing "symbolic meanings." At the very least, I claim that the ordinary distinctions that *are* maintained, including by powerful decision-making bodies with considerable influence on a global scale,[11] are morally inconsistent.

At a first glance, there seem to be at least two ways of resolving this inconsistency. First, if Western societies remain convinced that the non-therapeutic alteration of boys' genitalia should be considered permissible so long as it does not cross an arbitrary threshold of "harm," then they should consider allowing similar alterations to the genitals of little girls (if requested by the parents). Some authors – most notably Dena Davis[21] – have in fact made just such a suggestion.[11,132,133] It seems evident, however, that this "solution" would create more problems than it would solve. For example, it would require that Western laws regarding physical assault on a minor be rewritten, potentially creating large-scale disturbances throughout the legal system. This is because – as others have argued – cutting into a child's genitals without a medical diagnosis, and without its informed consent, meets the formal definition of criminal assault under the legal codes of most of these societies.[134] For example, as Svoboda, Adler, and Van Howe point out in a forthcoming paper with respect to the legal situation in the United States, "In banning non-therapeutic FGC ['female genital cutting'] in 1997, Congress stated that it 'infringes upon the guarantees of rights secured by Federal and State law, both statutory and constitutional.' That is to say, female genital cutting *was already unlawful*" prior to the enactment of specific legislation.[135]

Another problem, acknowledged by Davis, is that it would be very difficult indeed to "police" such newly approved "minimal" forms of FGA, to ensure that they were not being used as a cover for more invasive and harmful procedures. In fact, a very basic problem with the suggestion of harm-tolerance is the difficulty it presents in terms of specifying an appropriate threshold for harm that could be measured in an objective way. As Blackstone noted more than 200 years ago, "the law cannot draw [a] line between different degrees of violence."[136] Accordingly, as Robert Ludbrook explains, "Once the laws permit physical violence, decisions have to be made as to where within the continuum of violence the limits are to be fixed."[136] This could open the door for interested parties to argue, for any proposed act of cutting, that it is 'not harmful enough' to warrant the placement of

limitations on parental decision making. As Ludbrook argues, "The law is an important symbol and if [it] allows parents, carers and teachers to [so much as hit their] children, it is sending a message to these people and to the community generally that children are not entitled to the same right to bodily integrity as adults."[136]

The question of rights is arguably central to this issue. In Western societies, we teach our citizens (including our children) that they have a right to bodily integrity:[117] "a right to make decisions about what happens to [their] own body, [a] right to say no to unwanted touching, [a] right not to be physically or sexually assaulted."[136] This, Ludbrook argues, is "the most personal and arguably the most important of all human rights," next to the right to life itself.[136] Some authors have argued that FGA performed before an age of consent is a violation of such a right, "regardless of the degree of cutting or the extent of the complications that may or may not ensue."[1]

Undoubtedly, such a view is motivated at least in part by the fact that such cutting involves a very "private" part of the body – ie, a part with unique psycho-sexual significance – and that it is done before a girl can understand what is at stake in such a procedure, much less offer effective resistance. Indeed, genitals are not like other parts of the body. This can be seen in the fact that sexual assault, in Western societies, is typically regarded as a more severe and more personal violation than other kinds of bodily assault. Accordingly, the outright cutting and/or alteration of a child's genitals seems much more likely to be the sort of interference that would later be experienced as a harm, compared against various other childhood bodily alterations that are sometimes raised in the literature.

A child's right to bodily integrity: genital cutting vs. other alterations

Consider vaccinations, which some authors have suggested are morally, or even physically, equivalent to male circumcision.[137] Against this view, critics point out that vaccination does not remove erogenous tissue (nor any healthy tissue), nor does it risk harming sexual function, sensation, or satisfaction. In addition, it does not result in a visible change to the appearance of the body, much less a part of the body with respect to which aesthetic norms, feelings of self-esteem, etc, vary considerably from person to person, and often inspire very strong feelings.[62,137,138]

Orthodontic treatment is another childhood bodily modification that is sometimes compared with genital cutting.[139] Similar to vaccinations, dental braces do not remove nor risk damaging erogenous tissue,[k] and (moreover) they are usually put on with the age-appropriate consent of the affected individual. Although braces may be uncomfortable, and although they do make a difference to physical appearance, both the degree of discomfort and the type of alteration to appearance fall well within the child's understanding. In contrast, the permanent modification of genital tissue prior to an age of sexual debut is not something whose significance a child of any sex or gender is in a position to fully understand.[11]

Finally, consider minor cleft lip repair – another common "analogy" to male circumcision.[31] While this is typically done before a child understands what is at stake in the procedure, it likewise does not remove functional tissue that he or she might later value (and wish to have experienced intact); indeed, it is universally regarded as a means of repairing a defect and thus as a form of cosmetic enhancement. This is in contrast to both FGA and MGA, whose respective statuses as being enhancements (as opposed to diminishments,[140] or even mutilations[106,138]) are contentious even within the societies in which they have traditionally been performed.[11,37,58]

These (and other) differences between genital cutting and other types of body modification may help to explain why there is an active "genital autonomy"[141] movement in the United States, Europe, and elsewhere that is fueled by women, men, and intersex people who are extremely resentful about their childhood genital surgeries, but not an anti-orthodontics movement or an anti-cleft lip-repair movement.[23] (There is, of course, a very controversial anti-vaccination movement, but this is motivated, not by concerns about violations of a child's right to bodily integrity, but rather by unfounded concerns about vaccines contributing to an increased risk of autism and other problems).[142]

A new ethical framework

Taking all of these considerations into account, let me offer a second approach to resolving the "inconsistency" alluded to above, which has the potential to avoid the serious disadvantages that seem likely to follow from an increased tolerance for FGA. This approach would involve a decreased tolerance for MGA, and on the same grounds that have just been discussed. According to this approach, the test for moral permissibility (if not legal permissibility, as that may raise a different set of issues)[143] would rest not so much on considerations of sex or gender – according to which boys, compared to girls,

[k]They do pose a very small risk of damaging the lips, which might plausibly be considered erogenous tissue, but, in contrast to circumcision (in which the removal of dozens of square centimeters of erogenous tissue is a necessary component of the intervention itself), this would be an accidental side-effect, and one that is probably so rare as to be able to be discounted.

are treated less favorably – but more on considerations of informed consent, reflecting an underlying concern for the "genital autonomy"[141,144] of children.

Moira Dustin has described just such an approach. She suggests that one way to resolve the apparent double standard regarding male vs female forms of genital alteration in Western societies, "would be to argue for the application of consistent principles of choice … and the recognition of all non-therapeutic bodily modifications" as being "culturally" motivated.[114] "This could mean making a distinction," she continues, "between adults who can choose how to modify their bodies in irreversible ways – however much the majority might deplore their choices – and children who cannot."[114] The application of this framework would have several important implications:

> It would mean saying that male circumcision of baby boys, where it has been established that it has no [net]* medical benefits, is unacceptable; it would mean that it would be illegal to circumcise a girl under the age of consent; and it would mean [by contrast] that if an adult woman wants to have her genitals 'tidied up' after childbirth or her labia reduced through 'cosmetic' surgery, then she should be allowed to make that choice. This may not be a satisfactory position but it is a way of avoiding double standards while the real work of changing the attitudes that produce these practices takes place.[114]

I am sympathetic with this general framework. As I have argued elsewhere, "Children of whatever [sex or] gender should not have healthy parts of their most intimate sexual organs removed, before such a time as they can understand what is at stake in such a surgery and agree to it themselves."[43] Conversely, as Christine Mason and others have argued, adults should be free to use medical technologies to modify their own bodies and minds, in a process of self-creation, if that is what they truly want.[147–149] While I do not suggest that (non-therapeutic) MGA should be banned, necessarily,[85,150,151] it is clear that the current *laissez faire* attitude toward this practice that is typical of Western societies – and in particular the United States – can no longer be maintained without facing serious objection. FGA and MGA are both highly problematic practices, with far more overlap between them (both physically and symbolically) than is commonly understood: they should not be discussed, therefore, in hermetically-sealed moral discourses.[21,104] Instead, the relevant framework is one that analyses a child's right to bodily integrity, and carefully considers how tolerant we are willing to be, in these societies, of practices which irreversibly alter a person's "private parts" in a non-trivial fashion, in the absence of medical necessity,[145] and before the person has a chance to say "no."

*I have added the word "net" here because this is a crucial distinction. Obviously removing any part of the body might reduce the risk of some disease afflicting that part of the body: tissue that has been excised cannot host an infection (for example). The relevant notion is *net* health benefits, then, because any benefits that might in fact accrue from the amputation of healthy tissue have to be balanced against not only the risk of surgical complications, but also the value of the lost tissue itself; the short-term, intermediate, and long-term adverse consequences associated with the intervention;[145,146] and, in the case of genital operations in particular, the loss of choice concerning a very 'private' part of one's body.[23,146] Moreover, there should be a paucity of less invasive, less risky alternatives for achieving the health benefits in question, for "health benefits"-type arguments to be compelling.[20]

About the author

Brian D Earp is a scientist and ethicist. He holds degrees from Yale, Oxford, and Cambridge Universities, including an M.Phil. degree in the history, philosophy, and sociology of science and medicine, focusing on male and female genital altering surgeries. Brian has served as a Guest Editor for the *Journal of Medical Ethics*, editing a special issue on the topic of childhood circumcision, and has published widely in the leading journals in his field.

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Cultural Bias in American Medicine: The Case of Infant Male Circumcision

Brian D. Earp and David M. Shaw

ABSTRACT

In 2012 the American Academy of Pediatrics (AAP) released a policy statement and technical report stating that the health benefits of newborn male circumcision outweigh the risks. In response, a group of mostly European doctors suggested that this conclusion may have been due to cultural bias among the AAP Task Force on Circumcision, in part because the AAP's conclusion differed from that of international peer organizations despite relying on a similar evidence base. In this article, we evaluate the charge of cultural bias as well as the response to it by the AAP Task Force, focusing on possible sources of subjective judgments that could play into assessments of benefit versus risk. Along the way, we discuss ongoing disagreements about the ethical status of nontherapeutic infant male circumcision and draw some more general lessons about the problem of cultural bias in medicine.

INTRODUCTION

In 2012 the American Academy of Pediatrics (AAP) released a policy statement and technical report in which it concluded that the "health benefits of newborn male circumcision outweigh the risks."[1] In contrast to most policies issued by the AAP, this one proved controversial, not only in the United States but internationally. Part of the reason for the controversy was that its primary conclusion concerning benefits and risks differed from that of previous AAP task forces: while previous task forces had acknowledged both positive and negative aspects to newborn circumcision (with earlier policies recommending against the procedure and later policies adopting a more neutral stance), none had found that the negatives were outweighed by the positives.[2] More striking, however, was the fact that this same conclusion differed from that of all contemporary peer organizations—that is, national pediatric or general medical societies in other countries with comparable public health environments—despite relying on a similar evidence base.[3] Following the release of the AAP documents, international critics raised concerns regarding how the main conclusion had been reached (see table 1).[4]

The most prominent criticism came in the form of an article entitled "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," authored by a large group of pediatric and other health authorities from mainland Europe, the United Kingdom, and Canada. According to these authors, "only 1 of the arguments put forward by the [AAP] has some theoretical relevance in relation to infant male circumcision; namely, the pos-

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sible protection against urinary tract infections in infant boys, which can easily be treated with antibiotics without tissue loss."[5] According to this view, since approximately 100 circumcisions would be needed to prevent one urinary tract infection (UTI),[6] and since the same theoretical UTI could be treated nonsurgically—as it would be if the child were female—without significantly increasing the absolute risk of serious adverse consequences, most boys with a normally developing anatomy should expect to receive no net medical benefit from circumcision prior to their sexual debut.

The other claimed health benefits, according to the critics, including a reduced risk of female-to-male heterosexually transmitted human immunodeficiency virus (HIV) and penile cancer, "are questionable, weak, and likely to have little public health relevance in a Western context, and they do not represent compelling reasons for surgery before boys are old enough to decide for themselves."[7]

Assessing Benefit and Risk

Let us first assess the empirical disagreement concerning benefits and risks. Bostrom and Ord have proposed a "reversal test" for weighing alternative policy options that is useful for framing such an analysis.[8] Consider the following question: If the AAP had recommended *not* performing circumci-

TABLE 1. Key Reasons for International Skepticism Regarding the 2012 AAP Findings

1. Internal inconsistency
   The AAP technical report states that "the true incidence of complications after newborn circumcision is unknown"—due to such problems as inadequate follow-up and conflicting diagnostic criteria—but nevertheless states that the benefits of the surgery outweigh these unknown risks.[1]
2. Questionable methodology
   The report does not mention any formal procedure used to assign weights or values to individual benefits and risks, nor does it mention any heuristic by which these could be directly and meaningfully compared, suggesting that no such procedure was used. The AAP Task Force stated in a later publication, the "benefits were felt to outweigh the risks."[2]
3. Underestimation of adverse consequences
   The AAP Task Force did not consider the most serious complications associated with circumcision, typically documented in case reports or case series, as these were excluded from their literature review.[3]
4. Inadequate description of penile anatomy
   The AAP Task Force did not describe the anatomy or functions of the foreskin (the part of the penis removed by circumcision), suggesting that it did not consider this genital structure to have any inherent value. If the foreskin does have value, however, its removal is itself a harm, and this must be factored into any benefit-risk analysis.[4]
5. Inappropriate use of research findings
   The AAP Task Force conflated findings from studies assessing the effects of adult circumcision in sub-Saharan Africa (regarding, e.g., HIV transmission and sexual function) with findings pertaining to newborn circumcision in the U.S., without demonstrating that the two procedures or environments are appropriately analogous.[5]

NOTES

1. AAP, "Male Circumcision (Technical Report)," *Pediatrics* 130, no. 3 (2012): e756-85, e757.

2. AAP, "The AAP Task Force on Neonatal Circumcision: A Call for Respectful Dialogue," *Journal of Medical Ethics* 39, no. 7 (2013): 442-43, 442.

3. See, e.g., J.S. Svoboda and R.S. Van Howe, "Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 434-4.

4. The implicit perspective of the AAP Task Force appears to be inconsistent with the value typically assigned to the foreskin in societies where most men retain one (and thus have personal experience with the relevant tissue). The foreskin is a highly touch-sensitive, functional sleeve of tissue that can be manipulated during sex and foreplay: it is therefore *prima facie* reasonable to regard it as having value. For extensive discussion, see B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56. The apparent view of the AAP Task Force is also inconsistent with normative medical evaluations regarding other nondiseased body parts: see J.M. Hutson, "Circumcision: A Surgeon's Perspective," *Journal of Medical Ethics* 30, no. 3 (2004): 238-40. Consider the female genital labia, for instance, whose functional, sensory, and other attributes would be fully described in any comparable report discussing the merits and demerits of excising them: see e.g., M.P. Goodman, "Female Genital Cosmetic and Plastic Surgery: A Review," *Journal of Sexual Medicine* 8, no. 6 (2011): 1813-25.

5. M. Frisch et al., "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," *Pediatrics* 131, no. 4 (2013): 796-800, 796.; J.A. Bossio, C.F. Pukall, and S. Steele, "Review of the Current State of the Male Circumcision Literature," *Journal of Sexual Medicine* 11, no. 12 (2014): 2847-64.

sion (because its primary health benefit in childhood could be achieved less invasively and in a more targeted manner via treatment with antibiotics, as noted by the critics), would any significant medical harm result to children, on balance, if all physicians followed that advice?

The most likely answer is "no."[9] A recent analysis of 18 years of data from the capital region of Denmark, where nonreligious male circumcision is rarely performed except out of medical necessity, suggests that approximately 99.5 percent of boys will go through infancy, childhood, and adolescence without requiring a circumcision for therapeutic reasons.[10] To put this finding a different way, the data suggest that less than 1 percent of boys in settings comparable to that of the Danish study will face a foreskin-related medical problem requiring circumcision before an age of consent.

By contrast, what would happen if the AAP guidelines were followed? Although the AAP documents do not explicitly recommend newborn circumcision, the "affirmative" position regarding net benefit has been interpreted by some circumcision advocates as entailing a similar conclusion, such that it "should logically result in an increase in infant circumcisions in the United States."[11] If this does occur, the consequence would be that an indeterminate number of boys will have undergone a medically unnecessary genital surgery, the risks of which have not been adequately studied.

For example, with respect to surgical complications, the AAP Task Force states that, due to disagreements about diagnostic criteria and other limitations with the available data, the "true incidence" of surgical complications is currently unknown.[12] Other risks, including psychosexual risks,[13] risks to the developing nervous system, and long-term risks to neuroendocrine and immune system stress responses[14] are even less well studied. Finally, some risks, including feelings of loss or resentment, dissatisfaction with one's penile appearance, body-image problems, *et cetera*, are largely subjective in nature. This inherent subjectivity renders these risks difficult if not impossible to measure using standard scientific modalities.[15] Predicting such outcomes across a range of individual difference variables poses an even greater empirical challenge.[16]

The Importance of Subjective Factors

Whether boys and men regard themselves as having been harmed versus benefited by nontherapeutic circumcision depends on numerous factors. Among them are differences in attitudes concerning, for example, what constitutes a personally relevant benefit or risk when it comes to a medically elective surgery.[17] Recognizing such variability, a member of the AAP Task Force later acknowledged certain difficulties with the methodology employed by the task force in carrying out its risk-benefit assessment. Specifically, there was a "lack of a universally accepted metric to accurately measure or balance the risks and benefits [as well as] insufficient information about the actual incidence and burden of non-acute complications."[18]

Why is there no "universally accepted metric" for balancing risks and benefits? One reason is that any such metric is likely to be influenced, whether consciously or unconsciously, by the beliefs, values, and personal preferences of those applying it to the evidence.[19] As Akim McMath notes, "People disagree over what constitutes a harm and what constitutes a benefit" when it comes to circumcision.[20] For example, "some people believe circumcision benefits the child by bringing him closer to God, while others disagree" (see box 1).[21]

Such divergent prior beliefs, in turn, may influence how one interprets the relevant medical evidence. Consider a person who is committed to circumcising infants on religious grounds. Perhaps believing, on first principles, that God would not endorse a practice that was physically harmful, it is possible that such a person would be less inclined to regard the risks that have been attributed to circumcision as being empirically well supported. This inclination, in turn, could lead a person to give relatively more credence to evidence that appears to suggest a benefit-to-risk ratio in favor of circumcision, at least partially independently of the actual strength of the evidence.[22]

Now consider someone who regards nontherapeutic genital surgery performed on children as immoral, perhaps believing that such surgery violates a child's right to bodily integrity. Compared to a religious supporter of circumcision, this person might evaluate the same evidence rather differently. Since a finding of net medical or other harm would be *prima facie* more congenial to their moral stance, this person might give relatively more credence to evidence that appears to suggest a benefit-to-risk ratio weighing against circumcision, again at least partially independently of the actual strength of the evidence.

Even when there is widespread agreement about what constitutes a harm or benefit, the *weight* to be assigned to the outcome may still differ from person to person. Relevant factors in assigning such weight include one's tolerance for certain types of risk compared to others (for example, risks of omis-

sion versus commission, risks affecting some parts of the body versus others); the availability of alternative risk-reduction or benefit-promoting strategies and how one ranks these compared to the surgical option; and one's preferences and values regarding bodily aesthetics, sexual behavior, and the importance of conforming or not conforming to prevailing sociocultural norms.

To illustrate, some men might be less comfortable taking on the risks of circumcision, an act of commission (for example, glans amputation or loss of sexual function), than they are taking on the risks of failing to undergo circumcision, an act of omission (for example, acquiring a treatable infection or developing a rare form of cancer in old age). For many people, the risks associated with acts of commission, versus acts of omission, loom larger in the mind, creating a greater psychological burden and potential for regret. This asymmetry may obtain even when the absolute likelihood of an "omitted" risk is greater than that of a "committed" risk. Without knowing which type of risk a person is more comfortable taking on, however, it is not possible to determine which one "outweighs" the other.

For another example, consider that some men assign a positive value to the foreskin itself, to sexual

BOX 1. Disagreement about Benefits and Risks: What Are the Ethical Implications?

Faced with the problem of disagreement over what constitutes a benefit or risk when it comes to circumcision, it is often concluded that "the parents should decide." However, this does not necessarily follow. As McMath notes, "the child will have an interest in living according to his own values, which may not reflect those of his parents . . . . Only the child himself, when he is older, can be certain of his values." Thus, "if disagreement over values constitutes a reason to let the parents decide, it constitutes an even stronger reason to postpone the decision until the child himself can decide."[1]

Against this view, it is sometimes argued that infant circumcision is less risky than adult circumcision, such that the two are not equivalent choices. It is true that the two choices are not identical. However, at least two issues need to be clarified before the ethical implications of this fact can be assessed. First, the claim of "less risk" is not uncontroversial. It is based largely upon retrospective comparisons of nonconcurrent studies with results drawn from dissimilar populations, using dissimilar methods and criteria for identifying complications. Therefore, such comparisons do not adequately control for the skill of the practitioner, the specific technique employed, the setting of the surgery, the methods of data collection, and so on.[2]

Second, even if one were to grant an increase in the *relative* risk of complications in adulthood versus infancy, it is the difference in *absolute* risk that is more ethically relevant. Even strong proponents of infant circumcision contend that the absolute likelihood of clinically important, difficult-to-resolve surgical complications associated with circumcision is "low," regardless of the age at which the procedure is performed.[3] Given such a low baseline risk, according to the proponents, the existence of a relative risk reduction in the incidence of adverse events in infancy compared to adulthood is unlikely to be morally decisive. Instead, as the U.S. Centers for Disease Control and Prevention (CDC) states, "Delaying male circumcision until adolescence or adulthood obviates concerns about violation of autonomy" such that any medical disadvantages associated with such a delay "would be ethically compensated to some extent by the respect for the [bodily] integrity and autonomy of the individual."[4]

NOTES

Materials in this box are adapted from B.D. Earp, "Male Circumcision: Who Should Decide?" *Pediatrics* 37, no. 5 (2016): e-letter; B.D. Earp, "Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines," *Frontiers in Pediatrics* 3, no. 18 (2015): 1-6.; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

1. A. McMath, "Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions," *Journal of Medical Ethics* 41, no. 8 (2015): 687-90, 689.

2. H.A. Weiss et al., "Complications of Circumcision in Male Neonates, Infants and Children: A Systematic Review," *BMC Urology* 10, no. 2 (2010): 1-13; J.S. Svoboda and R.S. Van Howe, "Circumcision: A Bioethical Challenge," *Journal of Medical Ethics* 40, no. 7 (2013): e-letter.

3. B.J. Morris and E.C. Green, "Circumcision, Male," *Blackwell Encyclopedia of Health, Illness, Behavior, and Society* (Hoboken, N.J.: Wiley-Blackwell, 2014).

4. U.S. Centers for Disease Control and Prevention, "Background, Methods, and Synthesis of Scientific Information Used to Inform the Draft Recommendations for Providers Counseling Male Patients and Parents Regarding Elective Male Circumcision and the Prevention of HIV Infection and Other Adverse Health Outcomes," *U.S. Centers for Disease Control* (2014): 1-61, 39-40.

activities that require manipulation of the foreskin, or to the embodied state of genital intactness (that is, having a surgically unmodified penis).[23] Compared to men who assign a neutral or negative value to the foreskin, perhaps due to differing beliefs or cultural norms, the former are at a far greater risk of losing a good to circumcision: nearly 100 percent for the above-mentioned factors.[24] The magnitude or importance of that risk, in turn, depends on how much value a man places on such factors, which is not something that can be known before he is mentally mature.

Consider, for instance, a recent study of 196 sexually active Canadian adults that found that men who have sex with men (MSM), compared to heterosexual females, "indicated a strong preference toward intact penises for all sexual activities assessed and held more positive beliefs about intact penises."[25] This finding suggests that parents who authorize an elective circumcision for their infant son may risk differentially affecting his future sexual enjoyment depending upon his sexual orientation—something that will not be apparent until years later (see box 2 for further discussion).

To summarize, assessments of the comparative worth or weight of particular benefits and risks come down in large part to what one values or prefers. In asserting that the benefits of circumcision outweigh the risks, therefore, the AAP Task Force appears to have substituted its own subjective preferences and

BOX 2. Dealing with Uncertainty About Infants' Future (Bodily) Preferences

Not knowing a child's future preferences poses a challenge to parental and clinical decision making with respect to a wide range of potential pediatric interventions. When it comes to surgeries that permanently alter the body (for example, by removing nonregenerating tissue), it is sometimes pointed out that, whatever choice they make, parents will foreclose at least one future option for their child. Specifically: "parents who decide in favor of early surgery close off the child's future ability to make his own decision regarding surgery . . . while parents who refrain from early surgery close off the option for the [child] to undergo the surgery *during infancy or early childhood.*"[1]

Are these cases symmetrical? Circumcision provides a good illustration. If a noncircumcised adult is considering circumcision, for whatever reason, he can perform his own risk-benefit analysis of the surgery, taking into account his known preferences and the fullness of his social, sexual, and other circumstances. If he then chooses circumcision, he will be secure in the knowledge that he has done so voluntarily, undertaking a certain amount of risk to achieve a desired outcome. In other words, the adult with unmodified genitals—who now prefers that they be altered—has an option available with which to satisfy the preference, even if it is not ideal from his current perspective. By contrast, the man whose early circumcision was not desired, and is now a cause of significant distress, has no comparable remedy. He may attempt artificial foreskin "restoration"—if he has enough remaining penile skin to do so—but this may take years to accomplish, and the result will be a mere approximation of a prepuce, lacking the original tissue and nerve endings. Thus, it appears that the two cases are not symmetrical. In the deferred surgery case, there is far greater leeway for the individual to rectify an undesired situation.

Now, it could be argued that the noncircumcised man who wishes he were circumcised cannot truly satisfy his preference either. He may wish, for example, that the surgery had already taken place, perhaps in infancy, so that he would not now have to face the inconvenience. In this respect, he is not unlike the adult female in a similar social context who decides to undergo elective labial surgery for what she considers to be cosmetic reasons. Perhaps it would have been better—from her current perspective—to have undergone the procedure shortly after birth, so that she likewise would not have to face it now. But very few people in Western medicine would take this possibility as an argument in favor of neonatal labiaplasty. Indeed, such statements as "she won't even remember it," "she'll heal faster," "her future sexual partners will find her genitals to be more appealing," and "it's relatively less risky at this age" (see box 1)—all of which are commonly invoked in defense of infant male circumcision—would be considered problematic. The expectation thus appears to be that girls should be able to make such personal decisions for themselves when they are older and can understand what is at stake.

NOTES

Materials in this box are adapted from text in the essay "Circumcision, Sexual Experience, and Harm," which should be consulted for primary source citations; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

1. A. Carmack, L. Notini, and B.D. Earp, "Should Surgery for Hypospadias Be Performed before an Age of Consent?" *Journal of Sex Research* 53, no. 8 (2016): 1047-58, 1057.

values for the unknown, individually and culturally variable preferences and values of future boys and men. It is for this reason that careful consideration of the influences that may have played into those subjective factors is needed.

The Charge of Cultural Bias

Noting that the conclusions of the AAP Task Force were "far from those reached by physicians in most other Western countries,"[26] the authors of the international critique raised the prospect of cultural bias[27] as a possible explanation: "Seen from the outside, cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious."[28] They went on to state that in "Europe, Canada, and Australia, where infant male circumcision is considerably less common than in the United States, the AAP report is unlikely to influence circumcision practices," because again, "the conclusions of the report and policy statement seem to be strongly culturally biased."[29]

Recent events appear to support this prediction. For example, the 2015 policy on newborn circumcision from the Canadian Pediatric Society, which has historically endorsed the position of the AAP, instead rejected it, failing to conclude that the benefits of infant circumcision outweigh the risks.[30] Similarly, upon revisiting its 2010 policy in light of the AAP findings, the Royal Australasian College of Physicians reaffirmed its view that "the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand."[31]

In addition, the president of Germany's pediatric society, the Berufsverband der Kinder- und Jugendärzte, stated in a government hearing that "there is no reason from a medical point of view to remove an intact foreskin from underage boys or boys unable to give consent," adding that "the statement from the AAP [has] been graded by almost all other pediatric societies and associations worldwide as being scientifically untenable."[32] And in 2016 the Danish Medical Association released a statement characterizing nontherapeutic male circumcision as being sufficiently risky that it should "only be performed on children when there is a documented medical need."[33]

Nevertheless, the AAP Task Force contested the charge of cultural bias in a response piece. The critical passage from their reply is as follows: "All of [our critics] hail from Europe, where the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis. In contrast, approximately half of US males are circumcised, and half are not. Although that heterogeneity may lead to a more tolerant view toward circumcision in the United States than in Europe, the cultural 'bias' in the United States is much more likely to be a neutral one than that found in Europe, where there is a clear bias against circumcision."[34]

Noting that the conclusions of the AAP Task Force were "far from those reached by physicians in most other Western countries," the authors of the international critique raised the prospect of cultural bias as a possible explanation.

Our aim for the rest of this article is to assess this response by the AAP Task Force. Was the task force successful in dispelling the charge, levied by its international critics, that its evaluation of the medical literature may have been unduly influenced by cultural or other extrascientific factors? We consider the key claims of the AAP Task Force in turn.

DISCUSSION

The first claim of the AAP Task Force concerns differing cultural norms surrounding circumcision between the U.S. and Europe. In this context, we begin by correcting the assertion that all of the authors of the international commentary "hailed from Europe." In fact, one of the signatories was the Canadian pediatrician Noni MacDonald, a member of the Canadian Academy of Health Sciences, founding editor of *Pediatrics & Child Health*, and the first woman to become a dean of medicine in Canada.[35] However, the other signatories were indeed from Europe, where, according to the AAP Task Force

members, "the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis."[36] This claim inspires two observations that require further discussion.

Norms, Values, and Terminology

First, the AAP Task Force uses the term "uncircumcised" to describe whole or intact male genitalia. All normally developing boys are born with a foreskin, and most boys and men around the world do not have a surgically modified penis.[37] Despite this fact, the term "uncircumcised" frames circumcision as the default status, and recasts the natural penis as the linguistically marked category.[38] For a point of comparison, the AAP does not refer to infant girls' vulvae as "unlabiaplastied."[39] In other words, the choice of terminology employed by the AAP Task Force appears to reflect the prevailing cultural assumption(s) under which it was operating: namely, that the normative status for males is to be circumcised, rather than genitally intact.

The second observation has to do with the AAP Task Force's reference to a "cultural norm" in Europe, which "clearly favors" the intact penis. Given the comparative rarity of nontherapeutic circumcision outside of minority religious groups in European countries,[40] it is certainly possible that a norm exists that favors surgically unmodified male genitalia. However, a similar "norm" exists throughout Europe that favors surgically unmodified female genitalia, as well as surgically unmodified body parts generally. In other words, it is unclear whether the lack of a tendency to excise nondiseased tissue, whether from the body of a child or an adult, is the sort of thing that should be described as a "norm," unless all nonperformed actions are eligible to be called "norms" if their nonperformance is typical in some group.

But let us simply grant that there is a "cultural norm" in Europe that "clearly favors" the intact penis. It does not follow from this, as the AAP Task Force implies, that its European counterparts are "biased" against circumcised penises. This is because, whatever the wider cultural norm concerning circumcision happens to be in Europe, there is also a relevant *medical* norm, not only in Europe, but also in the U.S., which holds that (1) medically unnecessary surgeries should generally not be performed on healthy children, and (2) surgery should almost always be a last resort, rather than a first resort, for managing or preventing disease.[41]

Thus, it is not just a matter of two local, arbitrary cultural norms being pitted against one another. Rather, the *shared* norms governing responsible medical practice in Western countries are typically "biased" against such nontherapeutic procedures. Accordingly, by suggesting that a cultural norm that favors the nontherapeutic surgical modification of a child's penis "is somehow on par with, or just as reasonable as, a medical-ethical norm favoring the avoidance of such surgery unless it is absolutely required," the AAP Task Force could be seen as revealing its cultural hand.[42]

Indeed, only the U.S. and Israel, among Western developed nations, maintain a majority practice of routine neonatal male circumcision.[43] In the latter case, the explanation for the practice is predominately religious, being derived from a perceived scriptural mandate along with a historically rooted sense of shared Jewish identity, of which male circumcision in infancy is a symbol.[44] The historical process by which ritual circumcision became "medicalized" in the U.S.—and later entrenched as a wider cultural practice—has been documented elsewhere.[45] The point here is that the unique position of the U.S. medical establishment in favoring the nonreligious circumcision of male newborns suggests that it is the AAP Task Force, rather than its critics, that bears the greater burden in justifying its background cultural norms.

This view is further supported by research on "cultural cognition." As Yale psychologist Dan Kahan explains, a major tenet of cultural theory is that "individuals gravitate toward perceptions of risk that advance the way of life to which they are committed."[46] According to this view, moral concern guides not only response to risk, but also the basic faculty of risk perception.[47] Thus, each way of life and associated worldview "has its own typical risk portfolio," that "shuts out perception of some dangers and highlights others" in ways that selectively sustain the norms and practices to which one is most deeply devoted.[48]

With respect to the debate over cultural bias between the members of the AAP Task Force and their international critics, it is difficult to see how "not circumcising" would meet the criteria for being a distinctive component of a "worldview" or a "way of life" that might directly influence the risk perception of the mostly European group of doctors. In other words, while circumcising infant boys is (1) an entrenched birth custom in American culture that is deeply tied up with implicit and explicit notions of "good parenting,"[49] and (2) a central ritual practice within Judaism and Islam, it is less clear in what sense "not circumcising" is (or could be) either an entrenched birth custom or a central ritual practice in "European" culture. In fact, it is by defi-

nition not a practice, but the lack of one. Moreover, this lack of practice is not closely associated with "European" cultural identity in any specific, coherent sense: rather, it is simply one of a large number of rituals and other practices that is not particularly common in Europe.

A Child's Right to Physical Integrity

To see how anomalous the U.S. medical community's support for newborn male circumcision is, it may be useful to consider the nearest anatomical analog, namely, the nontherapeutic surgical modification of female genitalia (for example, for cultural or religious reasons).[50] Not only is such surgery normatively discouraged before an age of consent in Western medicine, but it is strictly forbidden by national and international law, primarily on the grounds that it violates a child's right to physical integrity.[51] According to the World Health Organization (WHO), this right is violated (see box 3) by all medically unnecessary alteration of the female genitalia, no matter how superficial or hygienically performed.[52] As a consequence, Western prohibitions of such genital alteration extend even to those forms that are significantly less invasive than male circumcision. This includes ritual "pricking" of the clitoral hood—FGM WHO Type 4—that does not remove tissue, rarely leads to long-term adverse health consequences, and is often carried out by trained healthcare providers in sterile settings.[53]

To explain this apparent discrepancy in treatment regarding male versus female children, the AAP Task Force argues that "the right to physical integrity is easier to defend in the context of a procedure that offers no potential benefit."[54] This is presumed to be the case for nontherapeutic female genital cutting (FGC). However, this response deserves closer scrutiny.

First, the "potential benefit" to which the AAP Task Force refers in this sentence is "medical benefit" or "health benefit." However, in the case of male circumcision, the AAP Task Force shows a willingness to consider potential nonmedical—that is, sociocultural—benefits as well, stating that "it is reasonable to take these nonmedical benefits . . . into consideration when making a decision about circumcision."[55] As the British Medical Association (BMA) notes, "Where a child is living in a culture in which circumcision is [believed to be] required for all males, [exclusion] may cause harm by, for example, complicating the individual's search for identity and sense of belonging."[56] However, the BMA also notes that "very similar arguments are also used to try and justify very harmful cultural procedures, such as female genital mutilation or ritual scarification. Furthermore, the harm of denying a person the opportunity to choose not to be circumcised must also be taken into account, together with the damage that can be done to the individual's relationship with his parents and the medical profession if he feels harmed by the procedure."[57]

Second, it may never be known whether a minor, sterilized form of FGC—such as neonatal labiaplasty—would offer a "potential benefit" in the sense implied by the AAP Task Force, because it would be illegal to conduct a properly controlled

BOX 3. A Child's Right to Physical Integrity: How Should it Be Applied?

A child's right to physical integrity is not absolute. Interventions that are clearly in the child's best interests, especially if they cannot be delayed until the child is competent to consent or decline (for example, emergency surgery to correct a heart defect) are universally agreed to be permissible. Trivial, superficial, or easily reversible interventions (for example, getting a haircut), or more serious, risky, or permanent interventions to which the child can give age-appropriate consent (for example, cosmetic orthodontia, participating in sports), are also usually permissible. However, the mere fact that children are pre-autonomous and cannot validly consent to most interventions, "medical" or otherwise, that affect their bodies (for example, being forced to eat their vegetables) does not entail that parents have an unfettered right to authorize all such interventions (for example, child sexual abuse). The less clear it is that a bodily encroachment is, all things considered, in the child's best interests (taking into account the child's interest in being able to autonomously make important self-affecting decisions in the future), the more likely it is that the child's bodily integrity rights are being impermissibly violated.

NOTES

Some material in this box is adapted from B.D. Earp, "The AAP Report on Circumcision: Bad Science + Bad Ethics = Bad Medicine," *Practical Ethics*, 29 August 2012, *http://blog.practicalethics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/.*

scientific study to secure the answer.[58] But one cannot rule the possibility of health benefits out.[59] Cancers of the labia, for instance, might be less likely to occur in someone whose labia have been surgically reduced, due to the decreased surface area of the relevant tissue.[60] Indeed, removing *any* healthy tissue from a child's body would likely reduce the risk of some disease that might otherwise affect that tissue, or other parts of the body through it.[61]

And yet, the mere prospect of some health benefit following from the removal of healthy tissue is not normally seen as sufficient grounds for overriding a child's right to physical integrity.[62] This principle holds true especially when there are alternative ways to achieve the same health benefit that do not involve surgery and its attendant risks—a consideration that applies to all of the health benefits that have been attributed to male circumcision.[63] Adding to this is the "private" nature of the body part in question, about which people have strong and often conflicting emotions (compare with, for example, the tonsils, which are in any case no longer routinely removed).[64] Given such strong emotions, the permanency of circumcision, and the special significance of the penis as compared to other parts of the body, it seems preferable to defer the surgery, all else being equal, until the person whose body will be affected by it is in a position to decide what is best for him.[65]

It is sometimes argued that infant male circumcision meets the "trivial" condition mentioned in box 3, and thus fails to rise to the level of a rights violation. Often, this argument is made by analogy with piercing the ear lobes of female infants: if the latter is permissible, why not the former?[66] There are two ways to respond to this argument. The first way is to suggest that perhaps ear piercing, too, should not be performed before the affected child can weigh in. If she understands that it will be painful, that there are certain risks involved, *et cetera*, and yet this is still something she would like to undertake, then it should be allowed.

The second way is to point out that the two practices—piercing infants' ears and infant male circumcision—are not commensurate. Ear piercing removes no tissue, it (minimally) alters a part of the body that is less sensitive both physically and symbolically, it creates a wound that is much smaller, and it is often reversible: the hole may close up over time if the child later decides that he or she would like to have earlobes free of holes. By contrast, infant male circumcision removes up to half of the motile skin system of the penis[67] (approximately 30 to 50 square centimeters of erogenous tissue in the average adult organ),[68] excises the portion of the penis that is most sensitive to light touch,[69] precludes all sexual activities that require manipulation of the foreskin,[70] and is irreversible: anyone who resents having had his foreskin removed cannot recover what was lost.

Nonmedical Motivations

Most of our discussion thus far has focused on the prospect of health benefits. But this is not the original reason for the practice of male circumcision, nor is it the main reason for its continuance today. As AAP Task Force member Andrew Freedman, MD, stated in a recent editorial: "Most circumcisions are done due to religious and cultural tradition. In the West, although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of nonmedical reasons. There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision. Few parents when really questioned are doing it solely to lower the risk of urinary tract infections or ulcerative sexually transmitted infections."[71]

In support of this observation, Freedman stated in a separate interview that he had circumcised his own son. "But I did it for religious, not medical reasons," he stated. "I did it because I had 3,000 years of ancestors looking over my shoulder."[72]

What relevance might this statement have for the debate over cultural bias? As Dan Kahan explains, when one's identity or standing in an affinity group depends at least partially on one's stance toward certain empirical matters, this can "generate motivated cognition relating to policy-relevant facts."[73] Such cognition does not require conscious awareness: "Even among modestly partisan individuals, shared ideological or cultural commitments are likely to be intertwined with membership in [certain] communities. . . . If a proposition about some policy-relevant fact comes to be commonly associated with membership in such a group, the prospect that one might form a contrary position can threaten one's standing within it. Thus . . . individuals are unconsciously motivated to resist empirical assertions [if] those assertions run contrary to the dominant belief within their groups."[74]

Consistent with this view, as Jonathan Koehler has described, fabricated research reports that appear to agree with scientists' prior beliefs are judged to be of higher quality than those that disagree, despite controlling for actual quality.[75] One possible explanation for more favorable appraisals in the "agree" condition is that scientists may "differen-

tially scrutinize" studies that yield belief-congruent versus belief-incongruent findings. Thus, Koehler argues, "Studies that are known to have yielded belief-congruent data may be examined less carefully for having obtained the 'correct' result, and may be presumed to have been conducted properly. On the other hand, when scientists evaluate studies that are not known to have produced 'correct' results . . . their suspicion that something may be wrong with the study is heightened."[76]

In line with this possibility, it is reasonable to think that a prior religious belief in the desirability of circumcision could—at least in principle—unconsciously influence one's perception of a study's relevance, methodological rigor, and clarity of results (as in the Koehler experiments) in such a way that the perceived quality of circumcision-supportive findings, compared to nonsupportive findings, would be inappropriately inflated.[77]

Another potential source of bias stems from the findings of a 2010 survey of 572 Canadian physicians by Andries Muller. "Although most respondents stated that they based their decisions on medical evidence," Muller discovered, "the circumcision status of, especially, the male respondents played a huge role in whether they were in support of circumcisions or not. Another factor that had an influence was the circumcision status of the respondents' sons."[78] Specifically, 68.3 percent of the circumcised males were in support of newborn male circumcision, whereas 68.8 percent of the noncircumcised males were opposed to it. In addition, 77.2 percent of those respondents whose sons were circumcised were in support of circumcision, whereas 64.7 percent of those whose sons were not circumcised were opposed to it.

Motivated Reasoning

How might these findings be explained? One possibility is that a doctor who was himself circumcised before he could consent or decline, or who has had his son circumcised under the same conditions, might be more likely than a doctor to whom these considerations do not apply to engage in a form of "motivated reasoning."[79] Specifically, he may be motivated, whether consciously or unconsciously, to evaluate the murky and heavily contested medical evidence concerning circumcision in such a way that his decision regarding his son—or his own circumcision status—can be independently justified on grounds of net benefit.[80]

This explanation is consistent with the well-supported theory of cognitive dissonance from the field of psychology.[81] If the medical evidence suggests that newborn circumcision is a net harm, or at least not a significant benefit, then a man who has already been circumcised—or who has had his son circumcised—will be confronted with a distressing thought: either that his parents did something to him that they probably ought not to have done (all else being equal), or that he has done something to his own son that he probably ought not to have done (all else being equal), or both.[82]

The key here is that being circumcised (lacking a foreskin), as opposed to not being circumcised (possessing a foreskin), is irreversible. In other words, if something is a net harm, but cannot be undone, cognitive dissonance theory suggests that the mind will do whatever it can to reframe what has taken place as a benefit. By contrast, if something can be undone—such as the state of not being circumcised—then there is much less likely to be cognitive dissonance in the first place in need of resolution, including in the possible form of a motivated interpretation of the empirical literature. Since it is likely that the circumcision status of the American versus European doctors (or that of their sons) is asymmetrical in this regard, this theoretical difference in cognitive dissonance may be of relevance to this debate.[83]

The 50-50 Defense

We turn now to a further claim made by the AAP Task Force, namely that "approximately half of US males are circumcised, and half are not" such that any "'bias' regarding circumcision in the United States is much more likely to be a neutral one."[84] How compelling is this response to the charge of cultural bias?

First, it is unclear on what grounds the AAP Task Force members base their assertion that approximately half of U.S. males are circumcised. According to the AAP's own technical report, from 1999 to 2010, the approximate percentage of newborn U.S. males who were circumcised ranged from 55.8 percent to 59.1 percent depending on the source. But these incidence rates "were derived from hospital-based surveys and do not include out-of-hospital circumcisions; thus, these data sources underestimate the actual rate of newborn male circumcision in the first month of life."[85] Such undercounting suggests that the current incidence of circumcision is more likely to be 60 percent or higher. However, that is not the most relevant statistic. More relevant would be the prevalence of circumcision, which factors in older men who were born in earlier decades when circumcision was more common, and whose attitudes would also need to be considered. The fig-

ure for prevalence has most recently been estimated to be more than 80 percent.[86]

But let us just assume, contrary to this evidence, that approximately 50 percent of U.S. males are circumcised, either in terms of the current rate or the current prevalence. It is a *non sequitur* to assert that *attitudes* toward circumcision in the U.S. are 50 percent favorable, equally tolerant of circumcised and noncircumcised penises, or otherwise "neutral" as the AAP Task Force implies. Cultural attitudes take time to change, and the implication of a recent drop in the rate or prevalence of circumcision for prevailing attitudes is unclear.

The more relevant question is narrower in scope. In judging whether the conclusions of the AAP Task Force were biased or unbiased with respect to the medical evidence concerning the circumcision of newborn males, it is not especially informative to allude to the percentage of circumcised men in the population at large. Instead, it seems important to determine the attitudes of the members of the AAP Task Force themselves—that is, the ones who reviewed the literature.

Evidence of such attitudes may be found in the 2016 editorial by Andrew Freedman. Referring explicitly to nonscientific political considerations, Freedman stated that "protecting" the parental option to circumcise "was not an idle concern" in the minds of the AAP Task Force members "at a time when there are serious efforts in both the United States and Europe to ban the procedure outright."[87] The reference appears to be to a failed 2011 ballot initiative in San Francisco that sought to criminalize nontherapeutic circumcision before the age of 18, and to a 2012 Cologne court judgment—later overturned by the German legislature—finding that circumcision of male minors without a medical indication constitutes bodily assault.[88]

In this context, one may wonder whether protecting the parental option to circumcise should in fact have been an idle concern. As we understand it, the remit of the AAP Task Force was to evaluate, as dispassionately as possible, the empirical evidence concerning the benefits and risks associated with newborn circumcision. Whether parents do or should have a right to authorize circumcision is an important and difficult question, and it is one that moral philosophers, bioethicists, legal theorists, and others are attempting to answer. But it seems fair to suggest that it is not a question that should inform, much less consciously and deliberately inform, a scientific report on the medical consequences of newborn male circumcision.

Whether parents do or should have a right to authorize circumcision is an important and difficult question, and it is one that moral philosophers, bioethicists, legal theorists, and others are attempting to answer.

Liberal societies depend on scientific personnel to provide unbiased, apolitical analyses of "the facts" pertaining to their public deliberations. This goal is difficult to achieve in practice, as scientists are not immune from personal, cultural, and other biasing factors even in the best of circumstances, as we have noted.[89] But it is widely held that scientific analysts should do their best to neutralize such factors, using the most effective means available. Seemingly, a scientific committee that sees itself as engaged, however tangentially, in "protecting" a contested cultural or religious rite (an aim with respect to which a finding of net medical benefit would presumably be auspicious) has not done its best in this regard.

A Note on Ethics—and Equipoise

We are not certain that it is appropriate for the AAP or any similar medical organization to opine on the ethics of circumcising male newborns:[90] if the question is about benefits and risks, these should be documented clearly and thoroughly, based solely upon the empirical data. Moreover, if weights or values are to be assigned, these should be assigned by the person contemplating the surgery in light of his own preferences and values, as we have argued; a policy committee is not best qualified to make such judgments for others.

If, however, an ethical discussion is to be included in a scientific report, it is desirable that more than one perspective be represented. In the context

of a debate that is as polarized as the one on circumcision of infant males,[91] it is notable that the single bioethicist appointed to the AAP Task Force, Douglas Diekema, MD, had already made his views on the subject clear, previously arguing in favor of the permissibility not only of male forms of circumcision, but also certain female forms of ritualized genital cutting, despite near-universal condemnation of the latter.[92]

This sole appointment is notable because the view that neither male nor female children deserve absolute protection from having their genitals cut for nontherapeutic reasons is an outlier position among policy experts. Moreover, the "harm principle" promoted by Diekema, which explicitly favors expansive parental rights over the advancement of children's best interests, is similarly contentious.[93] It is reasonable to think that a committee with as much influence as the AAP Task Force would strive to include a diversity of voices in its ethical discussions.

There are legitimate arguments to be made that newborn male circumcision should be considered morally and/or legally acceptable.[94] One could even argue that religious circumcision in particular should be tolerated *even if* it is a net (medical) harm, since there are numerous factors at play in such determinations apart from risk-benefit assessments. However, the moral and legal status of nontherapeutic procedures to alter genitals has become increasingly controversial in the past few decades, with a growing contingent of scholars maintaining that all such procedures performed on children (male, female, and intersex) should be discouraged, if not forbidden.[95]

Therefore, to achieve a properly balanced consideration of the opposing viewpoints, future committees in this area should consider appointing at least two ethicists who represent the range of current thinking on the issue. The dialectic between them, it is hoped, would yield a more nuanced and comprehensive ethical discussion than was evidenced in the 2012 AAP documents. As J. Steven Svoboda and Robert Van Howe have stated, these documents

> fail to mention foundational principles from biomedical ethics. Seemingly, such notions as respect for autonomy, a child's right to an open future, and the normally high bar set for surgical interventions on minors would be at least worth *alluding to* in a serious discussion of the moral permissibility of male circumcision. Yet the AAP's repeated, unsupported, alternative suggestion that, "In most situations, parents are granted wide latitude in terms of the decisions they make on behalf of their children" constitutes its entire ethical argument.[96]

Svoboda and Van Howe overstate their case, because the AAP Task Force does mention that parents and physicians have an "ethical duty to the child to attempt to secure the child's best interests and well-being."[97] However, the immediate next move of the AAP Task Force is to emphasize that reasonable people disagree as to what is in a child's best interests (see box 1), leading them to the "alternative suggestion" mentioned by Svoboda and Van Howe. In other words, given that people have different judgements about what best promotes a child's well-being, the AAP Task Force suggests that parents should normally be allowed to take or authorize any action whatsoever toward their child, unless it is "clearly contrary to the best interests of the child or places the child's health, well-being, or life at significant risk of serious harm."[98]

A problem with this view is that, just as reasonable people may disagree about what is in a child's best interests, reasonable people may also disagree about what is clearly *contrary* to a child's best interests, and about what places the child's health, *et cetera*, at "significant risk of serious harm." Removing part of a child's genitals in the absence of a clear medical need is the very sort of thing that many reasonable people do regard as a serious harm, regardless of whether there may also be certain modest health benefits that follow from such removal.[99] So what does this analysis suggest about the limits, if any, there should be on parental behavior? If reasonable people may disagree not only about "best interests," but also about "serious harm," then a practical implication of the AAP's proposal seems to be that parental decision making should remain essentially unfettered.

It is commonly accepted that, "in most situations," parents are (and should be) permitted to make decisions on behalf of their children (see box 3). But in the context of Western medicine, at least, one could also argue that nontherapeutic genital surgery is not "most situations." In other words, while it may be accurate to say that parents generally have "wide latitude" in bringing up their children as they see fit, it is also true that societies may justifiably place certain restrictions on parental actions, particularly when it comes to irreversible body modifications that a child may later regard as a harm.

To illustrate: in some jurisdictions, tattooing a child's body is not permitted, even when the parents believe that being tattooed is in a child's best

interests. With respect to the United Kingdom, for instance, as James Chegwidden notes, "the common law is very cautious before treating [even] children's consent as justifying any non-therapeutic body alteration."[100] Indeed, in British parliamentary debates regarding a proposed ban on tattooing prior to age 18, concerns were raised that "apply almost *identically* to the arguments voiced about circumcision, namely: the existence of persons who later regret having the procedure done; the difficulty of reversing the procedure; the danger of infections and other complications arising from the tattooing procedure; [. . .] the embarrassment felt by those tattooed who later regret it; the unhygienic conditions in which some tattooing is performed [and so on]."[101]

Failure to consistently apply this reasoning may lead to peculiar results. For instance, while parents would not be allowed to tattoo their son's foreskin for nontherapeutic reasons in such jurisdictions, they *would* be allowed to have his foreskin completely removed for nontherapeutic reasons, and then tattooed. This example provides further evidence that newborn male circumcision occupies an anomalous position in Western (medical) culture.

Perhaps even more relevant than tattooing, however, as we have already noted, is the practice of nontherapeutic FGC. In Western societies, including the U.S., parents may not cut into, much less excise, any part of a female child's genitalia when it is deemed medically unnecessary to do so. Crucially, this is the case even when (1) the cutting is less extensive, risky, or harmful than male circumcision; (2) the parents sincerely believe it is required by their religion; and (3) it is likely to confer significant social benefit on the child, due to the prevailing beliefs, attitudes, and expectations of the community in which she is being raised.[102]

In order to determine whether any particular nontherapeutic alteration of a child's body is ethically and perhaps also legally acceptable, therefore, it is not enough to invoke a vague conception of "serious harm" (such that, for any action X, an interested party could plausibly argue that it is "not harmful enough" to warrant state interference), nor to refer to the "wide latitude" that is typically granted to parents. Instead, it is necessary to triangulate between analogous cases to determine where the limits should lie.

CONCLUSION

As Shaw has argued, a near-exclusive focus in the medical literature on potential biases stemming from financial conflicts of interest "has tended to obscure the fact that other biasing factors can seriously compromise an author's impartiality and objectivity."[103] In the present context, we have argued that one such potentially biasing factor is whether one has been circumcised oneself, or has circumcised his or her son.[104] Because circumcision is irreversible, there is likely to be a strong motive among such persons to reach the conclusion that it is desirable, on balance, to be circumcised. For if it is not desirable on balance, there are few, if any, options for "undoing" what has already been done.

Moreover, having a personal or political stake in the circumcision of male infants, whether on religious or other grounds, could play a biasing role.[105] While individual AAP Task Force members may feel free to lobby for legal or other protections for nontherapeutic circumcision as private citizens, they should not allow such political ends to enter into their evaluations of the science. Moreover, a concerted effort should be made to balance out whatever political, moral, or other normative viewpoints there are among committee members, by appointing not only proponents of circumcision, but also critics. More generally, whenever professional medical or ethical opinion is polarized, qualified representatives of both poles should be included in the relevant scientific and policy discussions.

NOTES

1. AAP, "Circumcision Policy Statement," *Pediatrics* 130, no. 3 (2012): 585-86; AAP, "Male Circumcision (Technical Report)," *Pediatrics* 130, no. 3 (2012): e756-85, e757.

2. E. Shapiro, "American Academy of Pediatrics Policy Statements on Circumcision and Urinary Tract Infection," *Reviews in Urology* 1, no. 3 (1999): 154-56; S.E. Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," *University of Cincinnati Law Review* 72 (2003): 455-526.

3. See, e.g., KNMG, "Nontherapeutic Circumcision of Male Minors," *Royal Dutch Medical Association-KNMG* (2010), *https://www.circumstitions.com/Docs/KNMG-policy.pdf*; RACP, "Circumcision of Infant Males," *Royal Australasian College of Physicians* (2010) (including a summary of position statements from other medical bodies in the appendix), *https://www.racp.edu.au/docs/default-source/advocacy_library/circumcision-of-infant-males.pdf*; see also more recently, Canadian Paediatric Society, "Newborn Male Circumcision," *Paediatrics & Child Health* 20, no. 6 (2015): 311-320; and see C. England, "Doctors in Denmark Want to Stop Circumcision for Under-18s," *Independent*, 7 December 2016.

4. Various critiques in addition to those listed in table 1 were also raised: see the references collected in B.D. Earp, "Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines," *Frontiers in Pediatrics* 3, no. 18 (2015): 1-6. Note that re-

sponses and counter-responses to some of these critiques are available at the relevant journal websites.

5. M. Frisch et al., "Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision," *Pediatrics* 131, no. 4 (2013): 796-800, 796.

6. AAP, "Male Circumcision (Technical Report)," see note 1 above.

7. Frisch et al., "Cultural Bias," see note 5 above, p. 776.

8. N. Bostrom and T. Ord, "The Reversal Test: Eliminating Status Quo Bias in Applied Ethics," *Ethics* 116, no. 4 (2006): 656-79.

9. RACP, "Circumcision of Infant Males," see note 3 above.

10. I. Sneppen and J. Thorup, "Foreskin Morbidity in Uncircumcised Males," *Pediatrics* 137, no. 5 (2016): e20154340; see also M. Frisch and B.D. Earp, "Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries: A Critical Assessment of Recent Evidence," *Global Public Health*, in press.

11. B.J. Morris, S.A. Bailis, and T.E. Wiswell, "Circumcision Rates in the United States: Rising or Falling? What Effect Might the New Affirmative Pediatric Policy Statement Have?" *Mayo Clinic Proceedings* 89, no. 5 (2014): 677-86, 678. But see I. Jenkins, "Bias and Male Circumcision," *Mayo Clinic Proceedings* 89, no. 5 (2014): 677-86.

12. AAP, "Male Circumcision (Technical Report)," e772, see note 1 above. "The true incidence of complications after newborn circumcision is unknown, in part due to differing definitions of 'complication' and differing standards for determining the timing of when a complication has occurred (i.e., early or late). Adding to the confusion is the comingling of 'early' complications, such as bleeding or infection, with 'late' complications such as adhesions and meatal stenosis. Also, complication rates after an in-hospital procedure with trained personnel may be far different from those of the developing world and/or by untrained ritual providers."

13. See, e.g., G.J. Boyle et al., "Male Circumcision: Pain, Trauma, and Psychosexual Sequelae," *Journal of Health Psychology* 7, no. 3 (2002): 329-43; T. Hammond and A. Carmack, "Long-Term Adverse Outcomes from Neonatal Circumcision Reported in a Survey of 1,008 Men: An Overview of Health and Human Rights Implications," *International Journal of Human Rights* 21, no. 2 (2017): 189-218.

14. F. Schwaller and M. Fitzgerald, "The Consequences of Pain in Early Life: Injury-Induced Plasticity in Developing Pain Pathways," *European Journal of Neuroscience* 39, no. 3 (2014): 344-52; AAP, "Prevention and Management of Procedural Pain in the Neonate: An Update," *Pediatrics* 137, no. 2 (2016): e20154271; G. Page, "Are There Long-Term Consequences of Pain in Newborn or Very Young Infants?" *Journal of Perinatal Education* 13, no. 3 (2004): 10-17; A.N. Schore, "All Our Sons: The Developmental Neurobiology and Neuroendocrinology," *Infant Mental Health Journal* 38, no. 1 (2017): 15-52; M. Frisch and J. Simonsen, "Ritual Circumcision and Risk of Autism Spectrum Disorder in 0- to 9-Year-Old Boys: National Cohort Study in Denmark," *Journal of the Royal Society of Medicine* 108, no. 7 (2015): 266-79; M. Frisch and J. Simonsen, "Circumcision-Autism Link Needs Thorough Evaluation: Response to Morris and Wiswell," *Journal of the Royal Society of Medicine* 108, no. 8 (2015): 297-98.

15. P.J. Ball, "A Survey of Subjective Foreskin Sensation in 600 Intact Men," in *Bodily Integrity and the Politics of Circumcision* (New York: Springer, 2006), 177-88; R. Darby and L. Cox, "Objections of a Sentimental Character: The Subjective Dimensions of Foreskin Loss," *Matatu-Journal for African Culture and Society* 37, no. 1 (2009): 145-68; S. Johnsdotter, "Discourses on Sexual Pleasure after Genital Modifications: The Fallacy of Genital Determinism (a Response to J. Steven Svoboda)," *Global Discourse* 3, no. 2 (2013): 256-65; J. Richters, "Bodies, Pleasure and Displeasure," *Culture, Health & Sexuality* 11, no. 3 (2009): 225-36; B.D. Earp, "Infant Circumcision and Adult Penile Sensitivity: Implications for Sexual Experience," *Trends in Urology & Men's Health* 7, no. 4 (2016): 17-21; B.D. Earp, "Sex and Circumcision," *American Journal of Bioethics* 15, no. 2 (2015): 43-45.

16. L. Brotto et al., "Psychological and Interpersonal Dimensions of Sexual Function and Dysfunction," *Journal of Sexual Medicine* 13, no. 4 (2016): 538-71.

17. A. McMath, "Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions," *Journal of Medical Ethics* 41, no. 8 (2015): 687-90; H. Maslen et al., "Brain Stimulation for Treatment and Enhancement in Children: An Ethical Analysis," *Frontiers in Human Neuroscience* 8, no. 953 (2014): 1-5.

18. A.L. Freedman, "The Circumcision Debate: Beyond Benefits and Risks," *Pediatrics* 137, no. 5 (2016): e20160594.

19. See discussion in R.S. Van Howe, "The American Academy of Pediatrics and Female Genital Cutting: When National Organizations Are Guided by Personal Agendas," *Ethics & Medicine* 27, no. 3 (2011): 165-74.

20. McMath, "Infant Male Circumcision and the Autonomy of the Child," see note 17 above, p. 689.

21. Ibid.

22. See generally, D.M. Kahan, "Ideology, Motivated Reasoning, and Cognitive Reflection: An Experimental Study," *Judgment and Decision Making* 8, no. 4 (2013): 407-21; J.J. Koehler, "The Influence of Prior Beliefs on Scientific Judgments of Evidence Quality," *Organizational Behavior and Human Decision Processes* 56, no. 1 (1993): 28-55.

23. Hammond and Carmack, "Long-Term Adverse Outcomes," see note 13 above; Ball, "A Survey of Subjective Foreskin Sensation," see note 15 above; B.D. Earp and R. Darby, "Circumcision, Sexual Experience, and Harm," *University of Pennsylvania Journal of International Law* 37, no. 2 (online 2017): 1-56.

24. R. Darby, "Risks, Benefits, Complications and Harms: Neglected Factors in the Current Debate on Non-Therapeutic Circumcision," *Kennedy Institute of Ethics Journal* 25, no. 1 (2015): 1-34.

25. J. Bossio, C. Pukall, and K. Bartley, "You Either Have It or You Don't: The Impact of Male Circumcision

Status on Sexual Partners," *Canadian Journal of Human Sexuality* 24, no. 2 (2015): 104-19, 104.

26. For a more recent discussion, see M. Jansen, "Still Locked: A Reply to Wodak, Ziegler and Morris," *Journal of Paediatrics and Child Health* 53, no. 1 (2017): 93-4.

27. *Status quo bias*—i.e., in favor of continuing the practice of circumcision—would also apply in this case, although the international critics did not raise this issue. Another potential source of bias is what has been called *intervention bias*, namely, the tendency of doctors to favor taking action, including surgical action, when nonintervention is equally justified or more justified on strictly medical grounds: A.J. Foy and E.J. Filippone, "The Case for Intervention Bias in the Practice of Medicine," *Yale Journal of Biology and Medicine* 86, no. 2 (2013): 271-80. *Publication bias* may also play a role—the tendency of journals to favor publication of studies that appear to show a positive effect of the intervention in question, in this case circumcision: P.J. Easterbrook et al., "Publication Bias in Clinical Research," *Lancet* 337, no. 8746 (1991): 867-72; B.D. Earp, "The need for reporting negative results—a 90 year update," *Journal of Clinical and Translational Research* 3, no. 52 (2017): 1-4; B.D. Earp and P. Wilkinson, "The Publication Symmetry Test—A Simple Editorial Heuristic to Combat Publication Bias," *Journal of Clinical and Translational Research*, in press. Finally, *peer review bias* has also been mentioned as a possible factor: R.S. Van Howe, "Peer-Review Bias Regarding Circumcision in American Medical Publishing," in *Male and Female Circumcision* (New York: Springer US, 1999), 357-78.

28. Frisch et al., "Cultural Bias," see note 5 above, p. 796.

29. Ibid.

30. Canadian Paediatric Society, "Newborn Male Circumcision," see note 3 above.

31. RACP, "Circumcision of Infant Males," see note 3 above; see also K. Pringle, "Circumcision Health Risks and Benefits—Experts Respond," *Science Media Center*, 4 April 2014; D. Forbes, "Circumcision and the Best Interests of the Child," *Journal of Paediatrics and Child Health* 51, no. 3 (2015): 263-5; A.F. Na, T. Sharman, and J.M. Hutson, "Circumcision: Is It Worth It For 21st-Century Australian Boys?" *Journal of Paediatrics and Child Health* 51, no. 6 (2015): 580-3.

32. W. Hartmann, "Expert Statement: Dr Med. Wolfram Hartmann, President of 'Berufsverband Der Kinder-Und Jugendärzte' for the Hearing on the 26th of November 2012 Concerning the Drafting of a Federal Government Bill," 2012, *http://www.intactamerica.org/german_pediatrics_statement.*

33. As paraphrased in England, "Doctors in Denmark," see note 3 above. Please note that the British Medical Association is currently revising its guidelines; it is not known what position it will take.

34. AAP, "Cultural Bias and Circumcision: The AAP Task Force on Circumcision Responds," *Pediatrics* 131, no. 4 (2013): 801-4, 801.

35. Canadian Academy of Health Sciences/Académie Canadianne Des Sciences de La Santé, "Noni MacDonald," 5 April 2017, *http://cahs-acss.ca/noni-macdonald/.*

36. AAP, "Cultural Bias and Circumcision," see note 34 above, p. 801.

37. B.J. Morris et al., "Estimation of Country-Specific and Global Prevalence of Male Circumcision," *Population Health Metrics* 14, no. 4 (2016): 1-3; E. Wallerstein, "Circumcision: The Uniquely American Medical Enigma," *Urologic Clinics of North America* 12, no. 1 (1985): 123-32.

38. W.G. Wallace, "An Undeniable Need for Change: The Case for Redefining Human Penis Types: Intact, Circumcised, and Uncircumcised (All Three Forms Exist and All Are Different)," *Clinical Anatomy* 28, no. 5 (2015): 563-4; R.V. Hill, "Altered Anatomy Demands Dedicated Terminology: A Response to Wallace (2015)," *Clinical Anatomy* 28, no. 8 (2015): 960-1; W.G. Wallace, "An Undeniable Need for Recognition: What Do You Call a Man Who Has Undergone Foreskin Restoration? A Response to Hill (2015)," *Clinical Anatomy* 28, no. 8 (2015): 962-3.

39. It should be noted that in many cultures in which ritual female genital cutting is common and normative, girls with intact vulvae are also referred to (in English) as "uncircumcised," in many cases as an explicit pejorative. O. Bamgbose, "Women and the Law in Africa: Legal and Cultural Approaches to Sexual Matters in Africa: The Cry of the Adolescent Girl," *University of Miami International and Comparative Law Review* 10 (2001): 127-241; B. Shell-Duncan and Y. Hernlund, *Female "Circumcision" in Africa: Culture, Controversy, and Change* (Boulder, Colo.: Lynne Rienner, 2000).

40. Morris et al., "Estimation of Country-Specific and Global Prevalence of Male Circumcision," see note 37 above.

41. Na, Shaman, and Hutson, "Circumcision," see note 31 above.

42. B.D. Earp, "The AAP Report on Circumcision: Bad Science + Bad Ethics = Bad Medicine," *Practical Ethics*, 29 August 2012, *http://blog.practicalethics.ox.ac.uk/2012/08/the-aap-report-on-circumcision-bad-science-bad-ethics-bad-medicine/.*

43. Wallerstein, "Circumcision: The Uniquely American Medical Enigma," see note 37 above.

44. L.B. Glick, "Defying the Enlightenment: Jewish Ethnicity and Ethnic Circumcision," in *Genital Cutting: Protecting Children from Medical, Cultural, and Religious Infringements* (New York: Springer, 2013), 285-96; R.A. Shweder, "Shouting at the Hebrews: Imperial Liberalism versus Liberal Pluralism and the Practice of Male Circumcision," *Law, Culture and the Humanities* 5, no. 2 (2009): 247-65.

45. F.M. Hodges, "A Short History of the Institutionalization of Involuntary Sexual Mutilation in the United States," in *Sexual Mutilations* (New York: Springer, 1997), 17-40; D.L. Gollaher, *Circumcision: A History of the World's Most Controversial Surgery* (New York: Basic Books, 2000); D.L. Gollaher, "From Ritual to Science: The Medical Transformation of Circumcision in America," *Journal of Social History* 28, no. 1 (1994): 5-36; Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," see note 2 above.

46. D.M. Kahan, "Cultural Cognition as a Conception

of the Cultural Theory of Risk," in *Handbook of Risk Theory*, ed. S. Roeser et al. (Dordrecht: Springer Netherlands, 2012), 725-59, 728.

47. M. Douglas, *Risk Acceptability According to the Social Sciences* (New York: Russel Sage, 1985), 60.

48. M. Douglas and A.B. Wildavsky, *Risk and Culture: An Essay on the Selection of Technical and Environmental Dangers* (Berkeley, Calif.: University of California Press, 1982), 8, 85.

49. Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," see note 2 above.

50. For a detailed explanation of the dimensions along which the two procedures are analogous, see B.D. Earp, "Female Genital Mutilation and Male Circumcision: Toward an Autonomy-Based Ethical Framework," *Medicolegal and Bioethics* 5, no. 1 (2015): 89-104. See also, B.D. Earp, "Does Female Genital Mutilation Have Health Benefits? The Problem with Medicalizing Morality," *Quillette Magazine,* 15 August 2017.

51. For an in-depth discussion, see B.D. Earp, "Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on 'FGM,'" *Kennedy Institute of Ethics Journal* 26, no. 2 (2016): 105-44.

52. WHO, "Eliminating Female Genital Mutilation: An Interagency Statement," 2008, *apps.who.int/iris/handle/10665/43839.*

53. D.S. Davis, "Male and Female Genital Alteration: A Collision Course with the Law," *Health Matrix* 11 (2001): 487-570; K.S. Arora and A.J. Jacobs, "Female Genital Alteration: A Compromise Solution," *Journal of Medical Ethics* 42, no. 3 (2016): 148-54; A. Shahvisi, "Why UK Doctors Should Be Troubled by Female Genital Mutilation Legislation," *Clinical Ethics* 12, no. 2 (2016): 102-8; A.K. Rashid, S.S. Patil, and A.S. Valimalar, "The Practice of Female Genital Mutilation among the Rural Malays in North Malaysia," *Internet Journal of Third World Medicine* 9, no. 1 (2010): 1-8; S. Taha, "A Tiny Cut: Female Circumcision in South East Asia," *Islamic Monthly*, 12 March 2013; R. Steinfeld and B.D. Earp, "How Different Are Female, Male and Intersex Genital Cutting?" *Conversation*, 15 May 2017, *http://theconversation.com/how-different-are-female-male-and-intersex-genital-cutting-77569.*

54. AAP, "Cultural Bias and Circumcision," see note 34 above, p. 803.

55. AAP, "Male Circumcision (Technical Report)," e759, see note 1 above: ". . . there are social, cultural, religious, and familial benefits and harms to be considered as well. It is reasonable to take these nonmedical benefits and harms for an individual into consideration when making a decision about circumcision."

56. BMA, "The Law and Ethics of Male Circumcision: Guidance for Doctors," *Journal of Medical Ethics* 30, no. 3 (2004): 259-63, 261.

57. Ibid.

58. Earp, "Female Genital Mutilation and Male Circumcision," see note 50 above.

59. In this regard, the female genitalia are, if anything, relatively more hospitable to bacteria, yeasts, and other potential sources of infection or disease, than are the male genitalia due to the presence of the foreskin. E.J. Dielubanza and A.J. Schaeffer, "Urinary Tract Infections in Women," *Medical Clinics of North America* 95, no. 1 (2011): 27-41. However, we expect that few people in Western medicine would be tempted to leverage this observation into a research program looking at the prophylactic health benefits of removing folds of tissue from the pediatric vulva.

60. A.F. Chung, J.M. Woodruff, and J.L. Lewis, Jr. "Malignant Melanoma of the Vulva: A Report of 44 Cases," *Obstetrics & Gynecology* 45, no. 6 (1975): 638-46.

61. Thus, is conceivable that removing one testicle from each male newborn would reduce his risk of developing testicular cancer later in life without necessarily impairing normal development or fertility. It would also likely reduce the population-level incidence of testicular cancer and associated healthcare costs. Similarly, removing one breast bud from each infant girl would conceivably reduce her risk of developing breast cancer later in life—and so on. Again, however, few would see these possibilities as supporting a valid argument in favor of prophylactic testicle/breast bud removal from infant boys or girls.

62. Frisch and Earp, "Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries," see note 10 above; E. Ungar-Sargon, "On the Impermissibility of Infant Male Circumcision: A Response to Mazor (2013)," *Journal of Medical Ethics* 41, no. 2 (2015): 186-90.

63. The one exception to this may be in cases of recurrent, pathologic phimosis due to balanitis xerotica obliterans (lichen sclerosis et atrophicus), which is rare: A.M.K. Rickwood, "Medical Indications for Circumcision," *BJU International* 83, no. S1 (1999): 45-51. Most cases of true phimosis can be treated in less invasive ways than circumcision, such as by the application of a steroid cream: A. Orsola et al., "Conservative Treatment of Phimosis in Children Using a Topical Steroid," *Urology* 56, no. 2 (2000): 307-10.

64. A. Adams and E. Moyer, "Sex Is Never the Same: Men's Perspectives on Refusing Circumcision from an In-Depth Qualitative Study in Kwaluseni, Swaziland," *Global Public Health* 10, no. 5-6 (2015): 721-38; Hammond and Carmack, "Long-Term Adverse Outcomes from Neonatal Circumcision," see note 13 above; T. Hammond, "A Preliminary Poll of Men Circumcised in Infancy or Childhood," *BJU International* 83, no. S1 (1999): 85-92. Re: tonsillectomies, see B. Goodman, "New Guidelines on When Kids Need Tonsillectomies," *WebMD*, 2011, *http://www.webmd.com/oral-health/news/20110102/new-guidelines-on-when-kids-need-tonsillectomies.*

65. B.D. Earp, "In Defence of Genital Autonomy for Children," *Journal of Medical Ethics* 42, no. 3 (2016): 158-63.

66. S. Holm, "Irreversible Bodily Interventions in Children," *Journal of Medical Ethics* 30, no. 3 (2004): 237.

67. J. R. Taylor, A.P. Lockwood, and A.J. Taylor, "The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision," *British Journal of Urology* 77, no. 2 (1996): 291-5.

68. P. Werker, A. Terng, and M. Kon, "The Prepuce Free Flap: Dissection Feasibility Study and Clinical Application of a Super-Thin New Flap," *Plastic & Reconstructive Surgery* 102, no. 4 (1998): 1075-82; G. Kigozi et al., "Foreskin Surface Area and HIV Acquisition in Rakai, Uganda (Size Matters)," *AIDS* 23, no. 16 (2009): 2209-13.

69. J.A. Bossio, C. Pukall, and S. Steele, "Examining Penile Sensitivity in Neonatally Circumcised and Intact Men Using Quantitative Sensory Testing," *Journal of Urology* 195, no. 6 (June 2016): 1848-53; M.. Sorrells et al., "Fine-Touch Pressure Thresholds in the Adult Penis," *BJU International* 99, no. 4 (April 2007): 864-69; Earp, "Infant Circumcision and Adult Penile Sensitivity," see note 15 above.

70. D. Harrison, "Rethinking Circumcision and Sexuality in the United States," *Sexualities* 5, no. 3 (2002): 300-16; Earp, "Sex and Circumcision," see note 15 above.

71. Freedman, "The Circumcision Debate," see note 18 above, p. e20160594.

72. T. Merwin, "Fleshing out Change on Circumcision," *Jewish Week*, 9 September 2012, *http://jewishweek.timesofisrael.com/fleshing-out-change-on-circumcision/.*

73. Kahan, "Ideology, Motivated Reasoning, and Cognitive Reflection," see note 22 above, p. 408.

74. Ibid.

75. Koehler, "The Influence of Prior Beliefs on Scientific Judgments of Evidence Quality," see note 22 above, p. 28.

76. Ibid., 39.

77. The emphasis is on "in principle." It is not clear whether Freedman's statement from the interview, despite superficial appearances, has any direct relevance for the debate concerning potential bias among the AAP Task Force. As noted, it is possible that a commitment to circumcision on religious grounds could incline someone, whether consciously or unconsciously, to give relatively more weight to evidence suggesting that the procedure is medically beneficial. However, (a) the existence of such an inclination cannot simply be inferred from a single case, and (b) even if it could be inferred, this would not entail a particular policy conclusion.

78. A.J. Muller, "To Cut or Not to Cut? Personal Factors Influence Primary Care Physicians' Position on Elective Newborn Circumcision," *Journal of Men's Health* 7, no. 3 (2010): 227-32, 227.

79. Z. Kunda, "The Case for Motivated Reasoning," *Psychological Bulletin* 108, no. 3 (1990): 480-98.

80. An alternative explanation reverses causation. This explanation says that a doctor's dispassionate reading of the medical literature causes him to make a decision about the risk/benefit ratio of newborn circumcision, and this decision, in turn, is what causes him to circumcise (or not circumcise) his own son. This could very well explain, at least in principle, the observed association between those two variables. However, it could not explain the other observed association, namely the one between one's *own* circumcision status and one's evaluation of the literature. At least, it could not explain this association if one was circumcised in infancy or early childhood, as most of the doctors in this survey presumably were. This is because reverse causation in such a case would not be possible (one cannot retroactively circumcise oneself in infancy based on one's current, dispassionate reading of the medical literature).

81. L. Festinger, *A Theory of Cognitive Dissonance* (Stanford, Calif.: Stanford University Press, 1962); E. Harmon-Jones and C. Harmon-Jones, "Cognitive Dissonance Theory after 50 Years of Development," *Zeitschrift Für Sozialpsychologie* 38, no. 1 (2007): 7-16.

82. Waldeck, "Using Male Circumcision to Understand Social Norms as Multipliers," see note 2 above, p. 495.

83. We are reluctant to speculate about the circumcision statuses of the male AAP Task Force members or their European counterparts. However, if one considers the very high rate of neonatal circumcision in the United States until recently, and the very low rate of circumcision in Europe both historically and presently, the possibility of greater personal bias (in the sense just outlined) among the former cannot be discounted entirely. A related consideration can be illustrated by way of an analogy. Imagine a committee charged with preparing a technical report on the benefits and risks of labiaplasty for adolescent girls who have been diagnosed with "labial hypertrophy" (long labia). Now imagine an early draft of this report that does not include a detailed description of the anatomy and functions of the labia minora, that downplays the limitations of studies purporting to show that labiaplasty poses only a trivial risk to women's sexual enjoyment (or fails to mention such limitations altogether), and that implicitly assigns the female genital labia themselves a value of "zero" in its benefit-risk analysis (see table 1). It is not unreasonable to think that a female committee member with surgically unmodified genitalia, compared to one whose labia were removed in childhood, or who never had labia due to being male, would be significantly more likely to notice such oversights and propose that they be corrected before final publication. This is another sense, then, in which personal experience may factor into policy discussions.

84. AAP, "Cultural Bias and Circumcision," see note 34 above, p. 801.

85. AAP, "Male Circumcision (Technical Report)," see note 1 above, p. e758.

86. Morris, Bailis, and Wiswell, "Circumcision Rates in the United States," see note 11 above.

87. Freedman, "The Circumcision Debate," see note 18 above.

88. R. Merkel and H. Putzke, "After Cologne: Male Circumcision and the Law. Parental Right, Religious Liberty or Criminal Assault?" *Journal of Medical Ethics* 39, no. 7 (2013): 444-9.

89. B.D. Earp, "Mental Shortcuts," *Hastings Center Report* 46, no. 2 (2016): inside front cover; B.D. Earp and D. Trafimow, "Replication, Falsification, and the Crisis of Confidence in Social Psychology," *Frontiers in Psychology* 6, no. 621 (2015): 1-11.

90. See B.D. Earp, "'Legitimate Rape,' Moral Coherence, and Degrees of Sexual Harm," *Think* 14, no. 41

(2015): 9-20; see also E. Vogelstein, "Professional Hubris and Its Consequences: Why Organizations of Health-Care Professions Should Not Adopt Ethically Controversial Positions," *Bioethics* 30, no. 4 (2016): 234-43. Ironically given the arguments in the present article, Vogelstein explicitly exempts the AAP 2012 circumcision policy from his proposed prohibition on healthcare organizations adopting controversial positions. See R.S. Van Howe, "Response to Vogelstein: How the 2012 AAP Task Force on Circumcision Went Wrong," *Bioethics,* in press.

91. R. Collier, "Ugly, Messy and Nasty Debate Surrounds Circumcision," *Canadian Medical Association Journal* 184, no. 1 (2012): E25-6; B.D. Earp, "Addressing Polarisation in Science," *Journal of Medical Ethics* 41, no. 9 (2015): 782-4.

92. Van Howe, "The American Academy of Pediatrics and Female Genital Cutting," see note 19 above.

93. D. Diekema, "Parental Refusals of Medical Treatment: The Harm Principle as Threshold for State Intervention," *Theoretical Medicine and Bioethics* 25, no. 4 (2004): 243-64.

94. M. Benatar and D. Benatar, "Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision," *American Journal of Bioethics* 3, no. 2 (2003): 35-48; J. Mazor, "The Child's Interests and the Case for the Permissibility of Male Infant Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 421-28; J. Savulescu, "Male Circumcision and the Enhancement Debate: Harm Reduction, Not Prohibition," *Journal of Medical Ethics* 39, no. 7 (2013): 416-7.

95. M. Fox and M. Thomson, "Short Changed? The Law and Ethics of Male Circumcision," in *Children's Health and Children's Rights* (Leiden, the Netherlands: Brill, 2006), 161-82; D.L. DeLaet, "Framing Male Circumcision as a Human Rights Issue? Contributions to the Debate over the Universality of Human Rights," *Journal of Human Rights* 8, no. 4 (2009): 405-26; D.L. DeLaet, "Genital Autonomy, Children's Rights, and Competing Rights Claims in International Human Rights Law," *International Journal of Children's Rights* 20, no. 4 (2012): 554-83; G.J. Boyle et al., "Circumcision of Healthy Boys: Criminal Assault?" *Journal of Law and Medicine* 7, no. 1 (2000): 301-10; R. Merkel and H. Putzke, "After Cologne: Male Circumcision and the Law," see note 88 above; K.-K. Ford, "'First, Do No Harm': The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants," *Yale Law & Policy Review* 19, no. 2 (2001): 469-88; B.D. Earp, J. Hendry, and M. Thomson, "Reason and Paradox in Medical and Family Law: Shaping Children's Bodies," *Medical Law Review*, in press; B.D. Earp and R. Steinfeld, "Gender and Genital Cutting: A New Paradigm," in *Gifted Women, Fragile Men*, ed. T. G. Barbat, Euromind Monographs 2 (Brussels, Belgium: ALDE Group-EU Parliament, 2017); J.S. Svoboda, P.W. Adler, and R.S. Van Howe, "Circumcision Is Unethical and Unlawful," *Journal of Law, Medicine & Ethics* 44, no. 2 (2016): 263-82; J.S. Svoboda, "Promoting Genital Autonomy by Exploring Commonalities between Male, Female, Intersex, and Cosmetic Female Genital Cutting," *Global Discourse* 3, no. 2 (2013): 237-55; M. Dustin, "Female Genital Mutilation/Cutting in the UK: Challenging the Inconsistencies," *European Journal of Women's Studies* 17, no. 1 (2010): 7-23.

96. J.S. Svoboda and R.S. Van Howe, "Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision," *Journal of Medical Ethics* 39, no. 7 (2013): 434-4. 435.

97. AAP, "Male Circumcision (Technical Report)," see note 1 above, p. e759.

98. Ibid.

99. For a closely related view concerning female children's genitals specifically, see A. Rahman and N. Toubia, *Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies* (London and New York: Zed Books, 2000). These authors state, "The cutting of healthy genital organs for non-medical reasons is at its essence a basic violation of girls' and women's right to physical integrity. This is true regardless of the degree of cutting or the extent of the complications that may or may not ensue."

100. J. Chegwidden, "Response: Tasmanian Law Reform Institute Issues Paper No. 14: Non-Therapeutic Male Circumcision," 2009, *http://www.utas.edu.au/_data/assets/pdf_file/0003/28370/CircumcisionIssuesPaperA4toPrint.pdf.*

101. Ibid.

102. Davis, "Male and Female Genital Alteration," see note 53 above.

103. D.M. Shaw, "Beyond Conflicts of Interest: Disclosing Medical Biases," *Journal of the American Medical Association* 312, no. 7 (2014): 697-8. This is not to say that financial conflicts of interest are not relevant. As a reviewer for this paper points out, the fact that circumcision generates sometimes substantial incomes for American doctors in the context of a for-profit medical system should not be discounted. This monetary aspect plausibly does play a role in perpetuating circumcision in the United States. As Christopher Price states, "Circumcision is a very complex issue [about which it has been said that] 'Mothers demand it, doctors profit by it, and babies cannot complain about it.' It is estimated that, with more than one million circumcisions a year at a cost on the order of $200 each, doctors in the United States earn in excess of $200 million *per annum*, from circumcisions. Such a major financial incentive to continue routine neonatal circumcision helps cloud the legal and ethical issues inherent in this activity." C. Price, "Male Non-Therapeutic Circumcision: Legal and Ethical Issues," in *Male and Female Circumcision* (New York: Springer US, 1999), 425-54. With respect to the AAP Task Force in particular, we note that, while no financial (or other) conflicts of interest were disclosed in the original AAP documents, a financial conflict of interest was in fact included in the AAP response to the European critics, as follows: "FINANCIAL DISCLOSURE: Dr. Carlo is a Director of Mednax; the other authors have indicated they have no financial relationships relevant to this article to disclose." This disclosure is hard to interpret, as no details are given as to the nature of the financial conflict of interest; it is also of concern that the conflict—whatever it is—was not mentioned in the original policy statement or technical report. AAP, "Cultural

Bias and Circumcision," see note 34 above, p. 801.

104. Shaw has argued from this premise that committee members should be required to disclose, as a potential conflict of interest, whether they are circumcised or have circumcised their son (Shaw, "Beyond Conflicts of Interest," see note 103 above). However, we will not pursue that argument here.

105. R.S. Van Howe, "The American Academy of Pediatrics and Female Genital Cutting," see note 19 above.

Continuing Medical Education

CME Test for the *Journal of Pediatric Ethics*, Volume 1, Number 1

OVERVIEW

Participation in this CME activity consists of reviewing the article, "Cultural Bias in American Medicine: The Case of Infant Male Circumcision," in this issue of *Journal of Pediatric Ethics* and taking a six-question test. It is estimated that this activity will take approximately one hour.

To receive CME credit, please complete the following:

1. Review the article.
2. Complete the test and evaluation on this and the following page. (A passing score of 100 percent is required to earn credit.)
3. Detach your completed test and evaluation and mail it to Emily Rogers, MHA, Children's Hospitals and Clinics of Minnesota, Clinical Ethics Department, 2525 Chicago Avenue South 17-750, Minneapolis, MN 55404.
4. Upon successful completion, you will receive a certificate of completion.

TEST

1. In regard to what constitutes a harm or benefit, the following affect the *weight* assigned to the outcome (circle one):
   a. Individual tolerance for certain types of risk.
   b. Availability of alternative risk-reduction or benefit-promoting strategies.
   c. One's preferences and values.
   d. All of the above.

2. Cultural cognition guides not only response to risk, but also risk perception (check one):
   ☐ True ☐ False

3. Is a child's right to physical integrity absolute? (check one):
   ☐ True ☐ False

4. How will you change your role/practice based on the information shared in this article? Add a sheet to the test if needed or type your response and include it with the test:

5. There are some forms of "female genital mutilation" (as defined by the World Health Organization—WHO) that are *less* invasive than male circumcision as it is commonly performed in the United States (check one).
   ☐ True ☐ False

6. The "harm principle" has been criticized as a limit for parental action because (circle one):
   a. Just as reasonable people may disagree about what is in a child's "best interests," so too may they disagree about what constitutes placing the child at "significant risk of serious harm."
   b. It places too many restrictions on parental decision making.
   c. It is culturally biased.
   d. (a.) and (c.)

EVALUATION

1. The following objectives were met:
   a. Evaluate the charge of cultural bias, focusing on possible sources of subjective judgments that could play into assessment of benefit versus risk (check one):
      - ☐ Strongly agree
      - ☐ Agree
      - ☐ Neutral
      - ☐ Disagree
      - ☐ Strongly disagree

   b. Discuss ongoing disagreements about the ethical status of nontherapeutic infant male circumcision (check one):
      - ☐ Strongly agree
      - ☐ Agree
      - ☐ Neutral
      - ☐ Disagree
      - ☐ Strongly disagree

   c. Draw general lessons about the problem of cultural bias in medicine (check one):
      - ☐ Strongly agree
      - ☐ Agree
      - ☐ Neutral
      - ☐ Disagree
      - ☐ Strongly disagree

2. This activity was free of commercial bias (check one):
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly disagree

3. This activity was a valuable use of my time (check one):
   - ☐ Strongly agree
   - ☐ Agree
   - ☐ Neutral
   - ☐ Disagree
   - ☐ Strongly disagree

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Circumcision of male infants and children as a public health measure in developed countries: A critical assessment of recent evidence

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ABSTRACT

In December of 2014, an anonymous working group under the United States' Centers for Disease Control and Prevention (CDC) issued a draft of the first-ever federal recommendations regarding male circumcision. In accordance with the American Academy of Pediatrics' circumcision policy from 2012 – but in contrast to the more recent 2015 policy from the Canadian Paediatric Society as well as prior policies (still in force) from medical associations in Europe and Australasia – the CDC suggested that the benefits of the surgery outweigh the risks. In this article, we provide a brief scientific and conceptual analysis of the CDC's assessment of benefit versus risk, and argue that it deserves a closer look. Although we set aside the burgeoning bioethical debate surrounding the moral permissibility of performing non-therapeutic circumcisions on healthy minors, we argue that, from a scientific and medical perspective, current evidence suggests that such circumcision is not an appropriate public health measure for developed countries such as the United States.

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Introduction

Male circumcision is the surgical removal of part or all of the penile foreskin (Cold & Taylor, 1999). When circumcision is performed on children in the absence of penile disease, it raises a number of complex ethical issues, some of which have been discussed in the recent literature (e.g. Darby, 2015; Earp, 2015a, 2015b; Foddy, 2013; Frisch et al., 2013; Mazor, 2013; Munzer, 2015; Savulescu, 2013; Ungar-Sargon, 2015). Here, however, we focus exclusively on the empirical aspects of circumcision as they pertain to a published draft of the first-ever U.S. government policy on the subject, released in December of 2014.[1] Our central aim is to analyse the contention of the U.S. Centers for Disease Control and Prevention (CDC) that the prophylactic benefits of non-therapeutic male circumcision, as carried out prior to an age of consent, outweigh its associated risks

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in developed settings such as the United States, in light of the available evidence pertaining to this question.

Benefits versus risks

Do the benefits of circumcision outweigh the risks?[2] In recently proposed recommendations and an accompanying background report, an anonymous CDC working group has suggested that they do (2014a, 2014b). A similar claim was made in 2012 by an eight-member American Academy of Pediatrics (AAP) task force (2012a, 2012b), despite contrary policies from British, mainland European, and Australasian medical associations, all of which remain in force (e.g. British Medical Association, 2006; Royal Australasian College of Physicians, 2010; Royal Dutch Medical Association, 2010; see also National Health Service of England, 2016). In addition, the Canadian Paediatric Society (CPS), which has historically endorsed the AAP position, instead explicitly rejected it in its most recent policy (Sorokan, Finlay, & Jefferies, 2015).

What could explain this lack of international agreement with the U.S. view? There are several possibilities. At least one concerns the fact that 'The true incidence of complications after newborn circumcision is unknown', as acknowledged by the AAP task force (2012b, p. e772). But since 'complications' are one of the foremost risks of circumcision, and since their 'true incidence' has not been firmly established (see below), it becomes difficult to see how the benefits of the surgery could logically be asserted to outweigh them (Darby, 2015). This is especially the case given that, on the other side of the scale, the likelihood as well as the magnitude of the purported benefits of circumcision themselves are in dispute.

A further possibility has to do with ongoing disagreements over how to define 'complications' in the first place (see AAP, 2012a), as well as with differences of opinion concerning the relative weight or value to assign to individual benefits and risks. As AAP task force member Dr Andrew L. Freedman stated in a recent editorial, in addition to having 'insufficient information about the actual incidence and burden of nonacute complications', the AAP's 2012 assessment of benefits versus risks also suffered due to the 'lack of a universally accepted metric to accurately measure or balance the risks and benefits' (Freedman, 2016, p. 1).

To see the significance of this problem, which applies equally to the 2014 analysis by the CDC, consider the example of a modest reduction in the absolute risk of contracting certain sexually transmitted infections, a health benefit that is frequently attributed to – primarily adult – circumcision (see below). Considering that (1) children are not at risk of contracting sexually transmitted infections prior to sexual debut (an event that typically comes after the development of a capacity to provide informed consent to self-affecting interventions); (2) there are alternative modes of prevention that are less invasive, as well as less risky and more effective, than circumcision (i.e. safe sex practices when one does become sexually active); and (3) many of these infections can be treated effectively if they do occur, what is the weight or value that one should assign to this particular benefit?

For example, should it be considered 'worth' the risk, however slight, of a surgical mishap that causes permanent damage to the penile glans? Is it 'worth' the loss of the penile prepuce itself, which is a 100% risk of circumcision? Is it 'worth' the risk of

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removing too much penile skin (i.e. more than was intended), leading to painful erections later in life (see e.g. van Duyn & Warr, 1962; Krill, Palmer, & Palmer, 2011; Thorup, Thorup, & Ifaoui, 2013)? The answer to these questions cannot be 'objectively' determined (see Johnsdotter, 2013). Instead, they will depend upon such factors as how much value one places on having intact versus modified genitalia, how willing one is to engage in safe sex practices (even if one is circumcised), and how much risk one feels comfortable taking on when it comes to a surgery performed on a physically and symbolically sensitive part of one's body (Adams & Moyer, 2015, p. 723; see also Earp, 2016).[3]

Finally, it has been argued that the appropriate counterbalance to the potential benefits of circumcision is not only the risk of surgical complications (whatever those turn out to be), but also its short-term, intermediate, and long-term adverse consequences, both physical and psychological (Darby, 2015). Due to a lack of adequate research into these questions, however, the entire spectrum of potential circumcision harms (i.e. surgical risks plus additional negative consequences) has never been fully described. Moreover, at least some of these potential harms are likely to be subjective in nature (e.g. feelings of loss or resentment; see Darby & Cox, 2009; Goldman, 1999; Hammond, 1999), and therefore highly variable across individuals, as well as difficult to quantify in a meaningful way (Darby, 2015; Darby & Cox, 2009; Johnsdotter, 2013).

The contention of the CDC

Notwithstanding all of the concerns just mentioned, in support of its contention that the benefits of circumcision do in fact outweigh the risks, the CDC working group cites a review article first-authored by a retired molecular geneticist named Brian J. Morris (Morris, Bailis, & Wiswell, 2014a). As noted previously in this journal, Morris is 'a long-standing advocate of mass circumcision' (Bell, 2015, p. 558), who now serves as the primary spokesperson for a pro-circumcision lobbying organisation called the Circumcision Academy of Australia (CAA). According to this group's website (http://www.circumcisionaustralia.org), the CAA 'is not aligned with any medical body', but is rather a political entity seeking to expand health insurance coverage for non-medical circumcisions in Australia.[4]

Whether the CDC working group was aware of this context is unclear. Nevertheless, it approvingly quotes the benefit-to-risk ratio reported by Morris et al. (2014a) in its background report, which is stated as 100:1 in favour of circumcision. However, this is a figure that no other scientist, nor any recognised medical body to our knowledge, has ever been able to reproduce. Instead, it overstates the relative magnitude of the benefits of circumcision by a factor of approximately 100 according to the recent non-partisan analysis by the CPS (Sorokan et al., 2015). As the CPS states, 'the medical risk:benefit ratio of routine newborn male circumcision is closely balanced when current research is reviewed' (p. 4).

Given the *prima facie* implausibility of a 100:1 benefit-to-risk ratio in favour of circumcision, one might expect that the CDC working group would have sought out available criticisms of the paper by Morris et al. (2014a) in order to incorporate alternative perspectives. If so, they would have come across a critique published subsequently in the same journal, which states that the paper is 'marred by bias' and that its authors 'did not provide a dispassionate review' of the available evidence (Jenkins, 2014, p. 1588; but see

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Morris, Bailis, & Wiswell, 2014b).[5] In a similar vein, Dr Kevin Pringle, Professor of Paediatrics and Head of Obstetrics and Gynaecology at the University of Otago, stated:

> I find this paper to be extremely worrying. The most worrisome aspect is the emphasis on possible diseases that are reported to be significantly more common in the uncircumcised population and the complete lack of any attempt to accurately document the risk of the complications of circumcision. (2014)

Professor Pringle went on to state:

> As I read their table, the authors suggest that performing 10 circumcisions will prevent 1 case of phimosis and/or 1 case of balanitis. [But] 80% of children with phimosis respond to the simple application of a steroid cream and only a small percentage need a circumcision. Similarly, many cases of balanitis are associated with phimosis and if the phimosis is treated, they have no further trouble. Paediatric surgeons see most of the cases of phimosis and balanitis. They are nowhere near as common as is suggested in this paper. (2014)

A new population-based study from Denmark, where non-therapeutic childhood circumcision is rare, lends support to Professor Pringle's impression. In a stable Copenhagen population with on average 10,858 boys born each year between 1996 and 2014, only 53 boys needed a circumcision for medical reasons before age 18 years during the calendar year 2014. This indicates that approximately 99.5% of Danish boys will go through infancy, childhood, and adolescence without any medical need to be circumcised (Sneppen & Thorup, 2016).

Finally, other authors have described a separate review by Morris and a co-author as being of 'low quality' on account of the 'high risk of bias … introduced by the authors' well documented, unconditional support of the practice of circumcision' (Bossio, Pukall, & Steele, 2015, p. 1306; see also Donovan, 1999). In light of these considerations, it is not readily apparent why the CDC working group chose to rely so uncritically on the claims of Morris et al. in support of its main conclusion. For an Australian perspective, the working group might instead have cited the official 2010 policy of the Royal Australasian College of Physicians, which was recently re-affirmed after an evaluation of the AAP findings from 2012 (see Pringle, 2014; see also Forbes, 2015). This policy states: 'the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand' (RACP, 2010, p. 5).

The value of an intact sexual organ

In a previous section, we noted that the appropriate counterbalance to the benefits of circumcision is not only the (unknown) risk of surgical complications, but rather the sum total of negative consequences, that is, the harms. One harm of circumcision that has been argued to be intrinsic to the procedure is the loss of healthy, functional tissue (Hutson, 2004). Yet in its background material, the CDC does not describe the known anatomy of the penile prepuce, nor does it discuss in detail the protective and sexual functions that have been attributed to it in the medical literature (2014b). One possible consequence of these omissions is that they may be taken to imply that the foreskin itself should be assigned a value of 'zero' in harm–benefit calculations. Yet such a valuation is uncommon outside of circumcising societies, and is inconsistent with normative medical evaluations regarding other functional parts of the body (Hutson, 2004).

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The foreskin is a complex, double-layered structure, which protects the penile glans from environmental irritation, such as rubbing against diapers and clothing (Berry & Cross, 1956; Cold & Taylor, 1999). This elastic, motile sleeve of tissue has recently been shown to be the most touch-sensitive part of the penis (Bossio, Pukall, & Steele, 2016; consistent with Sorrells et al., 2007), composed of a moist mucous membrane on the inside and a protective skin layer on the outside. It is rich in specialised nerve endings and sensory structures involved in the normal functionality of the penis (Cold & Taylor, 1999), and it comprises up to 100 square centimeters in adult men, with reported mean values between 30 and 50 square centimeters (Kigozi et al., 2009; Werker, Terng, & Kon, 1998). While the scientific literature on the 'average' sexual consequences of circumcision is inconclusive and contradictory (Bossio, Pukall, & Steele, 2014, 2015; Johnsdotter, 2013) – and granting that circumcision is likely to affect different men differently, even when it is properly performed – at least two outcomes can be known with certainty due to the inherent nature of the procedure: first, any sensation in the foreskin itself is necessarily eliminated; and, second, any sexual (e.g. masturbatory) functions that require its manipulation are also of necessity precluded (Earp, 2015a, 2016).

Scientific inference from African trials

In its background report (CDC, 2014b), the CDC working group, like the AAP before it (2012b), emphasises three African trials concerning adult circumcision. These trials reported a modest reduction in the absolute risk of heterosexual, female-to-male human immunodeficiency virus (HIV) transmission (from 2.49% to 1.18%) during the first few years after circumcision in high-risk areas with a low baseline circumcision prevalence (CDC, 2014b). A number of concerns regarding both the internal and external validity of findings from these African trials have been raised (e.g. Boyle & Hill, 2011; Garenne, Giami, & Perrey, 2013; Green et al., 2010; but see Wamai et al., 2012 and further commentary by Bell, 2015), but even assuming that the reported efficacy estimates of the three African trials are scientifically valid, this does not necessarily imply that their findings are relevant elsewhere in the world.

The CDC does superficially acknowledge some of the problems associated with making scientific inferences from studies of adult males in Africa to newborn boys in the United States (2014b). However, the primary implication of such important caveats, namely that findings from the one context cannot responsibly be extrapolated to the other without a great deal of further investigation, is ultimately ignored. For example, the CDC background report (2014b) highlights two analyses of the costs and health consequences of circumcision which largely assume, based on unrepresentative observational data, that the findings from adults in Africa will apply directly to infant boys in the United States (Kacker, Frick, Gaydos, & Tobian, 2012; Sansom et al., 2010).

The inference is stretched even further. According to the CDC, all genitally intact adolescent U.S. boys and heterosexually active adult males (not only those in a few high-risk subgroups) 'should be informed about the significant, but partial, efficacy of male circumcision in reducing the risk of acquiring HIV and some STIs through heterosexual sex' (CDC, 2014a, p. 3). Since the absolute risk of acquiring HIV for the average intact heterosexual male in the United States is extremely low, however (McQuillan et al., 2006), the recommendation that *all* should be counseled about the 'significant' benefits of circumcision is arguably out of proportion (for an accessible discussion, see Bundick, 2009).

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European experience

The CDC does not consider the situation in Europe, where rates of HIV are similar to or lower than those in the United States. In 2011, for instance, according to the Central Intelligence Agency (CIA) World Factbook, the prevalence of HIV/AIDS in the age group 15–49 years was several times higher in the United States (0.6%), where around 80% of men are circumcised (CDC, 2014b), than in several countries of northern and western Europe (0.1–0.3%), where circumcision is uncommon (CIA, 2011). While numerous variables undoubtedly play into these differences, the fraction of circumcised men in a given population is unlikely to be a determining factor.

Against this view, the CDC cites a modelling study by Kacker et al. (2012) suggesting that if the rate of male circumcision were to drop to around 10% as in Europe, then the United States would be destined to experience a significant increase in HIV infections and a heavy burden of associated healthcare costs (2014b). Unfortunately, this analysis, and another one by Sansom et al. (2010), relied on highly speculative trans-cultural and age-range extrapolations, and both models used estimates of complication rates that are unrealistically low (0.4% and 0%, respectively), as we will demonstrate below. Taken together, then, the cited cost-effectiveness estimates of newborn circumcision in reducing HIV in the United States (Kacker et al., 2012; Sansom et al., 2010) are overly optimistic, notwithstanding the fact that one of these estimates (Sansom et al., 2010) actually failed to show a cost-saving impact among the majority population of white males.

Procedural and post-operative pain in infants

It is now well established that infants and small children have the full capacity to experience pain, and that early life exposure to noxious stimuli may have long-lasting implications for the developing nervous system (Fitzgerald & Beggs, 2001). Consistent with this view, a different AAP task force that was formed to investigate infant pain (rather than circumcision) has recently concluded that:

> Pain that newborns experience from routine medical procedures can be significant … Research suggests that repeated exposure to pain early in life can create changes in brain development and the body's stress response systems that can last into childhood. Because of this, a new American Academy of Pediatrics policy statement recommends [that] every health facility caring for newborns should use strategies to minimize the number of painful procedures performed. (2016)

Notwithstanding the clear importance of this issue, the problem of procedural and post-operative pain received only scant attention in the CDC's background report (2014b). The only cited study dealing with this question assessed pain scores among 583 boys ages 1–35 days who received local anesthesia (ring block) before they were circumcised (Banieghbal, 2009). Apparently, the CDC working group did not read the study carefully, but relied solely on the article's abstract, which states that 'only 6.5% of neonates under 1 week of age' experienced circumcisions with pain levels above a pre-defined threshold (Banieghbal, 2009, p. 359).

The quoted figure appears nowhere apart from the abstract (Banieghbal, 2009). An estimate of 6.7% is provided in a table, but that figure is miscalculated and should be 7.1%.

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While inaccurate reporting of key statistics is always regrettable, it is particularly worrying that the CDC would rely exclusively on such a report to minimise concerns about pain in infants.

In addition to this concern, the CDC missed entirely another key finding in the Banieghbal study. The ring block injections administered to all the boys resulted in above-threshold pain in fully 31% of <1 week-old boys and 85% of 1–5 week-old boys. In other words, simply being administered the anesthesia proved painful for many infants to a clinically significant degree. Additionally, among 1–5 week-old boys, 71% experienced above-threshold pain during the subsequent circumcision (Banieghbal, 2009). Consequently, the CDC's statement that '93.5% of neonates circumcised in the first week of life with appropriate analgesia gave no indication of pain on an objective, standardised neonatal pain rating system' (2014b, p. 25) misrepresents the overall findings from the study.

Finally, pain at the operating table is not the only pain to factor in. In one study of post-operative discomfort in 57 neonatally circumcised boys, parental assessment revealed that 16% of the boys experienced moderate to severe post-operative discomfort, while the remaining 84% were judged by their parents to have mild discomfort (Smith & Smith, 2000). In another study of 710 newborn boys in Michigan, 71% of parents reported varying degrees of circumcision-related pain in their infants (ranging from "minimal" to "much more than acceptable") up to six weeks after the surgery (Freeman et al., 2014).

Complication rates after circumcision

In a section evaluating the safety and risks associated with circumcision (CDC, 2014b), the CDC focuses on immediate surgical risks and short-term post-operative complications, as identified in U.S. register data. Three studies published between 16 and 40 years ago are given particular attention (Christakis et al., 2000; Gee & Ansell, 1976; Wiswell & Geschke, 1989). However, each of these studies was designed to address complications occurring no later than one month after neonatal circumcision; indeed, two studies dealt exclusively with complications occurring just during the post-partum hospital stay (Christakis et al., 2000; Gee & Ansell, 1976). As pointed out by others, basing evaluations of the frequency of complications after infant circumcision on insufficiently detailed and incomplete register data will likely produce 'a significant underestimation of the true frequency of complications' (Pieretti, Goldstein, & Pieretti-Vanmarcke, 2010, p. 517). For instance, serious or even fatal complications from post-operative bleeding or infection due to circumcision may plausibly be recorded as hemorrhage, circulatory collapse, or septicaemia without mention of the surgery that caused it (Dr A. Rotta, personal communication, 11 April 2016).[6] Likewise, when complications are treated in other hospitals or clinics than those responsible for the original circumcision, the general inability to cross-link register data in countries without a unique personal identifier for every citizen (such as the United States), may preclude the identification of such post-operative complications as being truly circumcision related (see Weiss, Larke, Halperin, & Schenker, 2010).[7]

In addition, a recent Canadian study by DeMaria, Abdulla, Pemberton, Raees, and Braga (2013) found:

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> Most physicians performing neonatal circumcisions in our community have received informal and unstructured training. This lack of formal instruction may explain the complications and unsatisfactory results witnessed in our pediatric urology practice. Many practitioners are not aware of the contraindications to neonatal circumcision and most non-surgeons perform the procedure without being able to handle common post-surgical complications. (p. 260)

Such a lack of formal training in circumcision may also prevent some doctors from recognising certain complications in the first place; complications that are not recognised cannot be reported.

Particularly worrying is the CDC's assessment of meatal stenosis, a narrowing of the urethral opening which is seen at far higher rates in circumcised boys compared to genitally intact boys (Bazmamoun, Ghorbanpour, & Mousavi-Bahar, 2008; Berry & Cross, 1956; van Howe, 2006; Joudi, Fathi, & Hiradfar, 2011). In support of its contention that complication rates of circumcision are trivially low, the CDC cites a study by El Bcheraoui et al. (2014). These authors looked at hospital billing claims to evaluate the broader issue of urethral strictures (which includes meatal stenosis) during the first 180 days after surgery. However, a narrowing of the urethral meatus may take considerably longer than 180 days for parents or doctors to detect (Berry & Cross, 1956; Campbell, 1943; Joudi et al., 2011; Upadhyay, Hammodat, & Pease, 1998), which means that the chosen window of analysis was too short. Accordingly, the observed low frequency of urethral strictures (0.01%) – and therefore the low overall frequency of complications for boys circumcised in infancy (0.4%) (El Bcheraoui et al., 2014) – most likely reflects a combination of insensitive research data and insufficient follow-up.

Given such limitations affecting register-based studies, more realistic estimates of complication rates should be drawn from clinical studies. However, surprisingly limited data exist to estimate the true rate of late complications occurring months to years after non-therapeutic circumcision. In a 2010 review of complications after newborn, infant, and childhood circumcisions, where no clear and consistent distinction was drawn between (1) ritual circumcision of healthy, predominantly infant boys and (2) therapeutic circumcision of predominantly older boys with foreskin pathology, investigators identified 52 studies from around the world, of which only one small prospective study from 1988 ($n = 43$; mean age at circumcision = 6.5 years) provided information about adverse outcomes beyond the first year after the surgery (Weiss et al., 2010). Indeed, the only adverse outcome for which a reasonable number of reports provide frequency estimates based on direct clinical examination is meatal stenosis, which is broadly considered to be one of the most common complications after circumcision (Bazmamoun et al., 2008; van Howe, 2006; Joudi et al., 2011; Kajbafzadeh et al., 2011; Mondal et al., 2013; Patel, 1966; Persad, Sharma, McTavish, Imber, & Mouriquand, 1995). From such clinical studies, it appears that between 5% and 20% of boys undergoing non-therapeutic circumcision by means of conventional surgical techniques will develop meatal stenosis.

In one Iranian study, which was published only as a meeting abstract, 5% of 102 neonates circumcised by the PlastiBell method developed meatal stenosis during on average 9 years of follow-up; the corresponding proportion was 15% of 105 neonates circumcised by means of classical circumcision surgery preceded by ligation of the frenular artery (Kajbafzadeh et al., 2011). Similarly, a study from the United States reported a 7% prevalence of meatal stenosis in 1009 neonatally circumcised boys older than 3 years (van Howe, 2006). The CDC downplayed this finding (2014b), however, preferring instead a report from

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Iran, which described a frequency of only 0.9% for meatal stenosis in boys ages 6–12 years (Yegane et al., 2006). Yet this is flawed referencing: the reported rate of meatal stenosis in these Iranian boys was for all circumcised boys, most of whom (97.18%) were circumcised *after* the neonatal period.

In several other clinical studies relying on direct penile inspection from as varied geographical areas as the United States, the United Kingdom, Bangladesh, and Iran, proportions of boys developing meatal stenosis after conventional circumcision surgery in infancy or early childhood were 7% (Bazmamoun et al., 2008), 8% (Patel, 1966; Persad et al., 1995), 10% (Mondal et al., 2013), or 20% (Joudi et al., 2011). All of these studies were ignored by the CDC. And yet their estimates are more consistent with the 7% meatal stenosis rate reported in the U.S. study by van Howe (2006), which the CDC dismissed, than with the 700-fold lower 0.01% urethral stricture rate reported by El Bcheraoui et al. (2014), to which the CDC paid particular attention.[8]

While no study is free of limitations, reported rates of 5–20% for post-circumcision meatal stenosis in clinical studies (Bazmamoun et al., 2008; van Howe, 2006; Joudi et al., 2011; Kajbafzadeh et al., 2011; Mondal et al., 2013; Patel, 1966; Persad et al., 1995) call attention to the need for extra caution in interpreting reports of absolute complication rates based on register data, such as that relied upon by El Bcheraoui et al. (2014).

Other studies confirm the impression that the CDC working group may have seriously underestimated the burden of complications after newborn circumcision. For instance, Pieretti et al. (2010) reported from a hospital department of pediatric surgery in Boston (just one of several referral centers in the region; total number of circumcisions unknown) that of the 8967 children (both boys and girls) operated on between 2003 and 2007, 4.7% of the operations were for late complications occurring 2–49 months after neonatal circumcision. Another indication of the magnitude of the problem was that, of all outpatient visits (again, of both boys and girls) to the department of pediatric urology at the same hospital during a one-year period between 2007 and 2008, 7.4% were for complaints related to newborn circumcision (Pieretti et al., 2010).

Summary and conclusion

In this brief analysis, we have identified numerous scientific and conceptual shortcomings in the 2012 circumcision policy from the AAP, as well as the more recent draft guidelines issued by the CDC. With respect to the latter, these included: (1) failure to provide a thorough description of the normal anatomy and functions of the penile structure being removed at circumcision (i.e. the foreskin); (2) failure to consider the intrinsic value to some men of having an unmodified genital organ; (3) undue reliance on findings from sub-Saharan Africa concerning circumcision of adult males (as opposed to infants or children); (4) uncritical reliance on a *prima facie* implausible benefit-risk analysis performed by a self-described circumcision advocate (see Davey et al., in press); (5) reliance on misreported statistics to downplay the problem of pain in the youngest of boys; (6) reliance on incomplete register data to assess the frequency of short-term post-operative complications associated with circumcision, leading to a likely underestimation of their true frequency; and (7) serious underestimation of the late-occurring harms of circumcision presenting months to years after the operation (most notably meatal stenosis). In light

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of these considerations, we believe that the CDC's overall assessment of benefits versus harms ('risks') of the surgery should be interpreted with extraordinary caution.

The apparent underassessment of meatal stenosis alone, possibly the most common late-occurring complication after neonatal circumcision, means that the CDC's claim of markedly lower complication rates in boys circumcised as infants ('less than ½ per cent'), compared to boys circumcised at ages 1–9 years ('approximately 9%') and those circumcised at age 10 years and older ('approximately 5%') (2014a, 2014b), is almost certainly inaccurate.

Indeed, with reported rates of meatal stenosis in neonatally circumcised boys in the 5–20% range, and with estimates of clinically significant procedural pain in around 30% (and some level of post-operative pain and discomfort in most, if not all newborn boys undergoing the operation), the least problematic age to circumcise a boy (if at all), even from a purely medical standpoint, may well be when he is old enough to decide for himself. This conclusion is supported by the recent evidence showing that very few genitally intact boys – 0.5% according to the new population-based study in Denmark (Sneppen & Thorup, 2016) – will need a circumcision for medical reasons before the age of 18.

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Notes

1. It is important to emphasise that this draft was made public, garnering much coverage in the popular media, prior to having been subjected to a formal peer review. In a notable turn of events, at least one medical professional who was invited by the CDC to perform such a review subsequently made his comments available online (van Howe, 2015). This freely accessible, 200+ page review is strongly critical of the CDC research and analysis, as are several other expert commentaries that were posted to the CDC website in response to a call for public feedback (e.g. Kupferschmid et al., 2015). Nevertheless, it is currently unclear whether, or when, the CDC intends to revise its recommendations in light of such critical feedback or else formalise them (or a modified version of them) as official policy.
2. It is widely acknowledged that removing the foreskin of the penis may confer certain health benefits, in much the same way that removing healthy tissue from any other part of the body could be expected to reduce the risk of medical problems affecting – or introduced via – that tissue (see e.g. Kluge, 1994). For example, routinely removing one testicle from every male child would almost certainly reduce the individual boy's risk and the population-wide incidence of testicular cancer; but the costs, harms, and other disadvantages (sometimes misleadingly referred to as 'risks', see Darby, 2015) of prophylactic testicle removal would need to be factored into the equation, along with an array of moral considerations concerning autonomy, consent, and bodily integrity (not addressed in the present paper). In the case of male circumcision, then, the question is not whether certain health benefits may in fact ensue from the sheer surgical removal of the foreskin, but whether, in light of alternative, less invasive, means of achieving the same desired health outcomes, the benefits are *sufficient* to outweigh the costs, harms, and other disadvantages (i.e. 'risks'), some of which may be subjective in nature and therefore difficult to quantify (see e.g. Adams & Moyer, 2015; Darby & Cox, 2009; Johnsdotter, 2013).
3. Moreover, as AAP task force member Freedman (2016) has additionally noted, in the United States, at least,

> although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of non-medical reasons. There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision. (p. 1)

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Consistent with this perspective, Freedman has stated in a separate interview:

> I circumcised [my own son] myself on my parents' kitchen table on the eighth day of his life. But I did it for religious, not medical reasons. I did it because I had 3,000 years of ancestors looking over my shoulder. (see http://www.thejewishweek.com/features/new-york-minute/fleshing-out-change-circumcision#zpW7AFLaLTQsqJMH.99)

Granting these considerations, a further question is raised, however, regarding who should get to decide about circumcision in light of such non-medical factors (about which there is no universal agreement about how to weigh them): the parents, as assumed by Dr Freedman (including in his own case), or the individual who must undergo the surgery and therefore live with its consequences, positive or negative, as judged in light of his own considered preferences and values (i.e. the child himself, when he reaches an age of competence)? As we have just seen, even purely 'medical' factors may be weighed differently in the minds of different individuals; how much more contentious might non-medical factors be?

4. It appears that such expansion of coverage would be of direct financial benefit to several CAA board members, including the organisation's inaugural president, Dr C. Terry Russell (Russell Medical Center, 'Trusted Australian Circumcision Since 1993', http://www.circumcision.net.au), along with board members Dr Mojtaba Athari (Melbourne Vasectomy & Circumcision, http://www.mvandc.com.au/circumcision/), Dr Luke Bukallil (who has performed 'over 2000' circumcisions, http://drluke.biz/Circumcision/circumcision.htm), Dr Mohamed Hajoona (Victoria Circumcision Clinic, http://www.vcc.net.au), Dr Colin C.M. Moore (The Australian Center for Cosmetic and Penile Surgery, http://www.drcolinmoore.com), and Dr Anthony Dilley (who 'conducts up to 40 circumcisions per week', http://www.dailytelegraph.com.au/news/nsw/unkindest-cut-of-all-back-in-favour/story-e6freuzi-1225991948585). The group's political petition to 'restore elective male circumcision to public hospitals … increase the Medicare rebate [and] ensure [that] Medicare applies to prophylactic circumcision not just circumcision for medical problems' can be found here: http://chn.ge/1otJ9Bv. A similar petition posted separately by Brian Morris is available here: https://www.change.org/p/nsw-ministry-of-health-restore-elective-male-circumcision-to-public-hospitals.
5. Please note that the reply to Jenkins by Morris et al. (2014b) suffers from many of the same problems that Jenkins pointed out in his critique of their original paper. For example, most of the references in the reply are to other contested papers by Morris and colleagues (with no mention of published criticisms of those papers), creating what others have described as a 'rabbit hole' of selective self-citation (Svoboda & van Howe, 2013).
6. Alexandre T. Rotta, M.D., FCCM, is the Linsalata Family Chair in Pediatric Critical Care and Emergency Medicine, and Chief, Division of Pediatric Critical Care, Rainbow Babies & Children's Hospital (University Hospitals of Cleveland); as well as Professor, Department of Pediatrics, Case Western Reserve University School of Medicine. Dr Rotta describes some of the difficulties in linking circumcision-related complications with the circumcision surgery itself due to coding issues in an interview that is available online at the following link: https://www.youtube.com/watch?v=x_BohYj-VMw.
7. Further, indirect support for this view comes from a recent review paper by Springer (2014) concerning complications associated with surgery for hypospadias, another penile surgery that is often carried out in infancy or early childhood. As summarised by Carmack, Notini, and Earp (in press), on the issue of underreporting, Springer 'identified numerous barriers to complete reporting of surgical, functional, cosmetic, and quality-of-life outcomes' associated with the surgery, including

> numerous techniques in use; most publications reflecting single-center and single-surgeon retrospective case series with limited follow-up periods and small numbers of patients undergoing follow-up; transition of care from pediatric to adult specialists, thus limiting follow-up into the period when sexual activity is likely to occur;

> assessment of cosmetic outcomes by surgeons who may be biased to approve of their own 'work' … and difficulty assessing sexual function and behavior in young adults. (p. 6)

Many of these 'barriers to complete reporting' of adverse outcomes are likely to apply to circumcision as well, although the matter has not been adequately studied to date. This lack of direct and comprehensive research into the issue calls for still further caution in interpreting available estimates of circumcision-related complications.

8. Indeed, the CDC working group mistakenly listed the El Bcheraoui et al. (2014) paper twice – as references 158 and 164 – in its background report (CDC, 2014b), and as one of only 15 highlighted references in the shorter recommendation document (CDC, 2014a).

Disclosure statement

Both authors have published articles and taken part in national and international debates concerning health-related, sexual, and ethical aspects of male and female circumcision. From a medical ethics perspective, they are generally sceptical about the advisability of performing non-therapeutic genital surgeries on minor children.

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CIRCUMCISION, SEXUAL EXPERIENCE, AND HARM

BRIAN D. EARP AND ROBERT DARBY*

ABSTRACT

Surgically modifying the genitals of children – female, male, and intersex – has drawn increased scrutiny in recent years. In Western societies, it is illegal to modify the healthy genitals of female children in any way or to any extent in the absence of a strict medical indication. By contrast, modifying the healthy genitals of male children and intersex children is currently permitted. In this journal in 2015, Stephen R. Munzer discussed a controversial German court case from 2012 (and its aftermath) that called into question the legal status of nontherapeutic male circumcision (NTC), particularly as it is carried out in infancy or early childhood. Whether NTC is legal before an age of consent depends partly upon abstract principles relating to the best interpretation of the relevant laws, and partly upon empirical and conceptual questions concerning the degree to which, and ways in which, such circumcision can reasonably be understood as a harm. In this article, we explore some of these latter questions in light of Professor Munzer's analysis, paying special attention to the subjective, personal, and individually and culturally variable dimensions of judgments about benefit versus harm. We also highlight some of the inconsistencies in the current legal treatment of male versus female forms of nontherapeutic childhood genital alteration, and suggest that problematically gendered assumptions about the sexual body may play a role in bringing about and sustaining such inconsistencies.

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1. INTRODUCTION

In a recent article in this journal, Stephen R. Munzer provided a nuanced and fair-minded discussion of the ongoing moral, legal, and medical controversy surrounding the nontherapeutic circumcision ("NTC") of male infants and children.[1] His focus was on the Cologne ruling of 7 May 2012, which held that it is a criminal offense under the German Basic Law (Grundgesetz) to circumcise a male minor unless it is medically indicated[2] (a decision that was subsequently nullified by the passage of a special law by the German legislature).[3] In his analysis of the ruling and its political aftermath, Professor Munzer emphasized the sharply contrasting perspectives that have come to characterize this at times "uncivil" debate.[4] In this article, we shall highlight some of the key issues raised by Munzer that in our judgment deserve further attention. We focus in particular on the sexual implications of NTC and on the subjective elements of judgments about harm.

1.1. Risk and Personal Preference

Much of the controversy surrounding NTC concerns the extent to which, and ways in which, it may reasonably be understood as a harm. Although we will touch on some of the ongoing scientific disputes about the positive and negative physical consequences of NTC (chiefly claimed health

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[1] Stephen R. Munzer, *Secularization, Anti-minority Sentiment, and Cultural Norms in the German Circumcision Controversy*, 37 U. PA. J. INT'L. L. 503 (2015). For introductions to the controversy by the present authors, *see generally* Brian D. Earp & Robert Darby, *Does Science Support Infant Circumcision?* THE SKEPTIC (2014), *available at* https://www.academia.edu/ 9872471/Does_ science_support_infant_circumcision; Brian D. Earp, *The Ethics of Infant Male Circumcision*, 39(7) J. MED. ETHICS 418 (2013).

[2] No. 151 Ns 169/11, Landgericht Köln [LG Köln] [Regional Court of Cologne] May 7, 2012, NEUE JURISTISCHE WOCHENSCHRIFT [NJW], 2128. As Jan F. Orth explains, "Regional Courts *(Landgerichte)* in Germany have chambers for criminal and civil law cases, both as court of first instance and as court of appeals. In this case, the chamber acted as a court of appeals." Jan F. Orth, *Explaining the Cologne Circumcision Decision*, 77 J. CRIM. L. 497, 497 (2013).

[3] For discussion, *see generally* Diana Aurenque & Urban Wiesing, *German Law on Circumcision and Its Debate: How an Ethical and Legal Issue Turned Political*, 29 BIOETHICS 203, 203–10 (2015); Reinhard Merkel & Holm Putzke, *After Cologne: Male Circumcision and the Law: Parental Right, Religious Liberty or Criminal Assault?* 39(7) J. MED. ETHICS 444, 444-49 (2013).

[4] *See* Roger Collier, *Ugly, Messy and Nasty Debate Surrounds Circumcision*, 184(1) C.M.A.J. E25-E26, E25 (2012) (discussing polarized attitudes and the resulting "uncivil debate" surrounding male circumcision).

benefits versus surgical complications), these will not be the focus of our discussion. Instead, we shall argue that "new medical evidence on the risks and benefits of circumcision" is unlikely to provide compelling grounds for "an empirical refutation"[5] of either of the principle stances on NTC: namely, that the procedure is on balance harmful as opposed to beneficial.

Why do we think that new medical evidence is unlikely to settle such disagreement? First, it is apparent that the scientific literature in this area is itself highly politicized,[6] showing signs of polarization[7] as well as personal, ideological, and cultural biases[8] among many of those responsible for

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[5] Munzer, *supra* n.1, at 532.

[6] *See, e.g.*, Peter Aggleton, *"Just a Snip"? A Social History of Male Circumcision*, 29 REPROD. HEALTH MATTERS 15, 15 (2007) (questioning "the value neutrality of an act so profound in its social significance and so rich in meaning" and highlighting "how male circumcision – like its counterpart female genital mutilation – is nearly always a strongly political act, enacted upon others by those with power"); Sara Johnsdotter, *Discourses on Sexual Pleasure After Genital Modifications: the Fallacy of Genital Determinism (a Response to J. Steven Svoboda)*, 3(2) GLOB. DISC. 256, 256 (2013) (demonstrating that "medical statements about effects [of circumcision] on sexual pleasure are associated with politics").

[7] *See, e.g.*, Kirsten Bell, *HIV Prevention: Making Male Circumcision the 'Right' Tool for the Job*, 10(5-6) GLOB. PUBLIC HEALTH 552, 552 (2015) (stressing "the need to expand the parameters of the debate beyond the current polarised landscape, which presents us with a problematic either/or scenario regarding the efficacy of male circumcision"); Brian D. Earp, *Addressing Polarisation in Science*, 41(9) J. MED. ETHICS 782, 782-83 (2015) (using the literature on male circumcision as an example of polarization in science).

[8] *See, e.g.*, Jennifer A. Bossio, et al., *A Review of the Current State of the Male Circumcision Literature*, 11(12) J. SEX. MED. 2847, 2848 (2014) (stating that "[t]he literature documenting the risks and benefits associated with neonatal circumcision is often influenced by author biases"); Jennifer A. Bossio, et al., *Response to: The Literature Supports Policies Promoting Neonatal Male Circumcision in N. America*, 12(5) J. SEX. MED. 1306, 1306 (2015) (noting the "high risk of bias" in an oft-cited review article "introduced by the authors' well documented, unconditional support of the practice of circumcision"); Morten Frisch et al., *Cultural Bias in the AAP's 2012 Technical Report and Policy Statement on Male Circumcision*, 131(4) PEDIATR. 796, 796 (2013) (stating that "cultural bias reflecting the normality of nontherapeutic male circumcision in the United States seems obvious," which may explain why the conclusions expressed in the American Academy of Pediatrics' 2012 statement on circumcision "are different from those reached by physicians in other parts of the Western world, including Europe, Canada, and Australia"); Ronald Goldman, *Circumcision Policy: A Psychosocial Perspective*, 9(9) PAEDIATR. & CHILD HEALTH 630, 630 (2004) (speculating that "conflicting opinions and conclusions in the medical literature … together with the tenacity with which advocates and critics of circumcision hold on to their viewpoints, suggest that deep, unrecognized or implicit psychosocial factors are involved"); Andries J. Muller, *To Cut Or Not To Cut? Personal Factors Influence Primary Care Physicians' Position on Elective Newborn Circumcision*, 7 J. MEN'S HEALTH 227, 227 (2010) (reporting the results of a survey of 572 doctors, finding that "[a]lthough most respondents stated that they based their decisions on medical evidence, the circumcision status of, especially, the male respondents played a huge role in whether they were in support of circumcisions or not. Another factor that had an influence was the circumcision status of the respondents' sons"); Brian D. Earp & David M. Shaw, *Cultural Bias in American Medicine: The Case of Infant Male Circumcision*, J. PEDIATR. ETHICS (in press) (for a general discussion).

producing and interpreting the relevant research and turning it into policy.[9] This can, at times, make it difficult, if not impossible, to determine what "the evidence" really suggests. But suppose that were not the case, and there were instead an agreed-upon set of "objective" facts concerning the likelihood of various physical and non-physical consequences of NTC, under whatever specified conditions. Still, one could not settle the question of how each benefit or risk should be characterized, much less weighted, in terms of subjective factors including the affected male's preferences and values. To illustrate this idea, take the concept of risk. Philosopher Scott Campbell argues,

> one of the components of risk is harm. This is the level of badness or loss associated with the occurrence of x. Harm does not just include physical injury but any sort of circumstance that P would prefer not to be the case. If there is nothing bad about x at all then P is not at risk from x. This entails that our attitudes and preferences partly determine risk, because our attitudes and preferences determine what counts as a harm.[10]

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[9] Such biases arguably point in both directions. *See, e.g.*, Jennifer A. Bossio, et al., *Re: Examining Penile Sensitivity in Neonatally Circumcised and Intact Men Using Quantitative Sensory Testing*, 195 J. UROL. 1848, 1852-53 (2016) (stating that their findings should not be interpreted as supporting "either the pro or anti-circumcision 'camp'" and that "[o]ne does not have to search far for [personal] biases in the circumcision literature, such as frequent references to non-peer-reviewed articles and author involvement in anti or pro-circumcision advocacy groups"). *See also* AAP, *Cultural Bias and Circumcision: The AAP Task Force on Circumcision Responds*, 131(4) PEDIATR. 801, 801 (2013) (stating that their critics "hail from Europe, where the vast majority of men are uncircumcised and the cultural norm clearly favors the uncircumcised penis [and there] is a clear bias against circumcision"). In response to this contention, however, *see* Brian D. Earp, *The AAP Report on Circumcision*, PRACTICAL ETHICS (2012), *available at* https://www.academia.edu/15617255/The_AAP_report_on_circumcision_Bad_science_bad_ethics_bad_medicine (pointing out that being "biased" against medically unnecessary surgeries performed on nonconsenting minors is usually regarded as the default position in Western medicine, regardless of a doctor's country of origin).

[10] Here P refers to a person and x to an action or occurrence. The quote is from Scott Campbell, *Risk and the Subjectivity of Preference*, 9 J. RISK RES. 225, 226-27 (2006). Campbell then emphasizes the objective nature of certain harms, once the subjective preferences are known: "It is true that risk is subjective in the sense that it depends upon our preferences … risk is not independent of minds and cultures." But once one's preferences are known, "then whether there exists a risk, and how much of a risk there is, is a matter of objective fact." Suppose that action A could lead to x, where x is something contrary to your preferences, and therefore a harm to you. It follows from this proposition that "it is a fact about the world that in doing A, you risk x. … It would be misleading to say that such a fact is purely subjective. Given that person P regards x as a harm and that A could lead to x, it is then an objective fact about the world that P runs the risk of x in doing A." *Id.*, at 227-28.

Note that something could be bad for a person even if he does not prefer that the circumstances were different: for example, his preferences could be tied to a gross misunderstanding about the state of the world.[11] But assuming he is reasonably well-informed, and that his preferences fall within some rationally defensible spectrum, his own assessment of whether x poses a risk to him—and, if it does, the nature and degree of the risk—must be factored into the equation.[12] As Campbell states, in many cases, we "cannot determine whether or not x is a risk" without first taking stock of people's preferences.[13]

But preferences vary between groups and individuals. In the case of NTC, sources of variance include people's tolerance for certain kinds of risk compared to others (and related attitudes concerning available risk-management strategies), judgments about the real-world importance of alleged benefits or risks, and assessments of their personal relevance given one's habits and circumstances. Preferences may also vary over time as people are exposed to different perspectives, form new impressions, or process additional information.

In short, there is a fundamentally unstable, personal dimension to assessments of benefit versus risk (which we take to mean "prospect of benefit" versus "risk of harm" for the purposes of this analysis).[14] This subjective element is especially pertinent to childhood NTC since it involves

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[11] Some risk theorists are objectivists about harm, at least in certain cases. Campbell notes that "it may not always be the case that harm is just a matter of people's own preferences. For example, suppose P wishes to commit an act of self-mutilation. Is there no harm to P in carrying out such an action just because it is in accordance with P's own wishes?" Some moral philosophers and others say no. "They would claim that P's self-mutilation is a harm for P, regardless of whether or not he (or anyone else) realizes it" (Campbell, *supra* n.10, at 229). That Campbell chooses "mutilation" to make his point is telling; indeed, the laceration or removal of non-diseased, functional bodily tissue—which is what we assume he means by "mutilation" in this context—is the very sort of thing that many people do regard as in-and-of-itself a harm. We will not, however defend this view in the present essay. Instead, we shall simply try to show that it is reasonable for a man to regard someone else's having cut off his foreskin when he was an infant or young child as a harm (i.e., something contrary to his considered preferences).

[12] We are using the masculine pronoun in this paragraph because the topic of discussion is male circumcision; however, the argument applies regardless of sex or gender.

[13] Campbell, *supra* n.10, at 227-228.

[14] *See* Robert Darby, *Risks, Benefits, Complications and Harms: Neglected Factors in the Current Debate on Non-Therapeutic Circumcision*, 25(1) KENNEDY INSTITUTE OF ETHICS J. 1(2015) (emphasizing that the term "risk" in biomedical ethics is usually taken to mean risk of any type of harm, physical or non-physical, and not just the risk of surgical complications, as implicitly assumed in the 2012 circumcision policy of the American Academy of Pediatrics).

the involuntary surgical alteration of a psychosexually significant part of the body—the penis. Needless to say, individual attitudes concerning the aesthetics of the penis, whether surgically modified or natural, as well as the sensual and symbolic significance of the organ, vary considerably both within and between cultures. Moreover, the state of one's genitals, circumcised or intact, can inspire strong emotions relating to one's sexuality, self-image, and self-esteem.[15] It is for these reasons that we shall emphasize the sexual implications of NTC in our discussion.

1.2. Science, Sex, and Subjectivity

In discussing these implications, we adopt a skeptical attitude toward the prospect of assessing them scientifically, much less applying them universally.[16] In this regard, we are sympathetic to the view of Juliet Richters, who notes that "[a]rguments about circumcision reveal something of the limitations of evidence-based medicine. They can tell us how many circumcisions are necessary to prevent one case of penile cancer (about 1000),

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[15] As physician Thomas Ritter suggests: "Males in particular, because of their convex genital makeup, visually confront, and probably assess, their penises many times a day. Daily the male awakens with an erection. The penis must be touched when washing, dressing, and directing the urinary stream," and when conducting other aspects of his daily routine. "A man usually regards his penis as an extremely valued possession, and in its frequent perusal, cannot fail to associate with it emotions, reminiscences, and possible fantasies." Thomas J. Ritter, *Foreword* to ROSEMARY ROMBERG, CIRCUMCISION: THE PAINFUL DILEMMA, vii, vii-ix (Bergin and Garvey, 1985).

[16] Please note that such purported assessments often are applied universally in both the empirical and policy literatures. *See* Bossio, et al., *Review of Male Circumcision Literature*, *supra* n.8, at 2847-64. As these authors note, there are "important problems with using men who undergo circumcision as adults to draw conclusions about the impact of the procedure on sexual functioning" generally. In North America, for example, most circumcisions occur in neonates, and the effects of undergoing circumcision at this age compared to adulthood "are unknown with regard to factors such as pain perception, penile sensitivity, and sexual functioning." Moreover, many of the participants in the studies the authors review "consisted of nonrandom samples of men who had undergone circumcision to correct medical or sexual issues involving their genitals." But in such self-selected samples, "self- reported outcomes are likely to be heavily biased by the men's own decisions to have the procedure." It is therefore problematic that when "policy statements about neonatal circumcision take sexual functioning into account, they primarily cite articles with the methodological shortcomings" just discussed: "the populations that compose the current research in the area of circumcision and sexual functioning are not comparable to the typical healthy, neonatally circumcised male in North America." *Id.*, at 2853.

but they cannot [adequately] engage with the subjective experiences of the sexual body."[17]

> And yet such experiences are crucial for making intelligible judgments of benefit versus harm, while at the same time being highly individualized: they may be quite different from person to person even if the "objective" outcomes of circumcision are held constant for the sake of analysis. As Sara Johnsdotter argues, "[w]hile genitalia usually are central to sexual activity, and can be seen as a prerequisite for sexual intercourse, it is a misapprehension to see the state of them (cut or uncut) as determinative of the individual's experience of the sexual encounter."[18]

Below, we will provide evidence that many men, including a substantial number of men from majority-circumcising cultures or sub-cultures, regard themselves as being sexually or otherwise harmed by circumcision. This perception of harm often exists even in the absence of surgical complications or other commonly acknowledged "medical" risks of circumcision:[19] the men feel harmed simply by virtue of having had their foreskins removed, especially without their consent.[20] This response is due to two main factors: first, the positive value the men assign to the notion or embodied state of genital intactness or wholeness, as well as to the foreskin itself (a structure lost to circumcision by design); and second, the negative value they assign to various outcomes of circumcision that are intrinsic to the procedure. These outcomes include the denuded appearance of the penis (or the appearance of its scar tissue), changes in external tactile properties of the

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[17] Juliet Richters, *Bodies, Pleasure and Displeasure*, 11(3) CULT. HEALTH SEX. 225, 229 (2009). Note that the figure on cancer provided by Richters is one of the lowest available estimates; others range as high as 322,000 (see the discussion of penile cancer *infra*).

[18] Johnsdotter, *supra* n.6, at 264.

[19] This perception of harm in the absence of medical problems has led some commentators to conclude that such judgments are misguided or out of proportion. For example, Ronald A. Lindsay has recently stated that "agonizing over the loss of a foreskin is an unwarranted, excessive reaction." Ronald A. Lindsay, *Male Circumcision and Self Determination*, HUFFINGTON POST (Dec. 13, 2016), *available at* http://www.huffingtonpost.com/ronald-a-lindsay/male-circumcision-and-sel_b_13600924.html. In contrast, we shall try to show that such feelings are not necessarily unwarranted or excessive, in part by drawing analogies to other cases.

[20] For evidence and extensive discussion, *see generally* Tim Hammond & Adrienne Carmack, *Long-term Adverse Outcomes from Neonatal Circumcision Reported in a Survey of 1,008 men: An Overview of Health and Human Rights Implications*, INT'L. J. HUM. RTS. (in press).

head of the penis that are brought about by circumcision, the foreclosure of the ability to experience sex with surgically unmodified genitalia (i.e., to engage in sexual activities that require manipulation of the foreskin), and the loss of personal choice concerning a very "private" part of the body.[21]

By contrast, other men regard themselves as being sexually (or otherwise) enhanced by virtue of having been circumcised, due to a different set of attitudes and values. For example, where circumcision is culturally normative, the foreskin might be presumed to be of limited or no intrinsic or instrumental value, or even of negative value, such that its loss to circumcision would be less likely to be construed as in-and-of-itself a harm.[22]

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[21] It is sometimes argued, correctly, that infants and young children do not have free choice with respect to many important aspects of their lives. But it is also true that there are certain restrictions that societies may place on the actions parents may permissibly take or authorize with respect to their children—particularly when it comes to permanent modifications of the child's body. For example, in some jurisdictions, parents may not authorize the tattooing of a child's body, even when the child requests it and the parents believe that it would be in the child's best interests. As barrister James Chegwidden notes, "the common law is very cautious before treating children's consent as justifying any non-therapeutic body alteration." In the decision of *Burrell v Harmer* [1967] Crim LR 169 (UK), for instance, "a tattoo artist was convicted of assault following his tattooing of two boys aged 12 and 13, *despite* their consent. The court observed that if a child [was] '*unable to appreciate the nature of an act, apparent consent to it was no consent at all*.' It held that such was the case with tattooing, since children are likely not to foresee the long-term consequences." James Chegwidden, *Response: Tasmanian Law Reform Institute Issues Paper No. 14: Non-therapeutic Male Circumcision* 1, 17-18 (n.d. [2009]). As Chegwidden goes on to note, the specific grounds given in the ensuing Parliamentary debates for a ban on tattooing before the age of 18 "apply almost *identically* to the arguments voiced about circumcision, namely:

- The existence of persons who later regret having the procedure done;
- The difficulty of reversing the procedure;
- The danger of infections and other complications arising from the tattooing procedure;
- The damage to the tattooed person's social integration and sometimes, to their feelings of self-worth;
- The embarrassment felt by those tattooed who later regret it;
- The unhygienic conditions in which some tattooing is performed.

Circumcision has not yet come under the same scrutiny as tattooing. But the logic behind the latter's banning is undeniably relevant to the former." *Id.* at 18. In addition, in Western societies, parents may not legally cut into, much less remove, any part of a female child's genitalia when it is deemed medically unnecessary to do so, including forms of such cutting or removal of tissue that are less physically invasive than the most common forms of male circumcision (see later discussion). Consequently, in order to determine whether any particular nontherapeutic alteration of a child's body is acceptable, it is necessary to triangulate between analogous cases to determine where the limits lie. By contrast, simply pointing out that infants and young children do not have the ability to make free choices, and that certain of their future options are regularly foreclosed upon as a part of normal (and even reasonable) parenting, is insufficient to draw justified conclusions about the permissibility of any particular action taken toward a child.

[22] *See infra*, Section 3.2.

But whatever the case, individual differences in circumcision-related body-image appraisals can affect one's sexual experiences in significant ways. Combined with differences in subjective weightings of the various other alleged benefits and risks of NTC, such appraisals pose a challenge for this debate. Specifically, they pose a challenge to any legal analysis that presumes the possibility of an "empirical refutation" of an asserted ratio of benefit to harm.

To frame this challenge, we begin by discussing the role of harm judgments generally in legal reasoning, with an emphasis on their "open textured" nature.[23] This nature goes a long way toward explaining the contradictory conclusions that are often drawn about the harmfulness of NTC. Then, to explore the sexual dimensions of this potential harmfulness, we describe some of the specific ways in which circumcision changes the penis, emphasizing the range of possible surgical, anatomical, and other outcomes. Following that, we share several personal accounts from men who have had differing responses to such penile alterations.

We will also discuss some of the benefits, both medical and non-medical, that have been attributed to circumcision. To this end, we explore how men may reasonably reach different conclusions about the importance or even relevance of those benefits, given alternative means of achieving them. Along the way, we reflect on the problem of uncertainty regarding whether a boy who is circumcised in infancy or early childhood will grow up to view himself as having been enhanced by circumcision, as opposed to diminished by it or even mutilated. In this regard, we emphasize the very intimate nature of the genitalia, as well as the temporal and geographic instability of the cultural, social, and other norms that typically influence such personal evaluations. Given such unstable conditions, we conclude that, in most cases, the balance of considerations weighs in favor of avoiding NTC in infancy or early childhood. In this way, each individual can perform his own risk-benefit analysis at an age of understanding, factoring in his personal preferences and values.

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[23] *See infra*, Section 2.1.

Finally, we draw attention to the current legal disparity in protections afforded to male versus female children when it comes to nontherapeutic genital alterations. Although we do not draw any hard and fast conclusions about how these disparities should be addressed, we do maintain that the *status quo* is untenable.

2. THE QUESTION OF HARM

Is circumcision, at least on balance, harmful? In addressing this question, Professor Munzer discusses the work of Dr. Bijan Fateh-Moghadam, who was critical of the Cologne decision. In Dr. Fateh-Moghadam's view, the "risk-benefit ratio of circumcision is acceptable," and therefore "parental consent to circumcision lies within the scope of the parents' discretion."[24] Of course, judgments about the acceptability of this ratio are likely to differ between reasonable people, and the claimed ratio itself may change with the shifting tides of scientific opinion. Nevertheless, according to Munzer, "[b]e the test acceptability or some other standard, Fateh-Moghadam's argument could be vulnerable to an empirical refutation."[25]

The idea that the acceptability of circumcision rests on a refutable empirical contention has significant historical precedent. In a 1890s treatise on the cultural, religious, and medical aspects of circumcision, the German Jewish physician Abraham Glassberg advocated circumcision of infants as a health precaution, but also conceded that if circumcision were shown to be harmful it would be necessary for the state to intervene.[26] Other defenders of cultural/religious circumcision have similarly proposed that, since circumcision was not at all harmful, not harmful on balance, or not harmful

[24] As summarized by Munzer, *supra* n.1, at 531.
[25] *Id.* at 532.
[26] *See* LEONARD GLICK, MARKED IN YOUR FLESH: CIRCUMCISION FROM ANCIENT JUDAEA TO MODERN AMERICA 134-36 (2005).

enough to warrant interference with parental prerogatives or traditional customs, it should remain unrestricted.[27]

The question of harm, then, has become central to the debate over the ethical and legal permissibility of circumcision. While critics of the practice often argue that it is harmful by its very nature–seeing the non-consensual loss of functional tissue as a sufficient condition for harm–or harmful on balance by virtue of its average consequences, defenders often suggest that the procedure does not cause or constitute harm except in the case of surgical mishaps. Some supporters go even further and claim that it is highly beneficial,[28] at least socially or spiritually if not necessarily physically.[29] Despite this disagreement, however, both sides appear to believe that there is one right answer to the question: either circumcision is harmful or it is not harmful, and—if one sets aside claims about intrinsic harm—"the evidence" will show us which is correct.

But there are difficulties with this way of framing the issue. First, as we have noted, "the evidence" is itself highly politicized and strenuously contested. Second, there are no universally agreed-upon benchmarks for defining harm or setting a harm threshold beyond which state interference

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[27] *See, e.g.*, Michael Benatar & David Benatar, *Between Prophylaxis and Child Abuse: The Ethics of Neonatal Male Circumcision*, 3(2) AM. J. BIOETH. 35 (2003) (arguing that since the benefits and harms of circumcision are balanced in their judgment, it is reasonable for parents to make the decision); Joseph Mazor, *The Child's Interests and the Case for the Permissibility of Male Infant Circumcision*, 39(7) J. MED. ETHICS 421 (2013) (suggesting that the balance of benefits and risks is close enough to permit parental choice, while conceding that if circumcision is not being carried out to fulfill a perceived religious obligation, the balance of interests most likely weighs against the procedure); AAP, *Circumcision Policy Statement*, 130 PEDIATR. 585 (2012) (asserting that the benefits of circumcision outweigh the risks and that parents should therefore be able to decide).

[28] *See, e.g.*, Brian J. Morris, *Why Circumcision is a Biomedical Imperative for the 21st century*, 29 BIOESSAYS 1147, 1147 (2007) (claiming that NTC "represents a surgical 'vaccine' against a wide variety of infections, adverse medical conditions and potentially fatal diseases over [the boy's] lifetime" providing "enormous public health benefits"). Professor Morris is probably the most vocal contemporary proponent of circumcision on health grounds; his publications are also generally regarded as among the most controversial. *See, e.g.*, Barry Lyons, *Male Infant Circumcision as a "HIV Vaccine,"* 6 PUBLIC HEALTH ETH. 90, 91 (2013) (criticizing the vaccine analogy and noting that "no western representative medical organization" agrees with Morris's extreme views).

[29] The latter claim functions as an escape valve: even if circumcision did entail harms, they would be outweighed by the sundry benefits. *See, e.g.*, Allan J. Jacobs & Kavita S. Arora, *Ritual Male Infant Circumcision and Human Rights*, 15(2) AM. J. BIOETH. 30 (2015) (making the claim that any harms that might be associated with NTC are compensated for or overbalanced by various medical and non-medical benefits).

would be justified. Third, any weighing of particular harms and benefits—even if their existence were undisputed and their likelihood precisely estimated—would result in different conclusions depending on one's starting assumptions, preferences, and values. Finally, as we explain in the following section, the very concept of "harm" lends itself to wide-ranging interpretations as to its meaning and proper scope of application.

2.1. Harm as an Open Textured Concept

That contradictory assertions have been made about the harmfulness of circumcision, often seemingly in good faith by proponents and critics alike, should come as no surprise. According to one widely accepted view, harm is an "open textured concept,"[30] a term introduced by the legal philosopher H. L. A. Hart. As Kwame Anthony Appiah has suggested, such concepts may be at play when "two people who both know what [the words they are using] mean can reasonably disagree about whether they apply in particular cases."[31] Hart argues that legal decisions depend upon the application of rules, which in turn depend on the interpretation of terms whose range of applicability is uncertain and often influenced by the values and interests of the parties to the discussion. He uses the simple example of a law that prohibits vehicles from entering a public park - which immediately raises the question of what counts as a vehicle. Does it include bicycles, skateboards, golf buggies, baby strollers, or children's pedal cars? The law cannot specify all the possible objects to be covered by the rule, so it is left to the courts to determine whether skateboards or golf buggies, for example, are vehicles and hence whether their operators are breaking the law by entering the park.

Interpretations of open texture terms can almost always be challenged, and lengthy legal appeals have arisen from disputes over the ambit of terms such as vehicle, structure, fair wages, reasonable price, and safe working conditions. Indeed, some expressions that bear more directly on the present issue of contested interventions into children's bodies—such as the oft-

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[30] H. L. A. HART, THE CONCEPT OF LAW 124-36 (3d ed. 2012) (1961).
[31] KWAME ANTHONY APPIAH, COSMOPOLITANISM: ETHICS IN A WORLD OF STRANGERS 58 (2007).

invoked "best interests" standard—are about as open textured as possible, and they have given rise to diverse interpretations, depending on, *inter alia*, the cultural presuppositions of the parties to the debate.

This influence of culture can be seen most vividly in the related case of ritualized female genital cutting, as discussed by Munzer.[32] This practice, or rather set of practices, is primarily seen by Western observers as being unambiguously harmful, "repugnant," and "intolerable."[33] But as Robert S. Van Howe has pointed out, "there are practitioners, especially in cultures where female circumcision is common, who fervently believe that [even the] more invasive forms of female circumcision … do not pose risks of physical or psychological harm."[34] This difference in perspective could be taken to suggest that culturally variant background assumptions—perhaps bolstered by conscious or unconscious "motivated cognitions"[35] aimed at reducing

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[32] Note that the World Health Organization uses the term "FGM" for Female Genital Mutilation, which is also the term employed by Munzer. But, among scholars of ritual genital cutting practices, this term has fallen out of favor for several reasons including its lack of value-neutrality. For discussions, *see generally* Dena S. Davis, *Male and Female Genital Alteration: A Collision Course With the Law*, 11 HEALTH MATRIX 487 (2001); Fuambai S. Ahmadu, *Why the Term Female Genital Mutilation Is Ethnocentric, Racist and Sexist – Let's Get Rid of It!*, HYSTERIA (2016), *available at* http://www.hystericalfeminisms.com/why-the-term-female-genital-mutilation-fgm-is-ethnocentric-racist-and-sexist-lets-get-rid-of-it/ (last visited Sept. 24, 2016). Increasingly, "FGC" for "Female Genital Cutting" or "FGA" for Female Genital Alteration(s) are the preferred terms. "Female circumcision" is sometimes employed as well.

[33] Munzer, *supra* n.1., at 561. For recent scholarship challenging this perspective as overly simplistic, *see generally* Public Policy Advisory Network on Female Genital Surgeries in Africa, *Seven Things to Know About Female Genital Surgeries in Africa*, 42(6) HASTINGS CENTER REP. 19 (2012); Richard A. Shweder, *The Goose and the Gander: The Genital Wars*, 3(2) GLOB. DISC. 348 (2013); Richard A. Shweder, *What About "Female Genital Mutilation"? And Why Understanding Culture Matters in the First Place*, 129(4) DAEDALUS 209 (2000); Brian D. Earp, *Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on "FGM,"* 26(2) KENNEDY INSTITUTE OF ETHICS J. 105 (2016); L. Amede Obiora, *Bridges and Barricades: Rethinking Polemics and Intransigence in the Campaign Against Female Circumcision*, 47 CASE W. RES. L. REV. 275 (1996); GENITAL CUTTING AND TRANSNATIONAL SISTERHOOD: DISPUTING US POLEMICS (Stanley M. James & Claire C. Robertson eds., 2002).

[34] Robert S. Van Howe, *The American Academy of Pediatrics and Female Genital Cutting: When National Organizations Are Guided by Personal Agendas*, 27(3) ETHICS & MED. 165, 167 (2011).

[35] One form of motivated reasoning is what Dan Kahan refers to as "cultural cognition:" namely, "the tendency of individuals to conform their perceptions of risk and other policy-consequential facts to their cultural worldviews." Dan M. Kahan, *The Supreme Court 2010 Term - Foreword: Neutral Principles, Motivated Cognition, and Some Problems for Constitutional Law*, 125 HARV. L. REV. 1, 23 (2011). For related discussions, *see generally* Adel S. Z. Abadeer, *Cognitive Dissonance and Gender Discrimination* in NORMS AND GENDER DISCRIMINATION IN THE ARAB WORLD 115 (2015); Cory J. Clark et al., *Moral Coherence Processes: Constructing Culpability and Consequences*, 6 CURRENT OPINION IN PSYCHOLOGY 123 (2015); Brian D. Earp, *'Legitimate Rape,' Moral Coherence, and Degrees of Sexual Harm*, 14(41) THINK 9 (2015).

cognitive dissonance—have the potential to stretch one's perceptions or interpretations of harm to a significant degree.[36] Moreover, when the purported social and cultural benefits of female circumcision are factored into the equation—including, in some groups, perceived aesthetic enhancement,[37] beliefs about improved cleanliness, and greater acceptance by one's peers and elders[38]—"practitioners could easily convince themselves that any harm is more than offset by the many perceived benefits."[39]

Dictionary definitions will not resolve such disagreements. The Shorter Oxford English Dictionary, for example, defines harm as "hurt, injury, damage, mischief."[40] Most people across a range of cultural settings would agree these things are bad, and often bad enough to warrant legal sanction. But the question of whether these terms are applicable to—or accurate descriptions of—any particular practice, such as nontherapeutic male or female genital cutting, requires deeper reflection, and, ultimately, heavily value-laden judgments.

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[36] In a classic study from 1964, Speisman and colleagues showed participants a film of what they call "primitive adolescent 'subincision' rites" (a relatively extreme form of ritualized male genital cutting), but manipulated how the film was framed by playing three different soundtracks (designed to influence participants' mindsets while watching the films) and comparing stress responses to a silent control condition. "The findings supported the importance of the process of cognitive appraisal [in] producing stress reactions, permitting the conclusion that the same visual stimulus varies in the amount of stress produced depending upon the nature of the cognitive appraisal the person makes." Jospeh C. Speisman et al., *Experimental Reduction of Stress Based on Ego-defense Theory*, 68(4) J. ABNORM. & SOC. PSYCHOL. 367, 367 (1964).

[37] *See, e.g.*, Lenore Manderson, *Local Rites and Body Politics: Tensions Between Cultural Diversity and Human Rights*, 6(2) INT'L FEMINIST J. POL. 285 (2004); Fuambai S. Ahmadu & Richard A. Shweder, *Disputing the Myth of the Sexual Dysfunction of Circumcised Women: An Interview with Fuambai S. Ahmadu by Richard A. Shweder*, 25(6) ANTHROPOL. TODAY 14 (2009).

[38] Bettina Shell-Duncan, et al., *Dynamics of Change in the Practice of Female Genital Cutting in Senegambia: Testing Predictions of Social Convention Theory*, 73(8) SOC. SCI. MED. 1275 (2011). These authors present original data suggesting that, in Senegal and the Gambia at least, "being circumcised serves as a signal to other circumcised women that a girl or woman has been trained to respect the authority of her circumcised elders and is worthy of inclusion in their social network. In this manner, FGC facilitates the accumulation of social capital by younger women and of power and prestige by elder women." *Id.* at 1275.

[39] Van Howe, *supra* n.34, at 167. For further discussion, *see generally* J. Steven Svoboda, *Promoting Genital Autonomy by Exploring Commonalities Between Male, Female, Intersex, and Cosmetic Female Genital Cutting*, 3(2) GLOB. DISC. 237 (2013); British Medical Association, *The Law and Ethics of Male Circumcision: Guidance for Doctors*, 30(3) J. MED. ETHICS 259 (2004).

[40] NEW SHORTER OXFORD ENGLISH DICTIONARY 1191 (Oxford: Clarendon Press, 1993).

2.2. A Legal Framework

In a legal context, there are several plausible frameworks for guiding such judgments, one of which comes from the work of Joel Feinberg. In his analysis of the moral limits of criminal law, Feinberg (whose influential "open future"[41] principle is also discussed by Munzer) defines harm as a "setback to interests." Interests, in turn, are glossed as ordinary desiderata shared by most people: "[t]he interests in one's own physical health and vigour, the integrity and normal functioning of one's body, the absence of absorbing pain and suffering or grotesque disfigurement … the absence of groundless anxieties and resentments, the capacity to engage normally in social intercourse and to enjoy and maintain friendships."[42]

Feinberg explains that despite their everyday nature, these interests are "the very most important interests a person has, and cry out for protection, for without their fulfillment a person is lost. … These minimal goods can be called a person's welfare interests. When they are blocked or damaged, a person is very seriously harmed."[43] Because these interests are so important, their violation falls properly within the domain of criminal law. Significantly, he adds that "[i]mpairment of function … is the most common form of a setback to welfare interests, and perhaps the mode characteristic of the most serious harms to persons."[44]

Functions are impaired "[w]hen they are weakened and lose their effectiveness. A broken arm is an impaired arm, one which has (temporarily) lost its capacity to serve a person's needs effectively, and in virtue of that impairment its possessor's welfare interest is harmed."[45] A person who deliberately breaks another person's arm will appropriately be prosecuted for causing him harm, even though the injury (the impairment) is temporary and

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[41] For critical discussions, *see generally* Robert Darby, *The Child's Right to an Open Future: Is the Principle Applicable to Non-Therapeutic Circumcision?* 39 J. MED. ETHICS 463 (2013); Eldar Sarajlic, *Can Culture Justify Infant Circumcision?* 29(4) RES PUBLICA 327 (2014).
[42] JOEL FEINBERG, HARM TO OTHERS 36-37 (1984) (emphasis added).
[43] *Id.* at 37.
[44] *Id.*
[45] *Id.* at 53.

the arm is expected to heal. If, therefore, NTC results in any impairment of function, even if only temporarily, it may be legitimate—according to this line of thought—for the law to regulate, restrict, or even prohibit it in certain circumstances.[46] We will return to this point in Section 3.3.

Here, too, one will find subjective, individually variable judgments about what *counts* as a functional impairment, as well as about how and by whom such impairments should be assessed. But such judgments cannot be entirely free-floating: to be credible, they must be firmly tethered to an informed understanding of what is actually implied by the practice in question. Since much of the legal literature treats NTC as a vague abstraction,[47] with minimal or no description of surgery itself or the part of the penis it is designed to remove, we shall take some time to elucidate these matters in the following section. Once we have a grasp of what NTC involves and how the penis is altered by it in the typical case, we will be in a better position to

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[46] In determining whether an action is sufficiently harmful to warrant legal sanction, it is noteworthy that one of the leading cases in this area has set the threshold rather low. This is the "Spanner" case (Rex v. Brown et al., 1993), in which the British appeals court found that although the activities in question involved adults, were consensual, and resulted in no permanent physical damage, such sado-masochist encounters were unlawful because they resulted in "actual bodily harm" and "wounding." In the words of Lord Templeman, "[t]he appellants belonged to a group of sado-masochistic homosexuals who … willingly participated in the commission of acts of violence against each other, including genital torture, for the sexual pleasure which it engendered in the giving and receiving of pain. The passive partner or victim in each case consented to the acts being committed and suffered no permanent injury." R v Brown [1993] 2 All ER 75. For our purposes, the key point from this case is that the harms (here glossed as injuries) inflicted on the passive participants were temporary - whipping, beating, hot wax, some scratching and minor laceration of the skin. All participants recovered quickly, without the need for any medical attention. The injuries were, in fact, both less severe and less permanent than those entailed by infant or early childhood NTC, which, in addition to lacking the consensual character of the aforementioned activities, permanently removes functional, non-diseased bodily tissue, and not infrequently requires subsequent medical attention to deal with bleeding, infection, pain, and other complications. Thus, while an individual's own implicit understanding of the term "harm" (as well as its proper scope of applicability) may certainly vary between groups and individuals, there is some Western legal precedent for construing bodily injuries that are less extensive than male circumcision as being in-and-of-themselves harmful. Importantly, this is the case notwithstanding that various countervailing benefits are often also claimed for the actions causing the injuries (e.g., sadomasochistic pleasure). It is therefore curious that Templeman chose to comment in passing that ritual (male) circumcision—along with ear-piercing and violent sports—were lawful activities, without explaining the logical basis for these exceptions. (Note that this is an *obiter dictum*, having no bearing on the issue decided in the case, and is therefore not legally binding; the court was deciding on the lawfulness of consensual sadomasochism, not ritual circumcision).

[47] For a criticism of this tendency, *see, e.g.*, David P. Lang, *Circumcision, Sexual Dysfunction, and the Child's Best Interests: Why the Anatomical Details Matter* 39(7) J. MED. ETHICS 429 (2013).

understand the sharply differing attitudes that some men have about whether they have been harmed by the procedure.

3. WHAT DOES NTC INVOLVE AND HOW DOES IT CHANGE THE PENIS?

For the purposes of this analysis, NTC is defined as the deliberate removal of part or all of the penile prepuce (foreskin) in a healthy individual for whom there is no immediate medical indication for the procedure. As the pathologists Christopher Cold and John Taylor state:

> The prepuce is an integral, normal part of the external genitalia, that forms the anatomical covering of the glans penis ... The outer epithelium has the protective function of internalising the glans [as well as the] urethral meatus (in the male) and the inner preputial epithelium, thus decreasing external irritation or contamination. The prepuce is a specialized, junctional mucocutaneous tissue which marks the boundary between mucosa and skin; it is similar to the eyelids, labia minora, anus and lips. The male prepuce also [typically] provides adequate mucosa and skin to cover the entire penis during erection. The unique innervation of the prepuce establishes its function as an erogenous tissue.[48]

The foreskin thus has two layers—the inner and outer epithelia—which, when unfolded, comprise about 30-50 square centimeters of highly sensitive tissue in the average adult organ (roughly the surface area of a credit card and about half the moveable skin system of the penis).[49] It is of course much smaller in infancy or early childhood. While removing this genital structure at such an age may appear to be simple or straightforward, it is in fact an intricate procedure that produces a range of physical and cosmetic outcomes. This variability, even for circumcisions that are "properly"

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[48] Christopher J. Cold & John R. Taylor, *The Prepuce*, 83(S1) BJU INT'L. 34, 34 (1999).

[49] Godfrey Kigozi et al., *Foreskin Surface Area and HIV Acquisition in Rakai, Uganda (Size Matters)*, 23(16) AIDS 2209 (2009); Paul Werker et al., *The Prepuce Free Flap: Dissection Feasibility Study and Clinical Application of a Super-Thin New Flap*, 102 PLAST. RECONSTR. SURG. 1075 (1998); Claude C. Malic et al., *Resuscitation Burn Card – a Useful Tool for Burn Injury Assessment*, 33(2) BURNS 195 (2007); John R. Taylor et al., *The Prepuce: Specialized Mucosa of the Penis and Its Loss to Circumcision*, 77(2) BRIT. J. UROL. 291 (1996).

performed, is important to keep in mind when attempting to draw any general conclusions about the potential harms of the procedure *per se*.

3.1. The Problem of Variability

The variability just mentioned arises from two main sources: the body part circumcision is designed to remove—the foreskin—and the method employed to remove it. To take the second point first, "[c]ircumcision methods can be classified into one of three types or combinations thereof: dorsal slit, shield and clamp, and excision."[50] Whichever method is used, practitioners must contend with the fact that the foreskin is not a discrete entity, like a finger or gall bladder, but rather a sheath of tissue wrapped around and integrated with the larger structure of which it is a part (i.e., the penis). Moreover, in infants and young children, the inside of the foreskin is usually firmly adherent to the head of the penis, since "[t]he fused mucosa of the glans penis and the inner lining of the prepuce separate [only] gradually over years, as a

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[50] Abdullahi Abdulwahab-Ahmed & Ismaila A. Mungadi, *Techniques of Male Circumcision*, 5(1) J. SURG. TECHNIQUE & CASE REP. 1, 2 (2013). Among "shield and clamp" style devices, the Gomco clamp is one of the most widely used (for video of a circumcision using this device, *see* http://newborns.stanford.edu/Gomco.html). If the person undergoing the circumcision is an infant, he is typically first placed into an apparatus called a "circumstraint" to which his arms and legs are strapped; in a religious setting, the child's limbs may simply be held down by a family member. Once the child is immobilized and a local anesthetic (if any) has been administered, a straight forceps is advanced between the glans and foreskin along the dorsal midline to the depth of the coronal sulcus. The forceps is then clamped along this line on the inside and outside of the foreskin. A slit is cut with a scalpel along the side of the forceps. The foreskin is then forcibly detached from the glans using a blunt probe, after which it is retracted toward the base of the penis. With the Gomco method, a metal bell is now placed over the newly exposed glans, after which the foreskin is pulled back up over the bell. A metal plate is placed over the bell, so that the prepuce becomes situated between the plate and the bell. A tensioning bar is then "hooked under a T-shaped piece on the top of the bell and screwed down tight to the metal plate; this traps the foreskin in position." At this point, a "scalpel is run around the upper surface of the plate to remove the prepuce after adequate strangulation." Abdulwahab-Ahmed & Mungadi, *Techniques of Male Circumcision*, at 2. The Gomco method, as with other common methods, thus proceeds by several discrete steps, each of which has the potential to go awry and so must be executed with care. As Aaron J. Krill and colleagues explain: "Complications from a Gomco circumcision are mainly related to technical factors. It is important to assure that the metal bell completely covers the glans, otherwise insufficient skin will be removed and accidental incision into the glans is possible." In addition, "overly aggressive retraction of the skin through the platform can lead to excessive skin removal and subsequent corrective surgery; conversely, insufficient drawing up of the skin will lead to an incomplete circumcision, which may also require corrective surgery." Finally, if the screw is not tightened sufficiently, this may result in "inadequate compression of the skin and subsequent bleeding." Aaron J. Krill et al., *Complications of Circumcision*, 11 SCI. WORLD J., 2458, 2459 (2011).

spontaneous biological process."[51] Consequently, NTC at this age requires "tearing the common prepuce/glans penis mucosa apart … with the concomitant risk of glanular excoriation and injury."[52] This step is not required in adult circumcision.

Depending on the specific technique or combination of techniques employed, the instrument or instruments used, and the skill of the practitioner, different quantities and types of tissue may be removed by circumcision[53] such that the effects of the procedure—including any complications[54]—are not uniform.[55] With respect to complications, estimates vary widely in the medical literature, ranging from an overall complication rate for neonatal NTC of a fraction of a per cent to a rate as high as 20% for meatal stenosis alone.[56] Such

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[51] Cold & Taylor, *supra* n.48, at 35.

[52] *Id.*

[53] For example, the frenulum, the highly sensitive tissue that connects the foreskin to the rest of the penis, may or may not be removed, depending upon the "style" of circumcision. *See* J. S. Paick et al., *Penile Sensitivity in Men with Premature Ejaculation.*, 10 INT'L J. IMPOTENCE RES. 247, 248-49 (1998) (showing that the frenulum is highly sensitive).

[54] Medical risks associated with circumcision include, but are not limited to: excessive bleeding, infection, inflammation, fistula formation, development of skin bridges, meatal stenosis (a narrowing of the urethral opening which can cause problems with urination), partial or complete penile amputation or other injury to the penis (in addition to the intended excision of the foreskin), and death. Krill et al., *supra* n.50, at 2459-66. Death is usually described as a rare complication of NTC, especially when it is performed in a modern clinical setting by a well-trained provider, although a lack of adequate record-keeping in the United States and some other countries where the surgery is common precludes the establishment of reliable annual figures. Alexandre T. Rotta, Personal Communication, Apr. 11, 2016 (Dr. Rotta holds the Chair in Pediatric Critical Care and Emergency Medicine and is Chief of the Division of Pediatric Critical Care, Rainbow Babies & Children's Hospital, University Hospitals of Cleveland).

[55] To reflect this lack of uniformity, J. Steven Svoboda and Robert Darby have proposed a typology of male circumcision to complement the classification of female genital cutting devised by the World Health Organization. The 7-point scale is based principally on the quantity of foreskin tissue removed, and ranges from mild lacerations without loss of tissue to partial or complete denudation of the penis. Robert Darby & J. Steven Svoboda, *A Rose by Any Other Name: Rethinking the Differences/Similarities Between Male and Female Genital Cutting*, 31(3) MED. ANTHROPOL. Q. 301(2007); J. Steven Svoboda & Robert Darby, *A Rose by Any Other Name: Symmetry and Asymmetry in Male and Female Genital Cutting* in FEARFUL SYMMETRIES: ESSAYS AND TESTIMONIES AROUND EXCISION AND CIRCUMCISION (Chantal Zabus ed., 2008).

[56] For references and discussion, *see* Morten Frisch & Brian D. Earp, *Circumcision of Male Infants and Children as a Public Health Measure in Developed Countries: A Critical Assessment of Recent Evidence*, GLOBAL PUB. HEALTH (in press), *available online ahead of print at* http://dx.doi.org/10.1080/17441692.2016.1184292. For a recent large-scale nationwide cohort study providing evidence that circumcision is associated with a marked increase in the risk of meatal stenosis and other urethral stricture disease, *see* Morten Frisch & Jacob Simonsen, *Cultural Background, Non-Therapeutic Circumcision And The Risk Of Meatal Stenosis And Other Urethral Stricture Disease: Two Nationwide Register-Based Cohort Studies In Denmark 1977–2013*, THE SURGEON (in press), *available online ahead of print at* http://www.thesurgeon.net/article/S1479-666X(16)30179-2/fulltext.

wide variation in professional estimates, in combination with ongoing disputes over the appropriate diagnostic criteria for some adverse events[57] and systematic barriers to complete reporting of even overt complications (including a lack of adequate long-term follow-up),[58] suggests that a definitive conclusion about the "medical" risks of NTC cannot at this time responsibly be drawn.[59]

Disparities arising from surgical factors are only part of the story. Such disparities are compounded by sometimes substantial individual differences in penile, including foreskin, anatomy.[60] These differences range from variations in the size and shape of the penis *in toto*, to the length, thickness, and surface area of the foreskin itself to the precise organization of the foreskin's innervation and vasculature, its elasticity and mobility, the number and distribution of nerve endings it contains, and the degree and quality of

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[57] *See, e.g.*, AAP, *Circumcision Policy Statement*, *supra* n.27, at e772 (stating: "The true incidence of complications after newborn circumcision is unknown, in part due to differing definitions of 'complication' and differing standards for determining the timing of when a complication has occurred." Adding to the problem is the "comingling of 'early' complications, such as bleeding or infection, with 'late' complications such as adhesions and meatal stenosis" and the fact that "complication rates after an in-hospital procedure with trained personnel may be far different from those of the developing world and/or by untrained ritual providers").

[58] For a discussion, *see generally*, Bossio et al., *Review of Male Circumcision Literature*, *supra* n.8, at 2847-64. *See also* Brian D. Earp, *The Need to Control for Socially Desirable Responding in Studies on the Sexual Effects of Male Circumcision*, 10(9) PLOS ONE 1 (2015) (recommending that future research on the sexual effects of circumcision be improved by employing much longer-term follow-up periods); Brian D. Earp, *Infant Circumcision and Adult Penile Sensitivity: Implications for Sexual Experience*, 7(4) TRENDS UROL. MEN'S HEALTH 17 (2016) (noting that generalizations about the effects of NTC on sexual outcome variables cannot be made beyond the limits entailed by the sample characteristics).

[59] One inevitable adverse consequence, however, is pain, both during the operation and the healing period. Because general anesthesia is contra-indicated in infants under six month of age, it is difficult, if not impossible, to provide fully effective pain control. Moreover, the local anesthetics that are used for neonatal circumcision require multiple injections either into the base or around the circumference of the penis; such injections are themselves painful as assessed by objective (i.e., behavioral) measures. Behrouz Banieghbal, *Optimal Time for Neonatal Circumcision: An Observation-Based Study*, 5(5) J. PEDIATR. UROL. 359 (2009). As Bellieni et al. noted after a survey of the literature, "there is no such thing as a pain-free circumcision." Carlo V. Bellieni et al., *Analgesia for Infants' Circumcision*, 39(38) IT. J. PEDIATR. n.p. (2013), *available at* http://www.ijponline.net/content/39/1/38. By contrast, in adult circumcision, general anesthesia can safely be used; the patient can also effectively manage his own discomfort as he heals.

[60] For example, in a study of 965 men, Kigozi et al. obtained measurements of foreskin surface area ranging from approximately 7 – 100 cm^2. Kigozi et al., *supra* n.49.

sensation transmitted by those nerve endings in response to different types of stimulation.[61]

To illustrate just one aspect of this variability, consider an individual whose foreskin plays a significant role in the generation or facilitation of pleasurable sensations during sexual intercourse, foreplay, or masturbation.[62] Compared to someone whose foreskin plays a less significant role, or even a negative role (perhaps due to anatomical or other anomalies), this person has more to lose, so to speak, by being circumcised—even if the "surgical" aspects of the procedure in both cases are identical.

To summarize, a typical circumcision is not "just a snip"[63] as is often asserted, but is rather a delicate surgical procedure consisting of several discrete steps, each of which carries risks.[64] These risks vary in their nature, likelihood, and magnitude as a function of numerous interacting variables—including the skill of the practitioner, the instruments used, the amount of tissue removed, and so on—many of which have not been adequately studied. Moreover, when they do occur, adverse events are likely to have an outsized impact on the affected individual due to the special significance of the organ

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[61] When NTC is performed on an infant or young child, the anatomical complexity is compressed into a small space. Since there is no determinate location where there foreskin "ends" and where the rest of the penis "begins," and since the organ will typically increase in size by more than 200% as the child develops (*see* Dr. Alan Greene, *Penis Size* (last updated Jan. 1, 2015), http://www.drgreene.com/qa-articles/penis-size/), there is a considerable amount of guesswork in terms of where to cut or apply the circumcision device. Therefore, there is an increased risk at this age, compared to NTC performed in later adolescence or adulthood, of removing more tissue than was intended or desired, which may result in insufficient slack in the remaining penile skin to accommodate a full erection later in life. This can lead to pain and discomfort during sex or masturbation, promote curvature of the penis, or contribute to other unwanted outcomes. *See* John van Duyn & William S. Warr, *Excessive Penile Skin Loss from Circumcision*, 51 J. MED. ASS'N GA. 394 (1962); Jorgen Thorup et al., *Complication Rate After Circumcision in a Paediatric Surgical Setting Should Not Be Neglected*, 60 DAN. MED. J. A4681 (2013). These adverse outcomes, however, might not become apparent until after puberty, when the organ has reached its full size and the individual becomes sexually active. As a result, they may never be recorded as a complication of the initial procedure, nor recognized by the individual as being due to the loss of his foreskin (as he has no other frame of reference).

[62] Or would play such a role, assuming it is not removed in infancy or childhood.

[63] Aggleton, *supra* n.6, at 15-21.

[64] While it is likely impossible to reach agreement on what an acceptable level of circumcision complications would look like, two principles should arguably govern any such efforts: (1) that the threshold of acceptability for cosmetic or nontherapeutic surgery should be higher than for therapeutic procedures; and (2) that the threshold for children and others incapable of providing valid consent should be higher still.

in question: it is not only the likelihood of a given risk that is important, but also its magnitude or importance were it actually to take place. That said, different men relate to their bodies differently, and the personal impact of specific outcomes associated with circumcision cannot be known in advance. Such uncertainty is especially apparent in the case of the one outcome of NTC that is (almost) guaranteed to occur, since it is the intended effect of the procedure: the loss of the foreskin itself.

3.2. Differing Attitudes Concerning Foreskin Loss

In the academic literature, as well as in popular discussion, the loss of the foreskin is rarely treated as an adverse consequence of circumcision. Yet whether one regards this loss as a harm will depend almost entirely on the value one assigns to the foreskin or to the notion of genital intactness.

The view that the foreskin has little value appears to be more common in cultural settings such as the United States, where, in contrast to most other industrialized nations, neonatal circumcision rates remain relatively high.[65] In such a context, popular knowledge about the surgically unmodified penis is likely to be comparatively lacking, such that the anatomy and functions of the foreskin might not be as robustly understood even by medical professionals. The majority of these medical professionals are either themselves neonatally circumcised males or non-circumcised females; in either case, they are relatively unlikely to have had significant personal experience with surgically unmodified male genitalia.[66]

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[65] Brian J. Morris et al., *Estimation of Country-Specific and Global Prevalence of Male Circumcision*, 14(1) POP. HEALTH METR. 1 (2016) (estimating the percentage of circumcised US males to be 71.2%; for comparison, the estimate for the UK is 20.7%; for Germany, 10.9%; for the Netherlands, 5.7%); Edward Wallerstein, *Circumcision: The Uniquely American Medical Enigma*, 12(1) UROL. CLIN'S. N. AM. 123, 123 (1985) (stating "[t]he continuing practice of routine neonatal nonreligious circumcision represents an enigma, particularly in the United States. About 80 percent of the world's population do *not* practice circumcision, nor have they ever done so. Among the non-circumcising nations are Holland, Belgium, France, Germany, Switzerland, Austria, Scandinavia, the USSR, China, and Japan").

[66] "Because circumcision is so common in the United States, the natural history of preputial development has been lost, and one must depend on observations made in countries in which circumcision usually is not practiced." MHAIRI MACDONALD ET AL., AVERY'S NEONATOLOGY: PATHOPHYSIOLOGY AND MANAGEMENT OF THE NEWBORN 1088 (Philadelphia: Lippincott Williams

For comparison, in contexts where ritualized female genital cutting is more normative, the anatomy, functions, and associated sensory implications of the surgically unmodified female genitalia are similarly thought to be inadequately understood.[67] In such settings, "uncircumcised" women are commonly stigmatized as having genitalia that are unsightly or difficult to clean.[68] Even the external clitoris—typically a highly valued body part among those who possess one—may be viewed in these settings as something that is ugly, unfeminine, or simply "extra," and hence as unnecessary for normal sexual functioning.[69] These observations indicate that there is a strong role for cultural conditioning in shaping one's assumptions about the importance of a given genital structure for intimate activity and sexual enjoyment.[70]

Such cultural conditioning is subject to change, however, and stigmatizing attitudes may not remain stable. As people are exposed to and learn about different cultural assumptions and practices regarding cut versus uncut genitalia—whether through travel, reading, or surfing the Internet—they may come to regard the majority practice of their own group as being harmful or otherwise problematic, and consequently re-assess the value of their own genital status. For example, Sara Johnsdotter and Birgitta Essén have recently documented evidence of "cultural change after migration" with

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& Wilkins, 6th ed.). For evidence showing that many US medical textbooks do not accurately describe the anatomy of the intact penis, *see, e.g.*, Gary L. Harryman, *An Analysis of the Accuracy of the Presentation of the Human Penis in Anatomical Source Materials* in FLESH AND BLOOD 17 (Denniston et al. eds., 2004).

[67] Sami A. Abu-Sahlieh, *To Mutilate in the Name of Jehovah or Allah: Legitimization of Male and Female Circumcision*, 13(7-8) MED. & L. 575 (1993) (discussing various misconceptions about the vulva and the clitoris among many groups that practice forms of ritualized female genital cutting).

[68] For examples and discussion, *see generally* Manderson, *supra* n.37, at 285-307.

[69] Lucretia Catania et al., *Pleasure and Orgasm in Women with Female Genital Mutilation/Cutting (FGM/C)*, 4(6) J. SEX. MED. 1666, 1673 (2007) (referring to circumcised women who "achieve orgasm by stimulating the vagina and consider the clitoris as something extra"). For further in-depth discussion, *see* Brian D. Earp, *In Defence of Genital Autonomy for Children*, 41(3) J. MED. ETHICS 158, 158-63 and the online Appendix (2016).

[70] The argument here is *a fortiori*. If even the widely accepted value of the external clitoris, at least in Western societies, is downplayed or disregarded by women who have little personal experience of the tissue, then how much more likely is it that the potential value of the penile foreskin might be downplayed or disregarded by men who have never experienced sex with one intact?

respect to female genital cutting practices among Somali immigrants to Sweden:

> … migration gives rise to cultural reflection: All the motives for [female] circumcision in Somalia are turned [inside] out in exiled life in Sweden. What was once largely seen as 'normal' and 'natural' about … cut and sewn genitalia was questioned in Sweden, when the women were met with shocked reactions among healthcare providers in maternal care and delivery rooms. A thitherto strong conviction that circumcision of girls was required by religion was questioned when Somalis met Arab Muslims, who do not circumcise their daughters … The fear that their daughters would be rejected at marriage if uncircumcised disappeared in the light of the immense Somali diaspora in the West, where Somali men can be expected to accept and even appreciate uncircumcised wives. In addition, the risk of stigmatization and ostracism disappeared when living in an environment where most girls are not circumcised.[71]

Similar stories are told by some circumcised men, whose realization that not everyone's penis has been cut like theirs—or that circumcision is in fact a minority practice in most Western countries outside of the United States—may prompt a difficult reevaluation of the normalcy of going through life without a foreskin. As one such man recounted to the psychologist Ronald Goldman:

> The shock and surprise of my life came when I was in junior high school, and I was in the showers after gym … I wondered what was wrong with those penises that looked different than mine … I soon realized I had part of me removed. I felt incomplete and very frustrated when I realized that I could never be like I was when I was born—intact. That frustration is with me to this day. Throughout life I have regretted my circumcision. Daily I wish I were whole.[72]

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[71] Sara Johnsdotter & Birgitta Essén, *Cultural Change after Migration: Circumcision of Girls in Western Migrant Communities*, 32 BEST PRACT. RES. CLIN. OBSTET. GYNAECOL. 15, *4 (2016) [page 4 of the online advanced publication *available at* http://www.sciencedirect.com/science/article/pii/S1521693415001959].

[72] Gregory J. Boyle et al., *Male Circumcision: Pain, Trauma and Psychosexual Sequelae*, 7(3) J. HEALTH PSYCHOL. 329, 329-43 (2002).

Such feelings are not uncommon, as the anthropologist Eric Silverman noted more than a decade ago:

> opposition to FC [female circumcision] is well known … Less obvious to anthropologists is an equally vociferous, diverse movement that opposes the routine medical and ritual circumcision of infant boys in the West. The number … of these activist groups [is] staggering … these groups are serious, and it would be incorrect to dismiss them as the fringe. They are fast moving to the center of legal, medical, and moral discourse. And they are both very angry and very aggressive.[73]

Strikingly, Silverman seems reluctant to consider, much less conclude, that any negative feelings experienced by circumcised men might be a reasonable reaction to having had part of their genitals removed without their consent—or indeed that such feelings might have anything whatsoever to do with the loss of the foreskin:

> I propose that for many opponents of the procedure, MC (male circumcision) is a potent symbol of anxieties that are not linked directly to the penis. Rather, the lost foreskin symbolizes a series of modern losses arising from historically specific anxieties. These anxieties concern the lost effectiveness of the political, economic, and judicial process; pluralism; violence; contested notions of masculinity, motherhood, sexuality, and gender; the medicalization of birth; vulnerability before technological advances … and the hypercapitalist com-modification of the body.[74]

While anxieties relating to such abstract concerns as "pluralism," "violence," or "motherhood" may very well have something to do with the way in which some or even many circumcised men feel about their altered penises (although we struggle to see the precise connection), it seems plausible that a more direct explanation is being overlooked. Specifically, insofar as the foreskin itself, or the surgically unmodified penis more generally, has properties it is reasonable to regard as valuable—sexually, aesthetically, or otherwise—then a man's experiencing the involuntary removal of that tissue

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[73] Eric K. Silverman, *Anthropology and Circumcision*, ANN. REV. ANTHROPOL. 419, 434 (2004) (internal references omitted).

[74] *Id.* at 436 (internal references omitted).

as an intrinsic harm should be viewed as a sensible reaction. Consider the following "Dear Abby" exchange, which shows a similar pattern of judgment to that of Silverman:

> **Dear Abby**: I am a young man who is currently in college. When I was an infant, I was circumcised, and I feel violated that my parents decided to circumcise me without my consent. When the doctor performed the surgery, he took too much off, which causes me pain. When I was in grade school, I was sexually assaulted by an older classmate, but I feel much more violated from the circumcision because it took a part of me that I can never get back. … My parents know how I feel and are sorry, but I still have negative feelings toward them because I can't get the procedure undone.
>
> – *Cut Short in California.*
>
> **Dear C. S.**: … The place to start would be your student health center to determine exactly what is causing your pain and if there is help for it. … In addition, I urge you to talk to a licensed mental health professional to help you work through your anger because it may be misdirected and a result of the sexual assault you experienced in grade school."[75]

In this exchange, Dear Abby (Jeanne Phillips) appears to appreciate that the physical pain associated with a circumcision that removed "too much" tissue is a serious concern that deserves some remedy. But the idea that the non-consensual loss of the foreskin itself might be valid grounds for anger or resentment does not appear to strike her as plausible. Instead, she proposes that the man's feelings might be "misdirected" from some other problem, for which he should seek the services of a mental health professional.

Recall that the foreskin is a touch-sensitive, motile sleeve of tissue that comprises dozens of square centimeters in the average adult organ.[76] Recent research relying on objective measures indicates that this tissue is the most sensitive part of the penis to light touch, while also being significantly more

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[75] Jean Phillips, *Dear Abby: Decision to Circumcise Causes Festering Anger*, DETROIT NEWS (Mar. 21, 2016), *available at* http://www.detroitnews.com/story/life/advice/2016/03/21/dear-abby-advice/81994520/.

[76] Cold & Taylor, *supra* n.48, at 34-44; Kigozi et al., *supra* n.49, at 2209; Werker et al., *supra* n.49, at 1075-82.

sensitive than the head of the penis to mild sensations of warmth.[77] Even if this tissue had no erotogenic properties whatsoever, which is generally understood not to be the case, one need only to imagine the involuntary removal of a comparable amount of non-diseased tissue from another part of the body—or perhaps from the genitals of a female child in the form of neonatal labiaplasty—to appreciate why some people might validly experience such removal as distressing.[78] The common failure to appreciate this distress in the Western discourse is itself a curious phenomenon, and it has led some anthropologists and sociologists to take a deeper look at the cultural constructions of male and female sexuality.

3.3. Differing Cultural Constructions of Male vs. Female Sexuality

Reading through the medical literature, one is liable to form the impression that the mere capacity to maintain an erection, ejaculate, impregnate one's female partner, or experience some degree of pleasurable sensation during sex, exhaust the scientific imagination on male sexuality. In other words, if these or other similar basic capacities are retained, many commentators are prepared to conclude that circumcision has negligible, if any, adverse effects on male "sexual function."[79] As the anthropologist Kirsten Bell has said of her North American college students:

> Over the course of our discussions … one thing became clear: students did not think that carving up male genitalia had any damaging effects on male sexuality as long as the penis remained largely intact. My students reasoned that as long as the man retained the ability to ejaculate, his sexuality was unimpaired. They were so ready to assert that female sexuality has been totally annihilated by genital surgery of any kind and so reluctant to proclaim that anything short of full frontal

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[77] Bossio et al., *Penile Sensitivity*, *supra* n.9, at 1848-53. *But see* Earp, *Infant Circumcision and Adult Penile Sensitivity*, *supra* n.58, at 17-21 (pointing out some of the ways in which Bossio et al. mischaracterized the findings from their own study).

[78] For an in-depth discussion, *see* Earp, *In Defence of Genital Autonomy*, *supra* n.69, at 158-63.

[79] Indeed, Munzer himself seems to endorse (or at least recognize) such a view when he writes, "[t]he sexual functioning of … men is, let us suppose, largely unaffected by removal of all or part of the prepuce." Munzer, *supra* n.1, at 560.

> castration will affect a man's sexuality in the same way, it seemed clear that something very interesting was being revealed. Importantly, their insistence seemed to have less to do with these practices themselves and more to do with underlying assumptions about the nature of female and male sexuality, assumptions echoed in the dominant discourses on genital cutting.[80]

A common assumption in this discourse, according to Marie Fox and Michael Thomson, is that "male sexual pleasure is not an issue provided the penis is adequate for penetration, thus privileging one popular understanding of male sexual function and pleasure." And yet "the sensitivity protected by the foreskin, the erogenous nature of the foreskin itself, and sexual practices relying on an intact penis—such as docking[81]—are all erased in these characterisations."[82]

According to this perspective—and now invoking Feinberg's conception of harm, discussed *supra*—it could be argued that circumcision necessarily impairs function because, whatever else it does, it impairs (indeed, eliminates) all sexual acts or functions that require manipulation of the foreskin itself.[83] These acts include a range of masturbatory styles that involve

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[80] Kirsten Bell, *Genital Cutting and Western Discourses on Sexuality*, 19(2) MED. ANTHROPOL. Q. 125, 127 (2005).

[81] "Docking" is a form of sex common among some men who have sex with men (MSM). As Harrison states: "The general idea … involves one man extending his foreskin in such a manner that it forms an orifice that is then penetrated by another (presumably erect) object. To put the point very bluntly, circumcision prohibits men from ever being on the 'giving' end of such a relationship, closing off a potential form of pleasure that some find to be very satisfying." Parents who authorize the circumcision of their sons, therefore, are "unwittingly circumscribing certain types of sexual behavior for their sons, and are thus limiting exploration of other sexual possibilities of the penis. Circumcision diverts male sexuality down a particular path, disallowing for certain erotic potentials." Daniel M. Harrison, *Rethinking Circumcision and Sexuality in the United States*, 5(3) SEXUALITIES 300, 310-11 (2002). On a related note, in a recent study of 196 Canadians, gay men "indicated a strong preference toward intact penises for all sexual activities assessed and held more positive beliefs about intact penises." Jennifer A. Bossio, et al., *You Either Have It or You Don't: The Impact of Male Circumcision Status on Sexual Partners*, 24(2) CAN. J. HUM. SEX. 104, 104 (2015). For further discussion, *see* Morten Frisch & Brian D. Earp, *Problems in the Qualitative Synthesis Paper on Sexual Outcomes Following Non-Medical Male Circumcision by Shabanzadeh et al.*, 63(7) DAN. MED. J. A5245 (2016) (noting that studies concluding that circumcision makes little or no difference to sexual experience are problematically heteronormative because they exclude by definition popular practices among MSM that require the presence of a foreskin).

[82] Michael Fox & Marie Thomson, *Foreskin is a Feminist Issue*, 24(60) AUS. FEMINIST STUD. 195, 200 (2009).

[83] *See* Brian D. Earp, *Sex and Circumcision*, 15(2) AM. J. BIOETH. 43 (2015).

gliding the foreskin back and forth over the head of the penis[84] as well as some forms of oral sex that similarly involve interplay with the foreskin. Of course, whether the inability to have one's foreskin orally or manually manipulated interferes with one's sexual enjoyment is not something that can be "objectively" determined: it depends on one's sexual preferences. For a point of comparison, consider that the female genital labia can also be "tugged, stretched, sucked on, and otherwise fondled during sexual interaction … for those for whom such activities are an important part of their sexual experience, the loss of labia," like the loss of the foreskin in men with analogous sexual preferences, would indeed represent a setback to their interests.[85]

Another necessary consequence of circumcision is a loss of sensation. At minimum, all sensation that would have been experienced "in" the excised tissue itself is eliminated by the procedure; there may also be an additional loss of sensation in the penile glans in some men due to its rubbing against clothing and other elements without the protective covering of the foreskin over the course of many years.[86] As Harrison states, "[s]ince circumcised men have no feeling in their foreskin (in fact, no foreskin at all), the only form of stimulation comes in the form of pressure on the head and the shaft of the penis, and in the orgasm itself."[87]

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[84] In response to a request for "any comments on feelings related to the foreskin during intercourse or masturbation," family practitioner Peter J. Ball notes that the "penis rolling in and out of its skin tube during intercourse was echoed by the answers to this question. Some fifty percent of intact men [in the survey] intimated here that, for them, the foreskin was essential for the enjoyment of sex whether for masturbation or intercourse." Peter J. Ball, *A Survey of Subjective Foreskin Sensation in 600 Intact Men* in BODILY INTEGRITY AND THE POLITICS OF CIRCUMCISION 177-88 (Denniston et al. eds., 2006).

[85] Earp, *In Defence of Genital Autonomy*, *supra* n.69, at 29 of the Online Appendix.

[86] For a recent study suggesting decreased glans sensitivity in circumcised compared to non-circumcised men, *see* Lisa Örtqvist et al., *Sexuality and Fertility in Men with Hypospadias; Improved Outcome*, ANDROLOGY (in press), *available online ahead of print at* http://onlinelibrary.wiley.com/doi/10.1111/andr.12309/full. While the main purpose of the study was to assess sexuality and fertility in men with hypospadias, as the title suggests, circumcised and non-circumcised men were used as controls. For further evidence of this view, *see* Morris L. Sorrells et al., *Fine-Touch Pressure Thresholds in the Adult Penis*, 99(4) BJU INT'L. 864, 864 (2007) (finding that "[t]he glans of the circumcised penis is less sensitive to fine touch than the glans of the uncircumcised penis. … Circumcision ablates the most sensitive parts of the penis"). Note that various critiques and counter-critiques of this study are available at the journal's website.

[87] Harrison, *supra* n.81, at 310.

Again, the question of whether this loss of sensation should be counted as a harm is not something with a universal answer: one and the same sensory decrement may be experienced differently by different men, depending on, among other things, their baseline sensitivity. Some men, for example, may believe that they are "too sensitive" and may struggle with what they or their partner(s) regard as premature ejaculation,[88] whereas other men may not feel "sensitive enough" and may struggle instead with a lack of sensation overall and possibly erectile dysfunction, especially as they get older.[89] Other individual differences can easily be imagined.

Given so much room for variation, it should come as no surprise that studies and surveys in this area produce conflicting results.[90] Some have concluded that adult circumcision was associated with reduced sexual functionality and/or enjoyment in some men,[91] while others have concluded

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[88] For critical discussions of the issue of premature ejaculation, *see* Ylva Söderfeldt et al., *Distress, Disease, Desire: Perspectives on the Medicalisation of Premature Ejaculation*, J. MED. ETHICS (in press), *available online ahead of print at* http://jme.bmj.com/content/early/2017/03/23/medethics-2015-103248 (questioning restrictive sexual norms that feed into the notion of premature ejaculation to the exclusion of other modes of sexual expression); Brian D. Earp & Julian Savulescu, *Love Drugs: Why Scientists Should Study the Effects of Pharmaceuticals on Human Romantic Relationships*, TECH. IN SOCIETY (in press), *available online ahead of print at* http://www.sciencedirect.com/science/article/pii/S0160791X1630118X (noting that a relative shortening or lengthening of the average time it takes for a man to ejaculate is not objectively better or worse than the alternative: it depends on the needs and preferences of those engaged in the sexual encounter).

[89] Earp, *Infant Circumcision and Adult Penile Sensitivity*, *supra* n.58, at 20.

[90] Until the early twentieth century, it was simply assumed that the foreskin was a primary source of sexual sensation in the male and that those who underwent circumcision lost much of the pleasure of sexual activity. *See* ROBERT DARBY, A SURGICAL TEMPTATION: THE DEMONIZATION OF THE FORESKIN AND THE RISE OF CIRCUMCISION IN BRITAIN (2005), especially Chapter 2. For a collection of quotations from medical and sex advice texts, *see Circumcision, The Foreskin and Sexuality: The Verdict of the Centuries*, CIRCUMCISION INFORMATION AUSTRALIA, *available at* http://www.circinfo.org/quote.html (last accessed Dec. 4, 2016). This assumption was certainly held by Victorian doctors who introduced circumcision as a means of controlling juvenile and adolescent sexuality, particularly to discourage masturbation. As late as the 1940s, American obstetricians were recommending circumcision for this reason. *See, e.g.*, Alan F. Guttmacher, *Should the Baby Be Circumcised?*, PARENTS MAG. No. 16 (Sept. 1941), *cited in* Robert Darby, *Targeting Patients Who Cannot Object? Re-Examining the Case for Non-Therapeutic Infant Circumcision*, SAGE OPEN (April-June 2016), *available at* http://journals.sagepub.com/doi/full/10.1177/2158244016649219. It was not until the 1990s that anatomical studies established the dense innervation and associated vascularity of the foreskin, supporting the traditional understanding that the foreskin was a principal sensory platform of the penis. *See* Cold & Taylor, *supra* n.48, at 34-44.

[91] *See, e.g.*, Daisik Kim & Myung Geol Pang, *The Effect of Male Circumcision on Sexuality*, 99(3) BJU INT'L 619, 619 (2007) (finding that "[m]asturbatory pleasure decreased after circumcision in 48% of the respondents, while 8% reported increased pleasure. Masturbatory difficulty increased after circumcision in 63% of the respondents but was easier in 37%." Approximately 6%

that such circumcision made little or no difference, or even enhanced sexual function or experience.[92] None of these studies allows one to draw meaningful conclusions about the effects of neonatal or early childhood circumcision, however,[93] since they rely on self-reports from men who have an active interest in the surgery's outcome, and all suffer from methodological limitations.[94] In

"answered that their sex lives improved, while 20% reported a worse sex life after circumcision").

[92] *See, e.g.*, John N. Krieger et al., *Adult Male Circumcision: Effects on Sexual Function and Sexual Satisfaction in Kisumu, Kenya*, 5(11) J. SEX. MED. 2610, 2610 (2008) (stating that "[a]dult male circumcision was not associated with sexual dysfunction. Circumcised men reported increased penile sensitivity and enhanced ease of reaching orgasm"). For a controversial review and summary, *see* Brian J. Morris and John N. Krieger, *Does Male Circumcision Affect Sexual Function, Sensitivity, or Satisfaction? A Systematic Review*, 10(11) J. SEX. MED. 2644, 2644 (2013) (stating that "the highest-quality studies suggest that medical male circumcision has no adverse effect on sexual function, sensitivity, sexual sensation, or satisfaction"). For critical commentaries on this paper *see, e.g.*, Gregory J. Boyle, *Does Male Circumcision Adversely Affect Sexual Sensation, Function, or Satisfaction? Critical Comment on Morris and Krieger (2013)*, 5 ADVANCES SEX. MED. 7, 7 (2015) (arguing that "by selectively citing Morris' own non-peer-reviewed letters and opinion pieces purporting to show flaws in studies reporting evidence of negative effects of circumcision, and by failing adequately to account for replies to these letters by the authors of the original research (and others), Morris and Krieger give an incomplete and misleading account of the available literature"); Bossio et al., *Response to: The Literature Supports Policies Promoting Neonatal Male Circumcision*, *supra* n.8, at 1306-07 (stating that "according to the SIGN criteria that Morris and Krieger utilize, would their entire review in question not warrant a rating of 'low quality' based on the 'high risk of bias' introduced by the authors' well documented, unconditional support of the practice of circumcision?"). For author replies, see the journal websites. For further discussion of the literature on the sexual effects of male circumcision, *see generally* Brian D. Earp, *Female Genital Mutilation and Male Circumcision: Toward an Autonomy-Based Ethical Framework*, 5(1) MEDICOLEGAL BIOETH. 89, Box 1 (2015).

[93] For large-scale studies including analyses of the sexual effects of early circumcision (as opposed to adult circumcision exclusively), *see, e.g.*, Morten Frisch et al., *Male Circumcision and Sexual Function in Men and Women: A Survey-Based, Cross-Sectional Study in Denmark*, 40(5) INT'L. J. EPIDEMIOL. 1367, 1367 (2011) (finding that "circumcision was associated with frequent orgasm difficulties in Danish men and with a range of frequent sexual difficulties in women, notably orgasm difficulties, dyspareunia and a sense of incomplete sexual needs fulfillment"); Guy A. Bronselaer et al., *Male Circumcision Decreases Penile Sensitivity as Measured in a Large Cohort*, 111(5) BJU INT'L. 820, 820 (2013) (reporting that "[f]or the glans penis, circumcised men reported decreased sexual pleasure and lower orgasm intensity. They also stated more effort was required to achieve orgasm, and a higher percentage of them experienced unusual sensations" including "burning, prickling, itching, or tingling and numbness of the glans penis"). Critiques and counter-critiques of both studies can be found at the journal websites.

[94] *See, e.g.*, Morten Frisch, *Author's Response to: Brian Morris et al., Does Sexual Function Survey in Denmark Offer Any Support for Male Circumcision Having an Adverse Effect?*, 41 INT'L. J. EPIDEMIOL. 312, 313 (2012) (noting that the questionnaires used in the study by Krieger et al. – *supra* n. 92 – were not well-designed: "several questions were too vague to capture possible differences between circumcised and not-yet circumcised participants." For example, there was a "lack of a clear distinction between intercourse and masturbation-related sexual problems and no distinction between premature ejaculation and trouble or inability to reach orgasm." Thus, "non-differential misclassification of sexual outcomes in these African trials probably favoured the null hypothesis of no difference, whether an association was truly present or not"). *See also* Earp, *Need to Control for Socially Desirable Responding*, *supra* n.58; Bossio et al., *Review of Male Circumcision Literature*, *supra* n.8.

any event, men do not experience sex as embodied statistical averages: the generalized conclusions that are often drawn from these studies reflect group means associated with particular samples of men (along whatever assessed dimension), and not necessarily the experience of any individual man, much less all men.[95]

Nevertheless, many men who were circumcised as infants do insist that they have been sexually harmed as a result of the procedure and strongly resent what was done to them without their consent. As noted earlier, often this absence of consent is as serious a cause of psychosexual distress as any overtly "physical" effects of the procedure.[96] Consider this statement from Leo Milgrom addressed to the Chief Rabbi of Denmark:

> What must I do if I want my foreskin back? I never wanted a strange man to touch me [on] my private parts. I would NEVER ON MY LIFE allow anyone to cut off a piece of my penis. … Imagine if our neighbors – for religious reasons – had the habit of cutting [the] earlobes, the outer joint of their little finger, or the nipples of their babies. Just like that, off with them. We would never allow that to happen. Nevertheless we accept something even worse: the cutting into and cutting off [of] parts of children's private and intimate sexual organs.[97]

Eran Sadeh, an Israeli citizen, offered a similar perspective the same year, in a speech he gave in Berlin in response to the Cologne ruling:

> I was born 43 years ago in Tel Aviv, a healthy baby with a perfect body. [Eight] days after I was born one man held my tiny legs down while another man cut a part of my penis off with a knife. I was in pain, I screamed, I bled. It's over. But the

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[95] Earp, *Infant Circumcision and Adult Penile Sensitivity*, *supra* n.58, at 20 (stating that "the current tendency to draw broad conclusions about the effects of neonatal circumcision on adult sexuality from group 'averages', thereby obscuring the responses of individual participants, is problematic. No one engages in sexual activity as an embodied statistical average; instead, each person's sexual experience is unique").

[96] For examples and discussion, *see generally* John Warren et al., *Circumcision of Children*, 312 BMJ 377 (1996); Tim Hammond, *A Preliminary Poll of Men Circumcised in Infancy or Childhood*, 83(S1) BJU INT'L 85 (1999); Robert Darby & Laurence Cox, *Objections of a Sentimental Character: The Subjective Dimensions of Foreskin Loss* in FEARFUL SYMMETRIES: ESSAYS AND TESTIMONIES AROUND EXCISION AND CIRCUMCISION (Chantal Zabus ed., 2008).

[97] Leo Milgrom, *Kan du give mig min forhud tilbage?* POLITIKEN (2013), *available at* http://politiken.dk/debat/kroniken/premium/ECE1701377/kan-du-give-mig-min-forhud-tilbage/ [translation by Leo Milgrom].

> part that was cut off from my penis is forever gone. … circumcision is nothing but a euphemism for forcibly amputating a healthy body part of a helpless child, causing irreversible bodily damage and pain and putting the child at risk. All this in the name of religion and tradition. … This will not do in a country that protects children's human rights, especially the right to bodily integrity and the right to equal protection by the law.[98]

Lindsay Watson, in his introduction to fifty personal accounts from circumcised men, many of whom consider themselves to have been harmed by a "successful" circumcision (one without serious medical complications or other unintended outcomes), reports that feelings of violation, grief, anger, resentment, shame, and humiliation are prominent.[99] Similar findings were reported by Hammond in 1999, and again in 2017.[100] None of these sources is based on a random sampling, and the feelings expressed may not be representative of the general population. Nevertheless, enough complaints have been raised to think that the proportion of men who do regard themselves as being harmed by circumcision is sufficient to warrant further attention.

Precise numbers are hard to come by, but a 2015 YouGov poll concluded that 10% of circumcised American men wish that they had not been circumcised.[101] In addition, a more recent, demographically diverse survey of 999 American men found that 13.6% wished that they had not been circumcised, with nearly a quarter of that sub-group reporting that they would "seriously consider" changing their circumcision status if it were possible—i.e., through a process of "foreskin restoration."[102] Consistent with this finding,

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[98] Eran Sadeh, "I was shocked," transcript and video *available at* https://justasnip.wordpress.com/2013/06/26/i-was-shocked/#more-914.

[99] LINDSAY WATSON, UNSPEAKABLE MUTILATIONS: CIRCUMCISED MEN SPEAK OUT (Ashburton, NZ: CreateSpace 2014). *Also available as an Amazon e-book at* http://www.amazon.com/Unspeakable-Mutilations-Circumcised-Men-Speak-ebook/dp/B00L5FPF2C/ref=pd_ybh_1.

[100] Hammond, *supra* n.96, at 85-92; Hammond & Carmack, *supra* n.20.

[101] *Available at* https://today.yougov.com/news/2015/02/03/younger-americans-circumcision/.

[102] The survey was conducted in late 2016 by researchers from Quinnipiac University and Yale University, including one of the present authors (Earp). The data are being written up and will soon be submitted for publication; in the meantime, they can be obtained by sending an email to brian.earp@yale.edu. Of the 999 total survey respondents, 771 reported being circumcised and answered the question, "Did you or do you ever wish that you were the opposite circumcision status?" Of the 771, 105 (13.6%) responded "Yes," 660 (85.6%) responded "No,"

there are many thousands of devices[103] currently being sold to men throughout the English-speaking world to assist with such "restoration." This is an arduous process that results, if successful, in a pseudo-prepuce consisting of modified penile shaft skin that lacks the original nerve tissue.[104] From this fact, it is reasonable to conclude that such men are highly unsatisfied with their circumcised state.[105]

Given that such efforts could be seen as a relatively extreme expression of dissatisfaction, there are likely to be "manifold more men who are seriously resentful about having been circumcised, but who do not go to such lengths to try to rectify their situation (or who may simply feel uncomfortable talking about such personal matters in public)."[106] Indeed, it is

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and the rest (n = 6) responded "Prefer not to answer." Of those who answered "Yes" (minus n = 4 who skipped the follow-up question), 25 (24.8%) reported that they would "seriously consider" changing their circumcision status if it were possible, i.e., through a foreskin restoration process. The remaining survey respondents included 182 men who reported not being circumcised, 35 men who reported not being sure of their circumcision status, and 11 who preferred not to report their circumcision status. Among non-circumcised men, 29 (15.9%) responded "Yes" to the above question, 151 (83%) responded "No," and the rest (n = 2) responded "Prefer not to answer." Given that NTC remains the prevailing cultural custom in the United States, it is notable that almost as many circumcised men (as a percentage of the total) have wished that they were not circumcised, as non-circumcised men have wished that they were circumcised (13.6% compared to 15.9%). Yet as we argue in Section 4.1., only men in the latter group have an adequate remedy available to them if they desire to change their status: that is, one can undertake circumcision in adulthood if one has not already been circumcised, but one cannot "undo" a circumcision after it has been done.

[103] *See* Earp, *Between Moral Relativism and Moral Hypocrisy*, *supra* n.33, at E9 of the Online Appendix (providing evidence based on sales records of the relevant devices obtained from the manufacturer).

[104] This refers to the use of weights, tapes, elastic straps, and other instruments to stretch any remaining tissue from the penile shaft up over the head of the penis. To do so requires the wearing of a contraption under one's clothing for multiple hours each day over the course of several months or years. For discussion, *see generally* Roger Collier, *Whole Again: The Practice of Foreskin Restoration*, 183 C.M.A.J. 2092 (2011); G. Corey Carlisle, *The Experience of Foreskin Restoration: A Case Study*, 35 J. PSYCHOL. & CHRISTIANITY 83 (2016); D. Schultheiss et al., *Uncircumcision: A Historical Review of Preputial Restoration*, 101 PLAST. RECONSTR.SURG. 1990 (1998).

[105] Watson, *supra* n.99.

[106] Earp, *Sex and Circumcision*, *supra* n.83, at 44. It is often asserted that "men don't complain" about being circumcised, so why should there be a movement against the practice? This assertion is problematic for two reasons. First, a great many men do complain, publicly, as noted by Silverman (*see also* https://www.mendocomplain.com). And second, a man's failure to publicly complain about his circumcision is not necessarily good evidence that he does not feel harmed. There are numerous barriers that may face a man even if he does feel harmed and desires to register a complaint: (1) pressure to conform; (2) fear that he will not be taken seriously or treated with compassion; (3) concern that his masculinity or sexual status/ability will be questioned; and (4) a lack of mainstream platforms willing to give such men a voice. *See, e.g.*, *Boyle* et al., *Male Circumcision: Pain, Trauma and Psychosexual Sequelae*, *supra* n. 72, at 336-37

improbable that there would be a vigorous, community-based anti-circumcision movement such as the one discussed by Silverman, *supra*, unless a significant number of men—and women—were convinced that circumcision was harmful.

4. WHAT ABOUT BENEFITS? THE OTHER SIDE OF THE COIN

We have so far been discussing some of the reasons why different men might reasonably reach different conclusions about whether they have been harmed by circumcision. A similar analysis applies to the question of benefits. Briefly, in addition to the social benefits that are often claimed for circumcision—such as a decreased risk of being teased by one's peers or ostracized by one's religious community (risks that could also be reduced by changing the relevant social norms, as is commonly suggested in the case of female circumcision)—evidence has accumulated that NTC may confer certain health-based benefits as well. The most significant of these is a reduction in the risk of contracting urinary tract infections (UTIs) in early childhood as well as some sexually-transmitted infections (STIs) after sexual debut.[107]

Some experts dispute these benefits, pointing to confounding factors in the original studies,[108] but we shall simply take them for granted in our

(discussing some of the reasons why men may be reluctant to disclose the feeling that they have been harmed by circumcision).

[107] Another commonly cited benefit of circumcision is reduced risk of penile cancer. However, as the American Academy of Pediatrics notes, based on available evidence, it would take between 909 and 322,000 circumcisions to prevent a single case of penile cancer. AAP, *Male Circumcision*, 130 PEDIATR. e756 (originally published online Aug. 27, 2012).

[108] *See, e.g.*, Robert S. Van Howe, *Effect of Confounding in the Association Between Circumcision Status and Urinary Tract Infection. 51*(1) J. INFECT. 59, 59 (2005) (stating that "[p]reviously reported differences in the rate of urinary tract infection by circumcision status could be entirely due to sampling and selection bias. Until clinical studies adequately control for sources of bias, circumcision should not be recommended as a preventive for urinary tract infection"); Robert S. Van Howe, *Sexually Transmitted Infections and Male Circumcision: A Systematic Review and Meta-analysis*, ISRN UROL. 1, 1 (2013), *available at* https://www.hindawi.com/journals/isrn/2013/109846/ (stating that "[i]n studies of general populations, there is no clear or consistent positive impact of circumcision on the risk of individual sexually transmitted infections." Consequently, "the prevention of sexually transmitted infections cannot rationally be interpreted as a benefit of circumcision, and any policy of circumcision for the general population to prevent sexually transmitted infections is not supported by the evidence in the medical literature"). For critiques and replies, see the journal websites.

analysis. For context, it should be noted that none of the pediatric or other medical bodies that have issued formal[109] policies on routine neonatal circumcision consider these health benefits to exceed the risks, regardless of the metric used.[110] The sole exception to this is the American Academy of Pediatrics (AAP), whose 2012 policy—due to expire this year—states that the medical benefits of circumcision "outweigh" the risk of surgical complications.[111] However, this claim was later softened after considerable international criticism[112] in an editorial by AAP Circumcision Task Force

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[109] A 2014 draft recommendation by the US Centers for Disease Control and Prevention echoes the findings of the American Academy of Pediatrics, but has not yet been revised in light of peer-review nor released in its final form. For further discussion, *see* Frisch & Earp, *Critical Assessment of Recent Evidence, supra* n.56; Brian D. Earp, *Do the Benefits of Male Circumcision Outweigh the Risks? A Critique of the Proposed CDC Guidelines*, 3 FRONT. PEDIATR. 18 (2015). For one of the invited peer-reviews of the CDC draft, *see* Robert S. Van Howe, *A CDC-Requested, Evidence-Based Critique of the Centers for Disease Control and Prevention 2014 Draft on Male Circumcision: How Ideology and Selective Science Lead to Superficial, Culturally-Biased Recommendations by the CDC* (2015), *available at* https://www.researchgate.net/profile/ Robert_Van_Howe.

[110] *See, e.g.*, Royal Dutch Medical Association, *Non-Therapeutic Circumcision of Male Minors* 1, 4 (2010), *available at* http://www.circumstitions.com/Docs/KNMG-policy.pdf (stating "[t]here is no convincing evidence that circumcision is useful or necessary in terms of prevention or hygiene … [in] light of the complications which can arise during or after circumcision [it] is not justifiable except on medical/therapeutic grounds." Stating also that "[i]nsofar as there are medical benefits, such as a possibly reduced risk of HIV infection, it is reasonable to put off circumcision until the age at which such a risk is relevant and the boy himself can decide about the intervention, or can opt for any available alternatives"); Royal Australasian College of Physicians (RACP), *Circumcision of Infant Males* 1, 5 (2010), *available at* https://www.racp.edu.au/docs/default-source/advocacy-library/circumcision-of-infant-males.pdf (stating that "[a]fter reviewing the currently available evidence, the RACP believes that the frequency of diseases modifiable by circumcision, the level of protection offered by circumcision and the complication rates of circumcision do not warrant routine infant circumcision in Australia and New Zealand"); Canadian Paediatric Society, Fetus and Newborn Committee, *Newborn Male Circumcision*, 20 PAEDIATR. CHILD HEALTH 311, 313 (2015) (stating that "the medical risk:benefit ratio of routine newborn male circumcision is closely balanced when current research is reviewed"). *See also* British Medical Association, *The Law and Ethics of Male Circumcision: Guidance for Doctors*, 30(3) J. MED. ETHICS 259, 260 (2004) (noting that "[t]here is a spectrum of views within the BMA's membership about whether non-therapeutic male circumcision is a beneficial, neutral, or harmful procedure or whether it is superfluous, and whether it should ever be done on a child who is not capable of deciding for himself." Stating also that "[t]he medical harms or benefits have not been unequivocally proved except to the extent that there are clear risks of harm if the procedure is done inexpertly").

[111] AAP, *Circumcision Policy Statement, supra* n.27.

[112] *See generally*, Frisch et al., *Cultural Bias in the AAP's 2012 Technical Report, supra* n.8; J. Steven Svoboda & Robert S. Van Howe, *Out of Step: Fatal Flaws in the Latest AAP Policy Report on Neonatal Circumcision*, 39(7) J. MED. ETHICS 434 (2013); Wolfram Hartmann, *Expert Statement: Dr Med. Wolfram Hartmann, President of "Berufsverband der Kinder- und Jugendärzte" [German Pediatric Society] for the Hearing on the 26th of November 2012 Concerning the Drafting of a Federal Government Bill*, BERUFSVERBAND DER KINDER- UND JUGENDÄRTZE (BVKJ) (2012) [German original available from http://www.kinderaerzte-im-netz.de/bvkj/ kinpopup/psfile/pdf/70/121126_Ste50aa5e211e6a6.pdf; English translation available from http://www.intactamerica.org/

member Dr. Andrew Freedman. Freedman stated that, in addition to having "insufficient information about the actual incidence and burden of nonacute complications," the AAP's 2012 assessment of benefit versus risk also suffered due to the "lack of a universally accepted metric to accurately measure or balance the risks and benefits."[113] Even more significantly, he went on to concede that

> although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of non-medical reasons. There can be no doubt that religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision."[114]

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german_pediatrics_statement]; Zachary T. Androus, *Critiquing Circumcision: In Search of a New Paradigm for Conceptualizing Genital Modification*, 3 GLOB. DISC. 266 (2013); Brian D. Earp, *The AAP Report on Circumcision, supra* n.9; Lyons, *Male Infant Circumcision as a "HIV Vaccine," supra* n.28. Critiques and counter-critiques to some of these papers are available at the journal websites.

[113] Given this absence or uncertainty of net benefit, it is relevant that several legal cases have determined that unnecessary surgery is in itself a harm, sometimes so serious that substantial damages have been awarded to plaintiffs who experienced no adverse effects from the treatment. In a US case, *Tortorella v. Castro* (2006), a doctor misread an MRI scan and removed healthy tissue. In holding him liable for damages, the California appeals court stated, "it seems self-evident that unnecessary surgery is injurious and causes harm to a patient. Even if a surgery is executed flawlessly, if the surgery were unnecessary, the surgery in and of itself constitutes harm." The court stated further, "the patient needlessly has gone under the knife and has been subject to pain and suffering." *See* Tortorella v. Castro, 43 Cal. Rptr. 3d 853, 855-56, 860, 862 (Cal. Dist. Ct. App. 2006). *See also* Dilieto v. Cnty. Obstetrics & Gynecology Grp., 297 Conn. 105 (2010) (physician liable for unnecessary removal of patient's reproductive organs); Murphy v. Blau, 2010 WL 745056 (Conn. 2010) (doctor deemed negligent in performing unnecessary surgery and failing to communicate the risks to the patient) (cited in Peter Adler, *Is Circumcision Legal?*, XVI(3) RICH. J. L. & PUB. INT. 439, 469 (2013)). In an Australian case, unnecessary dental work in itself was held to be a "trespass to the person," even though no additional harm resulted, and substantial damages (more than $1 million) were awarded to the patient. Dean v Phung [2012] NSWCA 223 (25 July 2012), *available at* http://www.austlii.edu.au/au/cases/nsw/NSWCA/2012/223.html. *See also [Unnecessary Extractions of Teeth constitutes Bodily Harm, Even If an Ignorant Patient Asks for It]*, 68(14) ZAHNARTZTL MITTZ. 769 (1978), *available at* http://www.ncbi.nlm.nih.gov/pubmed/277023. Most recently, a French man won a case against the surgeon who circumcised him as a consenting adult, then aged 26, after a diagnosis of phimosis. The court found that the surgeon had neglected to inform him about the risks and consequences of the surgery and failed to advise him of less harmful alternative therapies. Since the recommendation to circumcise was made "arbitrarily," the patient was awarded almost € 32,000 in compensation: € 5000 for moral damage resulting from the lack of information; € 3000 for physical and mental suffering; € 250 for temporary functional deficit and € 3,560 for permanent functional deficit; and € 20,000 for sexual harm because of "a partial loss of the ability to access pleasure." *See Circoncision: un Chirurgien Français Lourdement Condamné*, DROIT AU CORPS: POUR L'ABANDON DES MUTILATIONS SEXUELLES (June 24, 2016), *available at* http://www.droitaucorps.com/jugement-circoncision-france-2016.

[114] Andrew L. Freedman, *The Circumcision Debate: Beyond Benefits and Risks*, 137 PEDIATR. 1 (2016).

4.1. Weighing Benefits Against Risks: What Values Should One Assign (and Who Should Assign Them)?

It is uncontroversial that non-medical factors may reasonably factor into a person's decision about circumcision. What does inspire controversy, as Professor Munzer notes in his article, is the assumption implicit in Dr. Freedman's analysis that this person should be someone other than the individual who would be personally affected by the surgery were it to take place.[115] This assumption is also at play in the following discussion of a "trade-off" analysis of circumcision performed by Dimitri Christakis and colleagues:

> Parents' subjective weighing of the benefits of prevention and the harm of complications is fundamental to this decision-making process. Accordingly, we did not assign relative weights to the outcomes. Further, we believe that attempts to designate utilities for these outcomes—whether they be based on expert panels or community surveys—would be misguided. The weighing process in this decision should remain individualized and subjective, taking fully into account the parents' general degree of aversion to risk, and in particular whether the risk arises from either omitted or committed actions. Parents might well have greater feelings of guilt associated with adverse events arising from circumcision [i.e., a committed action], such as needing a penile wound repaired, than from a different adverse and somewhat preventable event [stemming from an omitted action], such as a [treatable] UTI occurring in uncircumcised boys. This aversion to committed action risk and its associated feelings may counter-balance or outweigh any potential benefits.[116]

In this passage, Christakis et al. are evaluating neonatal circumcision, specifically, so their invocation of the parents' subjective weightings is appropriate. But it is also important to consider the subjective weightings of the person who, to use their example, might need to have a penile wound repaired as a result of a surgical complication. This is a person for whom the

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[115] Brian D. Earp, *Male Circumcision: Who Should Decide?*, e-letter in 37(5) PEDIATR. (2016). Please note that minor portions of this section have been adapted from this letter.

[116] Demitri A. Christakis et al., *A Trade-off Analysis of Routine Newborn Circumcision.* 105(Supp. 2) PEDIATR. 246, 248 (2000).

stakes of the decision are arguably much higher, and for whom they are certainly much more personal. Needless to say, this person might reasonably conclude that such a risk—no matter how slight—is intolerable to him, given the nature of the organ in question. As Julian Savulescu has recently argued:

> The tendency today is to roll over and 'scientify' everything. Evidence will tell us what to do, people believe. But what [is required is an] ethical judgment about *weighing* risk and benefit. In Australia the speed limit is 100 km/h; in Germany, it is unlimited. Which is right? It depends on how you weigh convenience, pleasure, economic growth versus health. The safest speed to drive at is (almost) zero.[117]

Savulescu is right to emphasize the importance of weighing benefits against risks, in light of trade-offs and alternative options, and the intrinsically value-laden nature of this enterprise. To see how this insight applies to the specific health benefits that have been attributed to circumcision, let us first take the example of UTIs. According to the AAP, it would take about 100 circumcisions to prevent 1 UTI.[118] Given that boys have an approximately 1% absolute risk of getting a urinary tract infection in the first year of life,[119] regardless of circumcision status, and given that these infections can be treated effectively with oral antibiotics, as they are for girls, it seems fair to ask how much weight one should assign to this particular benefit.

A similar question applies to the claimed risk-reductions for STIs. Before one can make a determination about the importance of this benefit, one must consider a number of factors: (1) children are not at risk of contracting sexually transmitted infections before they become sexually active; (2) the absolute risk of the most serious of these infections is low in developed countries; (3) there are other, more effective modes of prevention that do not involve surgery and its attendant risks; (4) bacterial STIs, if they do occur, can

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[117] Julian Savulescu, *Bioethics: Why Philosophy is Essential for Progress*, 41(1) J. MED. ETHICS 28, 30 (2015) (emphasis added).
[118] AAP, *Male Circumcision*, *supra* n.107. *See also* Davinder Singh-Grewal, et al., *Circumcision for the Prevention of Urinary Tract Infection in Boys: A Systematic Review of Randomised Trials and Observational Studies*, 90(8) ARCH. DIS. CHILD. 853 (2005).
[119] *Id.*

typically be cured with antibiotics; and (5) viral STIs can now be prevented in some cases by vaccination, or otherwise managed with medications.[120]

Given these (and other) considerations, what is the relative weight or value that one should assign to a claimed risk-reduction for STIs? Is it worth the risk already mentioned—that of a "botched" circumcision? Is it worth the loss of the foreskin itself? Is it worth the risk of removing too much skin—as we saw in the "Dear Abby" exchange—which may lead to painful erections later in life? Is it worth the risk, no matter how slight, of death?[121]

The answers to these questions cannot be objectively determined. Instead, they will depend upon the value an individual places on having intact rather than modified genitalia, how willing he is to engage in safer sex practices (which is advised regardless of one's circumcision status, and in addition to which the marginal benefit of circumcision is negligible),[122] and

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[120] With respect to (1), proponents of circumcision often point out that some males become sexually active before an age at which they would be legally allowed to consent to circumcision (presumed to be 18). There are two ways to respond to this: first, the age of consent for circumcision could be lowered, perhaps to 15 or 16, if that really is the main issue; but second, this is mostly a red herring. As Van Howe notes, "[a]ccording to the CDC's own numbers, the risk of HIV infection under the age of 15 years is very low. How many 15 year olds are having unprotected sex with female partners who are HIV-infected?" Van Howe, *CDC-Requested Critique*, *supra* n.109, at 15. With respect (2), also concerning HIV, *see* Sarah Bundick, *Promoting Infant Male Circumcision to Reduce Transmission of HIV: A Flawed Policy for the US*, HARV. HEALTH & HUM. RIGHTS J. BLOG. (2009, Aug. 31), *available at* http://www.hhrjournal.org/2009/08/promoting-infant-male-circumcision-to-reduce-transmission-of-hiv-a-flawed-policy-for-the-us/ (pointing out that "[t]aken together, the data [as applied to the relevant populations] suggest that the number of HIV infections that could be prevented in the US by promoting infant male circumcision is likely to be only in the hundreds per year – a tiny fraction of the estimated 50,000 new HIV infections"). *See also* CDC, *HIV in the United States: At a Glance* (2016), *available at* https://www.cdc.gov/hiv/statistics/overview/ataglance.html (providing figures consistent with Bundick's analysis, in that new HIV infections are rare, and the most affected sub-groups would derive no benefit from circumcision, since they are primarily MSM, for whom there is no compelling evidence of a protective effect—see the review by Templeton et al. *infra* n.128). With respect to (3), we allude to condom-use and other safe sex strategies, which should be practiced whether or not one is circumcised, and which a man might rationally prefer over losing his foreskin (and then engaging in such strategies anyway, thereby virtually eliminating the marginal benefit for circumcision). With respect to (4) and (5), for an accessible overview, *see* National Institutes of Health, *Treatments for Specific Types of Sexually Transmitted Diseases and Sexually Transmitted Infections (STDs/STIs)* (2017), *available at* https://www.nichd.nih.gov/health/topics/stds/conditioninfo/Pages/specific.aspx (last accessed Jan. 14, 2017).

[121] For a recent example, *see* Lizzie Dearden, *Newborn Bleeds to Death after Doctor 'Persuades' Parents to Have Him Circumcised in Canada*, THE INDEPENDENT (Oct. 27, 2015), *available at* http://www.independent.co.uk/life-style/health-and-families/health-news/newborn-bleeds-to-death-after-doctor-persuades-parents-to-have-him-circumcised-in-canada-a6710061.html.

[122] *See, e.g.*, Akim McMath, *Infant Male Circumcision and the Autonomy of the Child: Two Ethical Questions*, 41(8) J. MED. ETHICS 687 (2015).

how much risk he is comfortable taking on when submitting to a surgical intervention on a part of the body that is both physically and symbolically sensitive.[123] None of this, however, can be known with certainty while the individual is still an infant; he can only report on his values when he is older and fully informed.[124]

That an individual's values can only be known when he is mentally mature, however, does not automatically lead to the conclusion that circumcision should be delayed. In fact, so long as the alternative is not strictly prohibited, a parental decision to refrain from circumcision in infancy is—as Munzer notes—still a decision, and one with which the child may later disagree. Again, this line of reasoning assumes that his parents were legally entitled to make such a choice in the first place; if they were not, the grown child could not rationally fault them for having left his genitals intact when he was an infant. Of course, this points to one possible solution to the collective action problems regarding teasing or other potential social harms,[125] as well as to the more general problem of uncertainty regarding the child's best interests (i.e., a legal prohibition that would apply across the board, thereby eliminating the grounds for teasing or uncertainty); but we shall not pursue that argument further.

In the meantime, whatever choice they make, parents will foreclose at least one future option for their child. Specifically:

> parents who decide in favor of early surgery close off the child's future ability to make his own decision regarding surgery (and run the risk of the child experiencing surgical

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[123] The foregoing paragraphs are loosely adapted from Frisch & Earp, *Critical Assessment of Recent Evidence*, *supra* n.56.

[124] As Munzer notes, it is possible that in infancy "there is now no fact of the matter concerning the future time at which a circumcised child attains majority in regard to his welcoming or regretting his circumcision" since "this possibility turns on the thorny philosophical problem of whether propositions about future contingents have a truth-value." *See* Munzer, *supra* n.1, at 533.

[125] For a discussion of analogous collective action problems in the case of female genital cutting, *see, e.g.*, Gerry Mackie, *Ending Footbinding and Infibulation: A Convention Account*, 61 AM. SOCIOL. REV. 999 (1996). For a short description of why social/structural solutions are needed in such cases, rather than a reliance on unilateral efforts by individuals, *see, e.g.*, Jim A. C. Everett et al., *A Tragedy of the (Academic) Commons: Interpreting the Replication Crisis in Psychology as a Social Dilemma for Early-career Researchers*, 6 FRONT. PSYCHOL. 1 (2015).

> complications, resentment, and so on), while parents who refrain from early surgery close off the option for the affected male to undergo the surgery *during infancy or early childhood*.[126]

That much cannot be disputed. But are these cases symmetrical? As Adrienne Carmack et al. note, "it is possible that the affected male whose parents opt against early surgery to allow him to make his own decision in the future may later decide in favor of surgery,"[127] and so he may. However, nontherapeutic circumcisions are rarely sought by adults with intact genitals, even in cultures in which circumcision is common and normative.[128] Therefore,

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[126] Adrienne Carmack et al., *Should Surgery for Hypospadias Be Performed Before An Age of Consent?*, 53 J. SEX RES. 1047, 1057 (2016) (emphasis added). Please note that while this analysis concerns surgery for hypospadias—a different penile surgery that is often carried out in infancy or early childhood—the same principles apply to NTC. Hence the use of this quote here.

[127] *Id.*

[128] Definitive figures on this issue are elusive, but analysis of rebates for circumcision procedures provided by the Australian government health insurance system, Medicare, suggests that approximately 3.8% of non-circumcised boys aged 15 in 2005 will have been circumcised by their 65th birthday – an annual rate of 0.076%. These figures were calculated by John Cozijn from data kept by the Health Insurance Commission (http://www.health.gov.au/medicarestats); *see* http://www.circinfo.org/statistics.html. In the US, a study by Chongyi Wei and colleagues found that even if they believed that circumcision provided significant protection against HIV, very few of the adult men they sampled would elect it for themselves. Chongyi Wei et al., *What Is the Potential Impact of Adult Circumcision on the HIV Epidemic Among Men Who Have Sex with Men in San Francisco?* 37 SEX TRANSM. DIS. 1 (2010). Proponents of circumcision sometimes cite this study to imply that such men must be irrational, or simply too afraid to undergo a surgery that they know is in their objective best interests. This claim is then harnessed into a paternalistic assertion that circumcision should take place in infancy. But there is an alternative explanation: perhaps such men simply regard their foreskins as valuable enough that they would prefer to keep their genitals intact, even if this meant a slight increase in the absolute risk of contracting HIV. Or perhaps the men understand that they are being asked a hypothetical question with a false premise: there is no compelling evidence that circumcision reduces the risk of HIV transmission among MSM. *See, e.g.*, David J. Templeton et al., *Male Circumcision to Reduce the Risk of HIV and Sexually Transmitted Infections Among Men who Have Sex with Men.*, 23 CURR. OPIN. INFECT. DIS. 45, 45 (2010) (stating that "[t]he evidence that circumcision reduces HIV and other STIs among MSM is weak and inconsistent [although] MSM who predominantly take the insertive role in anal intercourse may be at a lower risk of HIV infection." While some MSM "may be willing to undergo adult circumcision, should it be proven to reduce HIV acquisition risk, there is substantial potential that behavioural disinhibition could offset any benefits achieved by a circumcision intervention"). Indeed, the available data only suggest a reduction in risk from females to males during heterosexual intercourse; the trial looking at male to female transmission, by contrast, had to be stopped early due to futility—i.e., more infections occurring in the female partners of circumcised, compared to non-circumcised, men. Maria J. Wawer et al., *Circumcision in HIV-infected Men and its Effect on HIV Transmission to Female Partners in Rakai, Uganda: A Randomised Controlled Trial*, 374 LANCET 229, 229 (2009) (finding that "17 (18%) women in the intervention [circumcision] group and eight (12%) women in the control [no circumcision] group acquired HIV during follow-up … Circumcision of HIV-infected men did not reduce HIV transmission to female partners over 24 months; longer-term

this point may be mostly academic. Nevertheless, if a non-circumcised adult is considering NTC, for whatever reason, he can perform his own risk-benefit analysis of the surgery, taking into account the fullness of his circumstances. If he then chooses NTC, he will be secure in the knowledge that he has done so voluntarily, undertaking a certain amount of risk to achieve a desired outcome.

In such a case, as supporters of NTC often point out, there is an indeterminate likelihood that he would wish the surgery had already taken place, perhaps in infancy, so that he does not now have to face the inconvenience. In this respect, he is not unlike the adult female in a similar social context who decides to undergo elective labial surgery for what she considers to be cosmetic reasons.[129] Perhaps it would have been better—from her current perspective—to have undergone the procedure shortly after birth, so that she likewise would not have to face it now. But no one takes this possibility as an argument in favor of neonatal labiaplasty. Indeed, such statements as "she won't even remember it," "she'll heal faster," "her future sexual partners will find her genitals to be more appealing," and "it's less risky at this age"—all of which are regularly invoked in defense of NTC—would be considered offensive. Rather, the expectation is that girls should be able to make such personal decisions for themselves when they are older and can understand what is at stake.

In any event, the adult with unmodified genitals—who now prefers that they be altered—has an option available with which to satisfy the preference.[130] By contrast, the man whose early circumcision was not desired,

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effects could not be assessed. Condom use after male circumcision is essential for HIV prevention").

[129] We do not mean to imply that such "cosmetic" genital surgeries are unproblematic, simply because they are performed on adults. Nor do we maintain that the decision to pursue them is free from invidious social pressures stemming from, *inter alia*, distorted notions of what is "normal" and/or restricted views about what is "beautiful." We do suggest, however, that if a nontherapeutic genital surgery is to be performed, whether in response to unjust social pressures or anything else, it would be better if the proximate decision to undergo the surgery were made by the person whose genitals will be affected by it, all else being equal. For a related analysis, *see* Brian D. Earp, *Hymen "Restoration" in Cultures of Oppression: How Can Physicians Promote Individual Patient Welfare Without Becoming Complicit in the Perpetuation of Unjust Social Norms?*, 40 J. MED. ETHICS 431 (2014).

[130] Indeed, she or he can provide specific input as to the "style" of labiaplasty/circumcision that is desired (concerning how much tissue and of what kind to remove), and can also manage her/his pain control needs throughout the healing process. Neither of these features would apply in infancy.

and is now a cause of significant distress, has no comparable remedy. He may attempt artificial foreskin "restoration," as described earlier—if he has enough remaining penile skin to do so—but this may take years to accomplish, and the result will be a mere approximation of a prepuce: he can never recover the tissue or the nerve endings that were lost. Thus, it appears that the two cases are not symmetrical. In the deferred surgery case, there is far greater leeway for the individual to rectify an undesired situation.

4.2. The Question of Timing

Let us pursue this issue of timing further. As Akim McMath observes: "People disagree over what constitutes a harm and what constitutes a benefit" when it comes to circumcision. This disagreement is especially likely for non-medical harms and benefits, which allow even more room for subjective judgments than the ones we have so far considered. For example, "[s]ome people believe circumcision benefits the child by bringing him closer to God, while others disagree. In light of such disagreement, some commentators conclude that the parents should decide." But this does conclusion does not follow: "the child will have an interest in living according to his own values, which may not reflect those of his parents … Only the child himself, when he is older, can be certain of his values." Thus, McMath concludes, "if disagreement over values constitutes a reason to let the parents decide, it constitutes an even stronger reason to postpone the decision until the child himself can decide."[131]

Against this view, as Munzer notes, it is sometimes argued that circumcision—among practicing Jews at least—must be performed on the 8th day after birth to meet religious requirements (i.e., to fulfill a perceived divine covenant), and therefore cannot be postponed. This argument does carry considerable force, especially in light of the strong moral and legal protections that are typically afforded to religious practices in Western countries.

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[131] McMath, *supra* n.122, at 689.

However, it must be acknowledged that such protection does not currently extend to any form of nontherapeutic female genital cutting, no matter how slight, and no matter how sincere her parents' conviction that such cutting is religiously required.[132] Moreover, as Eldar Sarajlic notes, the argument rests on certain metaphysical assumptions that one might regard as highly questionable. For example,

> it presumes the existence of a divine entity that commands the performance of circumcision. While the question about the existence of such an entity is a matter of personal persuasion, the mere presumption can hardly warrant authorizing an invasive intervention into the body of another human being, even if in cases of parents and their children. Without a definite proof that such an intervention would bring metaphysical benefits (provided these are defined more precisely) to the child, circumcision cannot be justified [on best interest grounds].[133]

Furthermore, the claim about metaphysical salvation "presumes that the child will necessarily share their parents' metaphysical beliefs once it is

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[132] As Kavita S. Arora and Allan J. Jacobs point out, it is often claimed that female genital cutting is not truly a religious practice, because it is not mentioned in the Koran, the central scripture of Islam. But this view is highly simplistic and misleading. As they note, "legal protection of a religious practice is not [normally] contingent either on the orthodoxy of the practice or on a consensus within a religious tradition accepting the practice." Furthermore, "outsiders to a religious tradition cannot infer the practices of a religious system from a literal reading of its canonical texts. It is no more possible to define Islam within the four corners of the Quran than to define Christianity (which includes traditions ranging from Presbyterian to Pentecostal to Greek Orthodoxy) solely from a reading of the Bible." Rather, "the content of religious belief and practice are guided by interpretive texts and traditions. Thus, many Muslim scholars classify FGA as "Sunnah" or practice established by the prophet Muhammad. Though not prescribed explicitly in the Quran, the practice thus is religiously virtuous." Kavita S. Arora & Allan J. Jacobs, *Female Genital Alteration: A Compromise Solution*, 42 J. MED. ETHICS 148, 151 (2016). For further extensive discussion, *see* Dena S. Davis, *Male and Female Genital Alteration*, *supra* n.32; Brian D. Earp, Jennifer Hendry, and Michael Thomson, *Reason and Paradox in Medical and Family Law: Shaping Children's Bodies*, MED. L. REV. (in press) (noting that even if religious practices could be conceptually cordoned off from "merely" cultural ones, the latter would not necessarily be any less deserving of respect). *See also* Alex Myers, *Neonatal Male Circumcision, If Not Already Commonplace, Would Be Plainly Unacceptable by Modern Ethical Standards*, 15 AM. J. BIOETH. 54, 55 (2015) (noting that "in Sunni Islam, the dominant branch of Islam, two of the four schools of jurisprudence, Shafi'i and Hanbali, consider Type 1 female circumcision to be obligatory, while the other two schools, Maliki and Hanafi, recommend the practice." And going on to argue that "[t]he scriptural support for this is no weaker than that for male circumcision—both are derived from the secondary source of Islamic law known as the Hadıth … Thus, if we defer to religious justifications, we shall find that in many cases, the circumcision of female as well as male children could be permitted on this basis").

[133] Sarajlic, *supra* n. 41, no page numbers provided.

grown up."[134] But research shows that children are increasingly abandoning their parents' religion or otherwise changing their core beliefs as they get older.[135] In multi-religious, multi-ethnic, multi-cultural societies, children are regularly exposed to different belief systems and ways of life, and they often find as they mature that worldviews other than the one with which they were raised are more compelling. Permanently altering a child's body in accordance with just one defeasible metaphysical belief system—one which there is a non-trivial likelihood the child will later reject—is therefore problematic.

Another common argument against delaying NTC is that the surgery is "less risky" in infancy, such that deferring the decision to an age-of-consent would be undesirable from a medical perspective. If so, this would count as an ethically-relevant asymmetry pointing in the opposite direction to the one concerning available remedies for resentful adults. But this argument, too, is not straightforward. In the first place, it may be the case that any number of nontherapeutic bodily interventions are less risky in infancy compared to later in life: removing the earlobes, for example, may carry fewer surgical risks in the neonatal period than in adulthood, although we are not aware of any data on this question.[136] The same may be true of ritualized tooth extractions, or of the facial scarification procedures practiced by some groups.[137] The initial question, however, is whether such interventions are permissible at all, given the prevailing moral and legal norms of the wider society in which the child is being raised. If they are not, then the question of preferred timing on the basis of relative risk profiles does not arise.

Second, it is not clear that infant circumcision, compared to adult

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[134] *Id.*

[135] According to a recent summary of a Pew Research study, focusing just on the United States, "[w]hile the US public in general is becoming less religious, the nation's youngest adults are by many measures much less religious than everyone else." Indeed, "one of the most striking findings in the recently released Religious Landscape Study is that Millennials (young adults born between 1981 and 1996) are much less likely than older Americans to pray or attend church regularly or to consider religion an important part of their lives." David Masci, *Why Millennials are Less Religious than Older Americans*, PEW RESEARCH CENTER (Jan. 8, 2016), *available at* http://www.pewresearch.org/fact-tank/2016/01/08/qa-why-millennials-are-less-religious-than-older-americans/.

[136] As such removal would be considered assault.

[137] Again, we are not aware of any data on this subject.

circumcision, does in fact carry less surgical risk. The claim that it does, oft-repeated by NTC proponents, is based largely upon retrospective comparisons of non-concurrent studies with results drawn from dissimilar populations, using dissimilar methods and criteria for identifying complications.[138] Thus, these comparisons do not adequately control for the skill of the practitioner, the specific technique employed, the setting of the surgery, and the methods of data collection, among other factors.[139]

But even if we simply grant that there is an increase in the relative risk of complications between the surgery performed in childhood versus adulthood, it is the difference in absolute risk that is most ethically relevant. Even proponents of circumcision contend that the absolute likelihood of clinically important, difficult-to-resolve surgical complications associated with circumcision is "low," irrespective of the age at which the procedure is performed.[140] Given such a low baseline risk according to the proponents' view, the existence of a relative risk reduction in the incidence of adverse events in infancy compared to adulthood is unlikely to be morally decisive: a small risk divided by any amount is still a small risk.[141]

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[138] *See, e.g.*, Brian J. Morris et al., *A 'Snip' in Time: What is the Best Age to Circumcise?*, 12(1) BMC PEDIATR. n.p. (2012). For further discussion, *see* J. Steven Svoboda, & Robert S. Van Howe, *Circumcision: A Bioethical Challenge*, J. MED. ETHICS (2014) e-letter, *available at* http://www.arclaw.org/sites/default/files/svoboda-van-howe-circumcision-a-bioethical-challenge.pdf.

[139] There is also an "epistemic asymmetry" between men circumcised in infancy and men circumcised as adults in terms of their ability to recognize, and report on, any adverse outcomes. Men circumcised as adults have a conscious baseline against which they can assess any undesired consequences, whereas men circumcised as infants have no other frame of reference.

[140] *See, e.g.*, Brian J. Morris & Edward .C. Green, *Circumcision, Male* in THE WILEY BLACKWELL ENCYCLOPEDIA OF HEALTH, ILLNESS, BEHAVIOR, AND SOCIETY 253-56 (W. Cockerham, R. Dingwall & S. R. Quah, eds., 2014). Note, however, that even a low risk of such complications, when multiplied by the millions of circumcisions that are performed each year, will nevertheless result in what many people regard as an unacceptably large number of men who must go through life with penile deformities or other significant problems that they otherwise would not have to face. Against this view, it could be argued that many common things in life carry risk: swimming, playing sports, and so on. However, these activities are typically undertaken with the age-appropriate consent of the child, who has at least some understanding of what is likely implied by his or her participation. Procedures carried out on a child's genitals without a strict medical indication, we suggest, pose a different kind of risk, and one that might reasonably be judged to be less acceptable than the risks to which a child may expose himself by participating in sports or similar activities.

[141] As Sarah Williams notes, "[t]he size of the initial absolute risk is what's really important here. If the initial risk is very small, even a huge increase may not make much absolute difference." Sarah Williams, *Absolute Versus Relative Risk – Making Sense of Media Stories*, CANCER RESEARCH UK - SCIENCE BLOG (Mar. 15, 2013), *available at* http://scienceblog.cancerresearchuk.org/2013/03

If that much is right, the analysis returns to the necessary effects of circumcision, outlined earlier: (1) the loss of the foreskin itself, along with the loss of all sensations and erotic activities that rely on its being preserved, and (2) the loss of free choice in the matter if the procedure is performed in infancy or early childhood. As we have seen, men's attitudes regarding these necessary outcomes vary widely, and such attitudes are likely to be much more predictive of their satisfaction with circumcision than any minor discrepancies in surgical risk profiles as a function of timing.[142]

5. RELEVANCE OF CULTURAL AND SUBJECTIVE FACTORS: A SUMMARY

To summarize, whether NTC is harmful depends in large part upon the value one assigns to the foreskin. If the foreskin has value—or if it is reasonable for a man to regard his foreskin as having value—then its sheer removal can be counted as a harm. In the United States, Israel, and in some Muslim-majority countries, where infant and child circumcision remain common, the majority of adult males and their partners have never experienced sex with a foreskin. The bulk of their information comes from informal sources, such as TV shows or magazines, where the natural penis is likely to be referred to as "uncircumcised"—an arguably pejorative term that treats the surgically modified penis as the default[143]—and where it may also

/15/absolute-versus-relative-risk-making-sense-of-media-stories/.

[142] *See* Darby, *Targeting Patients Who Cannot Object*, *supra* n.90. Darby argues that the historical development of a strong preference for circumcising infants and children, rather than offering the operation as an elective to adults, had little to do with the interests of the child, the lower risk of complications, or the superior efficacy of early circumcision, but was rather related to the convenience of the operator, established habit, and the asymmetrical power relations between adults and children. Darby suggests that the argument that infancy is the "best time to circumcise" can be seen, in part, as making the false assumption that circumcision is desirable for all and will be necessary for most at some stage.

[143] Compare with a woman's chest, which we do not refer to as "un-mastectomized," or her vulva, which we do not call "unlabiaplastied." A further problem with this term is that it can be confused with foreskin restoration—an attempted act of "un-circumcising." *See* William G. Wallace, *An Undeniable Need for Change: The Case for Redefining Human Penis Types: Intact, Circumcised, and Uncircumcised (All Three Forms Exist and All Are Different)*, 28(5) CLIN. ANAT. 563 (2015).

be regarded as a source of crude humor.[144] In these cultural settings, even among health professionals, the foreskin may be erroneously regarded as a "useless flap of skin" that is prone to infection and other medical problems. Since the foreskin itself is assumed to have little value in such contexts, the principal perceived drawback of NTC becomes simply the risk of surgical complications. Especially when compared against the various medical and non-medical benefits that are often attributed to NTC in these societies, such a minor perceived risk can easily be discounted.

In contrast, in societies where NTC is relatively rare—i.e., most other industrialized nations—the foreskin is typically regarded with greater favor,[145] and it is the circumcised penis that is perceived as strange-looking and less than functionally optimal.[146] This contrast serves to highlight the contingent and at least partially arbitrary nature of such judgments: some men regard their own neonatal or childhood circumcisions as representing an aesthetic or sexual enhancement compared to the natural state, while others see it as a disfigurement or even a mutilation.[147] Since the cultural norms that inform such judgments are not stable, however, as noted *supra*—especially given advanced information technology, other forces of globalization, and accelerated cross-cultural exchange—there is a growing risk that parents' valuations of a proposed circumcision will differ from those of the child himself when he is older.

By authorizing the removal of an infant or young child's foreskin, therefore, a trade-off is initiated whose overall status rests upon future

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[144] *See generally*, Hugh Young, *'That Thing': Portrayal of the Foreskin and Circumcision in Popular Media*, 37 CIRCUMCISION & HUMAN RIGHTS 239 (Denniston et al. eds., 2009).

[145] One measure of the value placed on the foreskin in these countries is the number of prepuce-sparing procedures that have been developed for males with penile problems. For example, rather than resorting to circumcision as a treatment for pathological phimosis (an inability to retract the foreskin causing problems), a steroid cream will typically first be applied and, as a last resort, a minor procedure called preputioplasty will be attempted, which removes as little of the foreskin as possible while still resolving the problem. *See, e.g.*, T. M. Lane & L. M. South. *SURGICAL TECHNIQUE-Lateral Preputioplasty for Phimosis.* 44(5) J. ROYAL COL. SURG. EDIN. 310 (1999). *See also* Pa Dewan et al., *Phimosis: Is Circumcision Necessary?*, 32(4) J. PAEDIATR. & CHILD HEALTH, 285 (1996).

[146] *See, e.g.*, Androus, *supra* n.112, at 266-80.

[147] For extensive discussion of this point, *see* Earp, *Between Moral Relativism and Moral Hypocrisy*, *supra* n.33, at 105-144 and E1-E28. *See also* Boyle et al., *supra* n.72, at 329-34; Hammond, *supra* n.96, at 85-92.

subjective norms and preferences that will become increasingly hard to predict. As Hannah Maslen and colleagues argue:

> Whilst adults are in a position to decide whether effect X is valuable enough (to them) to justify incurring [loss] Y, children do not yet have the capacity or the life experience to make such trade-off decisions. They do not know what they will value when they grow up and nor do their parents. Whilst an intervention that improves X may count as an enhancement for the individual who does not care much about Y, another individual, valuing Y over X, will view the very same outcome as an impairment. In such cases—that is, cases in which the very status of an intervention's being an (overall) enhancement vs. an impairment is controversial—the weight of considerations should shift toward delaying the intervention until the individual who will actually be affected by it has sufficient capacity to decide. The more permanent and substantial the trade-off, the more this argument has force.[148]

6. TENTATIVE CONCLUSION: TOWARD GENDER EQUALITY?

The foregoing analysis does not necessarily show that parents should be legally prohibited from making decisions about the nontherapeutic surgical alteration of their children's genitals.[149] But once again we must emphasize that in the case of female children, such alterations are already illegal in countries such as Germany and the United States, and the law in these countries appears to be settled. As Munzer notes, these laws cover alterations to the vulva that are less physically invasive than male circumcision (such as pricking of the clitoral hood), as well as interventions that may be performed, at least in some groups, for similar if not identical reasons on both boys and girls.[150] As Dena Davis argued more than a decade ago with respect to the

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[148] Hannah Maslen et al., *Brain Stimulation for Treatment and Enhancement in Children: An Ethical Analysis*, 8(953) FRONT. HUM. NEUROSCI. 1, 4 (2014).

[149] For the view of one of the present authors on the question of a legal prohibition, *see* Brian D. Earp, *Things I Have Learned (So Far) About How to Do Practical Ethics*, PRACTICAL ETHICS (2014), *available at* blog.practicalethics.ox.ac.uk/ (arguing that pushing a ban before cultural readiness can often backfire).

[150] The most important and exhaustive analysis of these points is due to Dena Davis, *Male and Female Genital Alteration*, *supra* n.32. For further discussion, *see* Debra L. DeLaet, *Framing Male*

United States, this creates a legal "collision course" that can no longer be avoided:

> When one begins to question the normative status of male newborn alteration in the West, and when one thinks of female alteration as including even an hygienically administered 'nick,' one sees that the two practices, dramatically separated in the public imagination, actually have significant areas of overlap. [In fact] the two practices lack a legally defensible distinction, given the current wording of state and federal statutes. Thus, a complete laissez-faire attitude toward one practice coupled with total criminalization of the other, runs afoul of the 'free exercise' clause of the First Amendment. There are also troubling implications for the constitutional requirement of equal protection, because the laws appear to protect little girls, but not little boys, from religious and culturally motivated surgery.[151]

Munzer deserves credit for dedicating a section of his article to this "problematic" legal situation, as it is often side-stepped in these debates.[152] As he notes, in the aftermath of the Cologne judgment, just as the law was being clarified to ensure the legality of nontherapeutic circumcision of male infants, the law against any form of nontherapeutic female genital cutting (FGC) was being strengthened. This sort of inconsistency arises in part from the inherent subjectivity in harm judgments we have emphasized, which allows for gendered and other cultural assumptions to seep in. One such assumption may be that boys are (or should be) "tougher" than girls and therefore less liable to suffer harm given a comparable injury. As Bettina Shell-Duncan and Yvla Hernlund note, "there appears to exist in the West a tolerance of, and perhaps

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Circumcision as a Human Rights Issue? Contributions to the Debate over the Universality of Human Rights. 8(4), J. HUM. RTS., 405, 405 (2009) (arguing that "the most common forms of male and female circumcision are not sufficiently divergent practices to warrant a differential response from the international community and that there are more similarities between the two practices than is typically acknowledged"). *See also* Brian D. Earp, *Boys and Girls Alike: The Ethics Of Male And Female Circumcision* in WOMEN, HEALTH, & HEALTHCARE: READINGS ON SOCIAL, STRUCTURAL, & SYSTEMIC ISSUES 113-16 (E. C. H. Gathman ed., 2016) (arguing that there is substantial overlap between male and female genital cutting practices in terms of physical effects, underlying rationales, and symbolic meanings, when the full range of each is considered and like compared with like).

[151] Davis, *supra* n.32, at 448.

[152] Munzer, *supra* n.1, at 560.

appreciation for, the assumption that masculine [but not feminine] ideals are honed through painful initiations that respond to group needs."[153] Similarly, Fox and Thomson argue:

> Debates concerning [female] bodies have often focused on their vulnerability to harm – as is evident in the framing of debates around female circumcision. By contrast, male bodies are typically constructed as safe, bounded and impermeable … this may make it more difficult to uncover harms to boys – a contention which seems to be borne out by the tendency of Anglo-American legal commentators to minimise the harms inflicted on boys by circumcision with a concomitant propensity to exacerbate the risks occasioned by less invasive forms of female circumcision.[154]

Such an analysis has implications for interpreting the obligations contained in the UN Convention on the Rights of the Child (CRC), particularly the ambiguous article 24 (3): "States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children."[155] In his recent discussion of what this phrasing means, John Tobin points out:

> this phrase does not appear to require that the harm suffered to a child's health reach a certain threshold before the obligations of a State are invoked under Article 24 (3). On the contrary, it suggests that any aspect of a traditional practice which in any way has a negative impact on the health of a child, whether mental or physical, temporary or permanent, must be abolished. Moreover, the assessment as to the prejudicial impact of such a practice is not to be based on assumptions or speculation, which are invariably informed by social and cultural values, but on medical evidence which quantifies its physiological and or psychological impact.[156]

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[153] Shell-Duncan & Hernlund (eds.), FEMALE "CIRCUMCISION" IN AFRICA, *supra* n.152, at 16.
[154] Marie Fox & Michael Thomson, *Short Changed? The Law and Ethics of Male Circumcision* in CHILDREN'S HEALTH AND CHILDREN'S RIGHTS 161, 175–76 (Michael Freeman ed., 2006).
[155] U.N. Convention on the Rights of the Child, art. 24(3), *opened for signature* Nov. 20, 1989, 1577 U.N.T.S. 2 (entered into force Sept. 2, 1990).
[156] John Tobin, *The International Obligation to Abolish Traditional Practices Harmful to Children's Health: What Does It Mean and Require of States?*, 9(3) HUMAN RTS. L. REV. 373, 378 (2009).

Unfortunately, as discussed *supra*, taking medical evidence as the benchmark "obscures the complex debates as to the purported objectivity of medical knowledge."[157] The advantage of relying on medical claims, from the UN committee's point of view, was that it allowed them "to avoid the explicit condemnation of cultural practices by diverting attention from their cultural significance to their health impact."[158] Such a distinction is, however, difficult to maintain in practice because

> cultural and social values will invariably influence the understanding of harm, especially psychological harm. Ritual initiation ceremonies provide a good example of such a dilemma. They may involve the infliction of significant physiological harm which would prima facie fall within the scope of Article 24 (3).[159]

The contrary argument, as we noted earlier, is that if the traditional practice were prohibited or abolished, children who were not subject to the relevant initiation might be excluded or suffer other social setbacks which could lead to psychological harm. This empirically unsubstantiated proposition has long been prominent in the arguments of those who support the preservation of genital cutting rites, not only for boys, but also for girls, who may similarly suffer ridicule or discrimination from their peers for having failed to undergo the prescribed rituals.[160] Yet this way of arguing ignores the

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[157] *Id.*

[158] *Id.*

[159] *Id.*

[160] *See, e.g.*, Tobe Levin, *Nura Abdi, Fadumo Korn: No More Pudendal Desecration* in FEARFUL SYMMETRIES: ESSAYS AND TESTIMONIES AROUND EXCISION AND CIRCUMCISION 129, 135 (Chantal Zabus ed. 2008) (discussing the fact that in some communities, "[m]ale circumcision builds community; so does [circumcision of] girls … for desire to be included, to escape being mocked, drives" both practices. "The unaltered vagina is wet; it drips. Its effluvium emits an unpleasant smell. It must be erased," according to proponents of female genital cutting; this is similar to the claims of many proponents of male circumcision that the unaltered penis is "dirty" or difficult to clean, and therefore circumcision should be pursued); FEMALE "CIRCUMCISION" IN AFRICA: CULTURE, CONTROVERSY, AND CHANGE (Bettina Shell-Duncan & Yvla Hernlund eds. 2000) (with numerous contributing authors discussing various social pressures that drive female genital cutting practices in many communities, including the prospect of teasing). With respect to boys, note that according to one study, the most common penile characteristic to provoke teasing in school locker rooms in the US Midwest—where circumcision prevalence is especially high (87% in the study sample)—was penile size. Teasing for not being circumcised was far less common.

fact that a successful prohibition would alter the social norms all at once: no child can be teased for being "different down there" if all children have intact genitalia.

Notwithstanding this and other similarities between male and female genital cutting, Tobin notes that the CRC "has failed to make any substantive comments with respect to male circumcision, also a traditional practice."[161] In attempting to explain this discrepancy, Tobin refers to the (Anglophone) tendency to construct male circumcision as a "standard and benign medical practice,"[162] and observes that while the negative impact of FGC on a girl's health is "virtually uncontested,"[163] the evidence with respect to male circumcision is equivocal, at least when performed in a clinical setting. This would not, however, explain the "absence of concern for the practice in non-medical settings, where performance of the procedure is associated with significant levels of pain and the risk of infection."[164] Thus, again, the

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Regardless of the experience of teasing, very few of the men surveyed were unsatisfied with their penile appearance, and "experiencing teasing or witnessing others being teased about penile appearance did not have an effect on the desire for a different penile appearance." Moreover, compared to being circumcised, "being uncircumcised did not increase the rate of personally experienced teasing." Siobhan E. Alexander et al., *Teasing in School Locker Rooms Regarding Penile Appearance*. 193 J. UROL. 983, 985 (2015).

[161] Tobin, *supra* n.153, at 382-3.

[162] Citing Marie Fox & Michael Thomson, *Short Changed? The Law and Ethics of Male Circumcision*, 13 INT'L. J. CHILDREN'S RTS. 161, 161–81 (2005).

[163] However, *see* Carla M. Obermeyer, *The Health Consequences of Female Circumcision: Science, Advocacy, and Standards of Evidence*, 17(3) MED. ANTHROPOL. Q. 394, 394 (2003) (showing that "few studies are appropriately designed to measure health effects, that [female] circumcision is associated with significantly higher risks of a few well-defined complications, but … for other possible complications the evidence does not show significant differences"); Carla M. Obermeyer, *The Consequences of Female Circumcision for Health and Sexuality: An Update on the Evidence*, 7(5) CULT. HEALTH SEX. 443, 443 (2005) (a systematic review of published sources between 1997 and 2005 showing that "female circumcision is associated with some health consequences but that no statistically significant associations are documented for a number of health conditions." So, "statistically higher risks are documented for some but not all types of infections; the evidence regarding urinary symptoms is inconclusive; the evidence on obstetric and gynecological complications is mixed." For example, "increased risks have been reported for some complications of labour and delivery but not others, and for some symptoms such as abdominal pain and discharge, but not others such as infertility or increased mortality of mother or infant." Finally, "[c]oncerning sexuality, most of the existing studies suffer from conceptual and methodological shortcomings, and the available evidence does not support the hypotheses that circumcision destroys sexual function or precludes enjoyment of sexual relations"). *See also Seven Things to Know About Female Genital Surgeries in Africa*, *supra* n.33, at 19 (arguing that "in their passion to end the practice, antimutilation advocacy organizations often make claims about female genital surgeries in Africa that are inaccurate or overgeneralized or that don't apply to most cases").

[164] Tobin, *supra* n.153, at 383.

construction of harm appears to be influenced not only by "objective" factors, such as the degree of pain or the likelihood of surgical complications, but also by the sex or gender of the affected individual.

How the law, in Germany and elsewhere, will begin to address these inconsistencies is unclear. Given the special significance of the genitals as compared to other body parts, however, the widely varying cultural and individual attitudes concerning the state of them—cut or uncut—and the growing number of adults of all sexes and genders who are "coming out" as feeling harmed by their childhood genital surgeries, the inconsistencies will need to be addressed somehow. Whichever way the debate proceeds, the relative statuses and acceptability of male, female, and indeed intersex genital cutting[165] are likely to remain prominent in the legal and bioethical literatures for many years to come.

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[165] We have not been able to address intersex genital cutting in this article for lack of space. For key insights, *see generally* Nancy Ehrenreich & Mark Barr, *Intersex Surgery, Female Genital Cutting, and the Selective Condemnation of Cultural Practice*,. 40 HARV. CR-CLL REV. 71 (2005); J. Steven Svoboda, *Promoting Genital Autonomy*, *supra* n.38; Elizabeth Reis, *Intersex Surgeries, Circumcision, and the Making of "Normal,"* in GENITAL CUTTING: PROTECTING CHILDREN FROM MEDICAL, CULTURAL, AND RELIGIOUS INFRINGEMENTS 137-47 (2013); Anne Tamar-Mattis, *Exceptions to the Rule: Curing the Law's Failure to Protect Intersex Infants*, 21(59) BERKELEY J. GENDER L. & JUST. 59 (2006); Kishka-Kamari Ford, *"First, Do No Harm": The Fiction of Legal Parental Consent to Genital-Normalizing Surgery on Intersexed Infants*, 19(2) YALE L. & POL'Y. REV. 469 (2001).

Infant circumcision and adult penile sensitivity: implications for sexual experience

BRIAN D. EARP

A recent study reported that neonatal circumcision is not associated with changes in adult penile sensitivity, leading to viral coverage in both traditional and online media. In this commentary the author questions the conclusions drawn from the study and explores the relationship between objective assessments of penile sensitivity and subjective sexual experience and satisfaction. The author concludes with suggestions for improving future research.

What are the effects of infant male circumcision on adult penile sensitivity? Given that male circumcision is the most common paediatric surgery performed in the USA, in contrast to peer nations where the surgery has either fallen out of favour among health professionals or was never a medical norm to begin with,[1,2] it seems important to investigate this issue in as careful a manner as possible. In this way, parents who may be facing 'the circumcision decision' can be adequately informed about the potential consequences of the surgery for their child, at least along this dimension. Due in part to the polarised nature of scientific research on circumcision,[3] the medical literature to date has offered conflicting answers to the question of sensitivity,[4] prompting a recent turn to quantitative analyses relying on putatively objective measures.

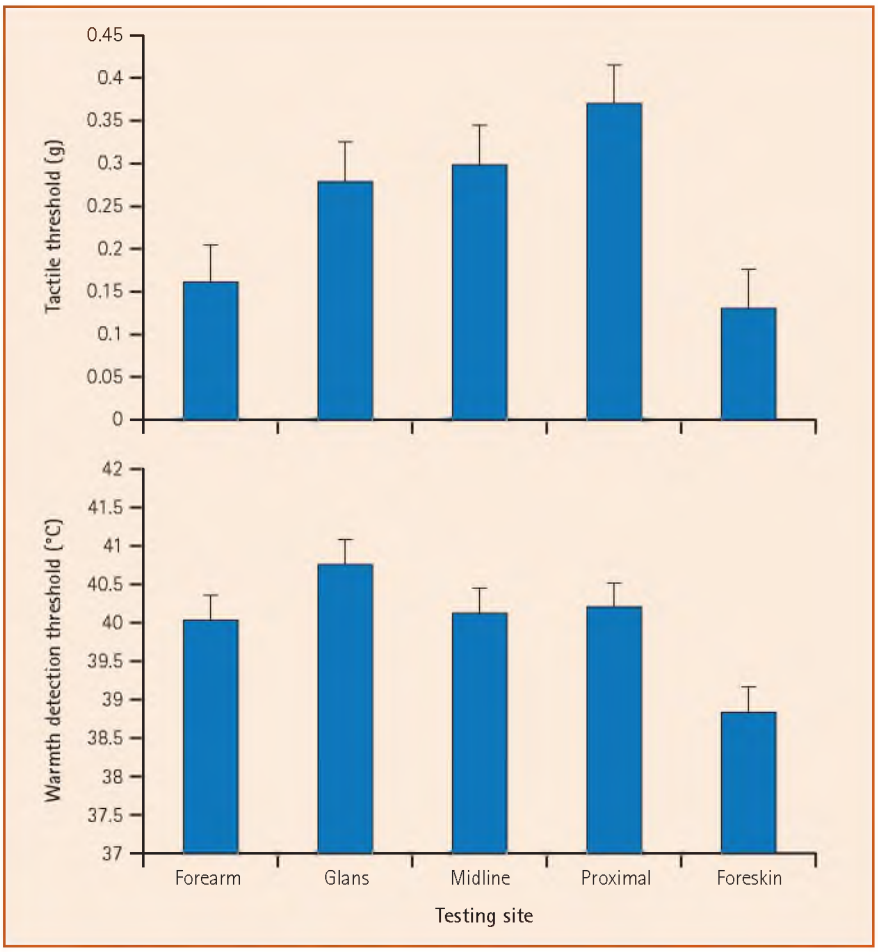

Figure 1. Tactile (top) and thermal (bottom) sensitivity thresholds across various parts of the penis and the forearm (used as baseline). A lower bar means more sensitive. The foreskin is the most touch-sensitive of the sites tested (adapted from Bossio et al*)*[5]

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BLOG
Circumcision and penile sensitivity: the debate continues
Read Brian Earp's accompanying blog and have your say at:
www.trendsinmenshealth.com/blog

In the latest such study,[5] Bossio, Pukall and Steele measured penile sensitivity in circumcised and genitally intact men using two complementary methods: the application of modified von Frey filaments to assess tactile sensitivity at various locations on the penis (for a video demonstration of this general testing procedure, see https://www.youtube.com/watch?v=j5mcWPYi3Zc); and a thermal analyser to assess absolute detection thresholds for sensations of warmth and heat. The authors report that their findings 'suggest minimal long-term implications for penile sensitivity [as] a result [of] neonatal circumcision', thereby challenging 'past research suggesting that the foreskin is the most sensitive part of the adult penis'.[5]

This conclusion was subsequently disseminated via a university press release,[6] garnering significant coverage in both traditional and online media outlets, including the *New York Times*.[7] Notably, such coverage largely repeated the main points from the press release without incorporating critical perspectives from other scientists, effectively taking the findings for granted.[8,9] Sample headlines included: 'Circumcision does NOT reduce sensitivity of the penis' (*Daily Mail*); 'Study finds no difference in sensitivity between circumcised versus non-circumcised men' (*Northern California News*); 'Foreskin doesn't make a man more sensitive, study finds' (*Vox*); and 'We finally know whether or not being circumcised affects sexual pleasure' (*Elite Daily*).

But is this what the study actually found? This article will demonstrate that not one of these 'headline' conclusions can responsibly be drawn from the findings of the study. In fact, the authors' own stated conclusions – concerning 'minimal long-term implications for penile sensitivity' – conflict with their published data. This episode, then, provides a good opportunity to reflect on some of the ways in which controversial men's sexual health findings can be misinterpreted and misconveyed to the wider public, thereby biasing subsequent discourse on the subject.[10] It also offers a chance to explore the relationship between objective studies of penile sensitivity and subjective experiences of sexual satisfaction, and to ask how studies in this area could be improved going forward.

> **The implications of the study for our understanding of the relationship between neonatal circumcision and adult sexual experience are limited**

WHAT DID THE STUDY SHOW?

To understand the implications of the study by Bossio *et al*, one can begin with the results section of their paper. According to the authors' own Figure 2, the foreskin – that is, the part of the penis that is removed by circumcision – is significantly more sensitive to tactile stimulation than any other assessed part of the penis; and it is significantly more sensitive to warmth than the penile glans (Figure 1). The researchers failed to find a statistically significant difference between the foreskin and other penile sites in terms of sensitivity to painful stimulation (both tactile and heat-induced); given that pain is typically understood to be unpleasant, however, this plausibly should not be construed as a downside.

Previous research has shown that the foreskin is richly supplied with nerve endings,[11] although the type and distribution of nerve endings and their role in sexual response is contested by some researchers. The foreskin makes up a substantial portion of the integrated penile skin system,[12] with a mean surface area of approximately 30–50cm^2 in the adult organ.[13,14] Hence, to remove this tissue is to reduce penile sensitivity by definition (no one disputes that the foreskin is sensitive to touch). In particular, all sensitivity afforded by the foreskin itself is necessarily eliminated, as are all subjective sensations that accompany the manipulation of this tissue during sexual activity.[15] Chief among these sensations may be the feeling of gliding or everting the foreskin back and forth over the penile glans (a distinctive motile gesture that is precluded by circumcision).[16]

When Bossio *et al* state that 'neonatal circumcision is not associated with changes in penile sensitivity', therefore, they make a conceptual error. This would be roughly akin to stating that neonatal removal of the little finger is not associated with changes in hand sensitivity, or, more directly, that neonatal labiaplasty is not associated with changes in vulval sensitivity. Given that the little finger is a part of the hand and that the labia are part of the vulva, and since each of these structures is sensitive in its own right, such statements cannot logically be true. What Bossio *et al* may be trying to convey is that there does not appear to be a meaningful sensory difference between circumcised and intact men in terms of the specific parts of the penis that are not removed by circumcision (in particular, the glans), setting aside surgical mishaps. That is a different claim, however, and the evidence adduced in support of it is far from conclusive.

SAMPLING LIMITATIONS IN THE STUDY

Firstly, the study is limited by its small sample size of only 62 men (30 circumcised, 32 intact) from a single city (Kingston) in Canada. As the authors

explain in their paper, this means that several tests were underpowered, which reduces the ability to draw valid inferences from any associated null results. Secondly, the study is limited by the constricted age range and homogenous sexual function status of the participants: the maximum age was 37 years (mean age 24.2 years) and participants were pre-selected to be free of sexual problems (see below). If circumcision is a risk factor for sexual problems, therefore, this cannot have been shown in the present study by design.

Nor does the study tell us anything about potential differences between circumcised and intact men in terms of reduced penile (including glans) sensitivity beyond the age of 37. Yet research suggests that concerns about sexual functioning begin to increase markedly after this age.[17–19] To see why this selection bias presents a problem for drawing general conclusions, one need only to imagine a study exploring the association between, say, smoking and respiratory capacity that excluded patients with chronic cough conditions over the age of 50.

Toward the end of their paper, Bossio *et al* state: 'Results from the current study, examining four types of stimulation over multiple testing sites, indicate that foreskin removal is not associated with [...] sexual dysfunction'. However, in their methods section, the authors state that one of the exclusion criteria for participation in the study was 'past/present sexual dysfunction'. It is simply not possible to draw meaningful conclusions about the effects of infant circumcision on sexual dysfunction in adulthood by first excluding men with sexual dysfunction from the study sample.

FROM STATIC SENSITIVITY TO DYNAMIC SEXUAL ACTIVITY

More generally, the implications of the study for our understanding of the relationship between neonatal circumcision and adult sexual experience are limited.

KEY POINTS

- **The findings from a recent, widely read study claiming that infant male circumcision does not affect adult penile sensitivity do not support this 'headline' conclusion**
- **The relationship between 'objective' measures of penile sensation and function and 'subjective' sexual experience is more complicated than studies of this kind can show**
- **Suggestions for methodological improvements in this area include focusing on individual differences in sexual activity, sexual attitudes and qualitative sexual sensation, extending follow-up into older age and exploring a wider range of sexual outcome variables**
- **From an ethical perspective, a precautionary approach weighs against infant male circumcision unless there is a genuine medical indication**

This is true as well for other studies employing similar methodologies, such as that by Sorrells *et al*, which assessed fine-touch pressure thresholds in the adult penis using a Semmes-Weinstein monofilament touch-test, comparing intact with circumcised men.[20] Sorrells *et al* reported that 'Circumcision ablates the most [touch] sensitive parts of the penis' (note that various critiques and counter-critiques of this study are available at the journal website).

Why are the implications limited? There are several reasons. Firstly, although the paper does not state so explicitly, Bossio *et al* appear to have performed their sensory tests on the penis in its flaccid state, which is not the state that most penises will be in during many types of sexual activity. Secondly, their sensitivity tests involved the static application of stimuli, whereas sexual stimulation is typically non-static. These very basic differences between the circumstances of the laboratory study by Bossio *et al* and most real-life sexual activities decrease the interpretability of associated findings.

Moreover, as noted earlier, the foreskin is an integrated component of the intact penile skin system, such that there is no determinate location where the foreskin 'ends' and where the rest of the penis 'begins'. Therefore, it is the dynamic movement of the foreskin, along with its particular interactions with the penile glans and shaft – across a range of receptive or interactive tissue environments – that would be most relevant to assessing the practical significance of this genital structure to sexual sensation and satisfaction.

Finally, the authors tested only a single location on the outside of the foreskin, whereas the inner layer of the foreskin – which becomes exposed when the foreskin is pulled back, as it is during some forms of masturbation and sexual intercourse – has different anatomical properties.[12] One such property is the relatively softer, mucosal surface, which could reasonably be expected to elicit different subjective sensations when being stimulated compared to the protective outer skin layer of the foreskin. These sensations were not assessed.

PSYCHOLOGICAL FACTORS

Further limitations stem from a lack of consideration of individual differences in psychological profiles. As Johnsdotter has recently argued,[21] research in this vein tends to rely on reductionist constructions of sexuality, which emphasise primarily the roles of anatomy and physiology in 'framing and describing sexual activities'. However, socially informed 'sensation

schemas will impact how we perceive bodily signals, whether we notice them at all, and what kind of meanings we ascribe to them'. Needless to say, 'Such complexity is difficult to capture in quantitative studies'.

Consider that some boys will grow up to regard their circumcision as an improvement compared to the natural state, while others will view the same excision of tissue as a diminishment or even a mutilation.[22–25] For instance, a man may wish that he had been able to experience sex with his foreskin intact; he may be curious about what it would have been like to be able to 'play' with that tissue (or have his partner do so) and feel resentful that this option was taken away from him. Other men, by contrast, will regard their circumcised state neutrally or even positively, particularly if they were socialised in a cultural context that regards circumcision as the norm.[26] What is important to recognise is that the sexual implications of the surgery are likely to differ between such cases due to mediating psychological factors.

Even purely 'physical' factors may be experienced differently. For example, some men may believe that they are 'too sensitive' (and therefore struggle with premature ejaculation); whereas other men do not feel 'sensitive enough' (and may consequently struggle with a lack of sensation and/or erectile dysfunction). Men are not identical when it comes to penile anatomy, including with respect to such attributes as density and distribution of nerve endings, the surface area of the foreskin, and so on. Circumcision, therefore, whether carried out in the infant period or later in adolescence or adulthood, is unlikely to have uniform effects.

CONCLUSION

Future studies on penile sensitivity should explore individual differences in attitudes toward circumcision, along with relevant psychological and contextual mediators. By contrast, the current tendency to draw broad conclusions about the effects of neonatal circumcision on adult sexuality from group 'averages', thereby obscuring the responses of individual participants, is problematic. No one engages in sexual activity as an embodied statistical average; instead, each person's sexual experience is unique. Moreover, it will be important to explore a wider range of sexual outcome variables and to do so with longer-term follow-up into older age.[27] In the meantime, a precautionary approach suggests that non-therapeutic circumcision should generally not be performed until boys can 'assess the sensitivity of their own foreskins as compared to other parts of the penis – as well as their role in sexual experience more generally – in light of their own considered sexual preferences and values'.[8, 28–30]

Declaration of interests: *none declared.*

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From: Bryan Bessner [mailto:bbessner@rogers.com]
Sent: 1. mars 2018 00:39
To: althingi@althingi.is
Subject: CIRCUMCISION

Members of the respected Icelandic Parliament,

Though I live in Canada and have not yet visited your interesting and beautiful country, I feel I must write to ask you to reconsider putting a ban on non-medical circumcision for infant boys. I am a Jew, and as such I was circumcised on my 8th day of life, as is our tradition. And although I am not a deeply religious person, I care about my spiritual/cultural background very much, and circumcision is simply part of that background.

I have never experienced any ill effects from this procedure. I am the proud father of two daughters, now 25 and 22, so my ability to function with this organ was clearly not affected. In fact, most studies I have read point to the health benefits of circumcision.

Other cultures follow this practice as well, such as the Islamic culture; surely you have no real reason to deny Islamic people or my people the right to this particular ritual. Please do not allow this law to be passed.

Respectfully,

Bryan Bessner

Toronto, Ontario, Canada

Frá: Bryon Gross [mailto:bryongross@ymail.com]
Sent: 25. febrúar 2018 14:13
Til: Ritstjóri vefsins <ritstjori@althingi.is>
Efni: Legislation

MY WIFE AND I WILL NOT BE TRAVELING TO YOU COUNTRY THIS YEAR FOR THE FOLLOWING REASONS:

YOUR PARLIAMENT IS REPORTEDLY CONSIDERING A BILL THAT AMOUNTS TO NOTHING LESS THAN A DIRECT ASSAULT ON THE JEWISH FAITH.

Incredibly, your proposed law would not only ban the circumcision of male infants, but would criminalize the act and make it punishable by up to six years in prison.

Simply put, this bill would deal a devastating blow to the right of every individual to serve his or her Creator as he or she sees fit.

The fact that Iceland's representatives have decided to single out circumcision, rather than banning all forms of cosmetic procedures on children belies their assertion that it is intended purely to protect the young. It's anti-Semitic.

Furthermore, given Iceland's treatment of Jews over the past 150 years, one would expect your country to tread a little more carefully.

In 1853, Iceland's parliament turned down a request by the king of Denmark to allow Jews to reside in the country.

In 1938, when Austrian Jews were trying to flee in the wake of the rise of Nazism, Iceland refused to allow them entry, callously leaving them to their fate.

As Dr. Vilhalmur Vilhalmsson noted in a comprehensive 2004 paper entitled, "Iceland, the Jews and anti-Semitism" published in Jewish Political Studies Review, "With regard to the Holocaust, Iceland is not a blank page." There were Icelanders in the Waffen SS who fought for Germany, while others served in concentration camps; the son of Iceland's first president was a member of the SS who escaped prosecution after the war. Icelandic officials went so far as to offer to pay the cost for the expulsion of Jews from its territory to Germany.

With such a dubious national record, Iceland should be ashamed of itself for even considering a ban on circumcision, which it must have known would arouse indignation among Jews and Muslims alike.

-----Original Message-----
From: Cecile Steinberg [mailto:cecilesteinberg18@gmail.com]
Sent: 1. mars 2018 02:13
To: althingi@althingi.is
Subject: Infant circumcision

I am writing to share my disappointment with your government's consideration of outlawing infant circumcision. I'm sure you are aware of how fundamental this ritual is to Judaism. If you follow through with this proposal, you send the message that Jews are unwelcome in your country.
I am truly shocked that in this day and age a country which considers itself a free and democratic society would behave in this way.

Cecile Steinberg

March 20, 2018

Alþingi
Kirkjustræti
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál. nefndasvid@althingi.is

Ágæta Alþingi / Dear Members of the Parliament:

The Children's Health & Human Rights Partnership (CHHRP) is a dedicated not-for-profit partnership of Canadian medical, legal, and ethics professionals working collaboratively towards ending forced non-therapeutic genital cutting of children in Canada. Our work is in accordance with the Canadian Charter of Rights and Freedoms and international human rights law.

We write today to respectfully request your support for the proposed restrictions on non-therapeutic male infant circumcision in Iceland. Our hope is that you will take a strong stand in favour of allowing males—when there is otherwise no immediate medical need—to decide upon and consent to circumcision at an age when they can fully understand the consequences. Such a stand would be consistent with the international movement of child protection advocates, especially paediatric and medical societies and children's ombudspersons in Nordic countries, who recognize this issue as an important human rights concern.

Child Rights International Network have noted in their recent 2018 report "What Lies Beneath"

> With the exception of female genital mutilation, which is rightly one of the most widely recognised and challenged harmful traditional practices, there are a number of other procedures that involve irreversibly altering children's genitals through

> surgery for no justifiable medical reason. These are: sex assignment of intersex children, forced sterilisation of children with learning disabilities, and routine male circumcision, all three of which remain legal in most countries around the world when performed on children. (p. 21-22)

Full Document
https://www.crin.org/sites/default/files/crin_report_2018_edition.pdf

We wish to refer you to the 2012 report from the International NGO Council on Violence against Children. This groundbreaking report identifies numerous harmful practices based on tradition, culture, religion or superstition that violate the rights of children and the Council explicitly includes male circumcision as one of these practices.

It is difficult to argue that circumcision of otherwise healthy children is not a medical, cultural or religious tradition and that many parental motivations for requesting infant or child circumcision can be considered superstitious or based on fear of the unknown. The International NGO Council on Violence against Children (2012) explained that these practices are "perpetrated through false beliefs about child development and the cause and treatment of ill-health. These may stem from religious edict or belief, or from tradition or superstition or in some cases be promoted by health practitioners" (p. 7). The latter is certainly the case in North America, where paediatric societies take ambiguous stands and fail to firmly reject any medical justification for newborn circumcision and who issue statements that ignore the functions, benefits, and natural development of the foreskin, while failing to identify the newborn's inherent right to bodily integrity.

In specifically identifying by male circumcision as a traditional practice that violates the rights of male children, the International NGO Council on Violence against Children (2012) stated that "non-consensual, non-therapeutic circumcision of boys, whatever the circumstances, constitutes a gross violation of their rights, including the right to physical integrity, to freedom of thought and religion and to protection from physical and mental violence" (p. 22).

The International NGO Council on Violence against Children advised that circumcision and the other identified harmful practices

> ...should be effectively prohibited, when necessary explicitly, with particular attention to ensuring there are no provisions enabling parents or others to consent to/authorise such harmful practices; that prohibition is upheld explicitly in states with multiple legal systems including customary and/or religious law; that prohibition extends effectively not only to direct perpetrators but to those facilitating, arranging or offering the child for these practices. (2012, p. 46)

Full Document
http://srsg.violenceagainstchildren.org/sites/default/files/documents/docs/InCo_Report_15Oct.pdf

It has become increasingly clear that Nordic countries are taking seriously their pledge to protect children as well as their international treaty commitments regarding this group of vulnerable citizens. Their medical associations, child welfare agencies, and some legislative bodies reject the promotion of circumcision of otherwise healthy children, especially when such promotion is done by medical professionals and associations. We at CHHRP believe that your duty to children extends to the introduction of Icelandic law that explicitly identifies the right of all children to physical integrity and eventual self-determination and prohibits all forms of non-therapeutic genital cutting.

CHHRP has learned that there may have been attempts from one or more representatives of the United States of America government to influence the Icelandic Althingi on this issue. We are deeply concerned by this allegation, in light of the fact that the United States is the only nation in the world which has refused to ratify the United Nations Convention on the Rights of the Child (UNCRC). Furthermore, the United States' national paediatric medical organization, the American Academy of Pediatrics (AAP), was publicly condemned by international paediatric authorities for its shoddy 2012 statement that failed to recognize the functions of the foreskin, the medical ethics involved in non-therapeutic circumcision, and the important human rights that are violated by those who circumcise otherwise healthy

children. We direct you to one such rebuke signed by 38 physicians from 16 European nations as well as Canada.

Full Document:
http://pediatrics.aappublications.org/content/early/2013/03/12/peds.2012-2896.full.pdf+html

SUMMARY

Iceland has always been a leader in the international arena when it comes to recognizing human rights — in some cases long before many other nations. We look forward to seeing this trend continue with the enactment of legislation that ensures that all Icelandic children are protected from non-therapeutic genital cutting.

Respectfully submitted,

Dr. Christopher Guest, MD, FRCPC
Medical Director

Dr. Ali A. Rizvi, MD
Advisory Board Member

Dr. Arif Bhimji, MD
Advisory Board Member

Dr. Cameron Bowman, MD, FRCSC
Advisory Board Member

Dr. Tracy Cassels, BA, MA, PhD
Advisory Board Member

Steven Caswell, JD
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Brian Moher, LLB
Advisory Board Member

Layli Samson, JD
Advisory Board Member

Monica Zamfir, JD
Advisory Board Member

Kira Antinuk, RN, BScN, MN
Nursing Director

CCEE-CEC Joint Statement

It is with great concern that Christian, Jewish and Muslim organisations in Europe take note of a proposal tabled in the Icelandic parliament Althing to ban non-medically indicated circumcision of male children. If the proposal were made into law, parents could face up to six years in prison if they have religious circumcision performed on a boy child.
This move would not only amount to an infringement of the fundamental human right of Freedom of Religion or Belief, but would also be perceived as a signal that people with a Jewish or Muslim background are no longer welcome to Iceland.

Circumcision has for thousands of years been practised by religious communities across the faith spectrum; it is a fundamental feature of religious practise in Judaism, Islam and some Christian traditions, such as the Ethiopian and Eritrean Orthodox churches. Circumcision is not an optional ceremony, but at the very core of religious practice. It is with this particular religious rite that male children are welcomed to their religion, providing them a sign of God's covenant with humanity. For these communities, it is an integral expression of faith.

"It is important that circumcision is practised legally, in a medically appropriate and safe setting, so that the child's health is not jeopardized", says CEC President Bishop Christopher Hill and adds that "We should not forget that it is a right recognised in the UN convention of the rights of the child to belong to and to be educated in the religious tradition of his or her family."

He also draws attention to the fact that circumcision is a standard secular medical procedure in several countries – with established medical guidelines – which can even be beneficial. It cannot, therefore, be argued that the intervention amounts to an unacceptable violation of corporeal integrity. Thus, such a limitation of freedom of religion or belief cannot be justified by objective reasons.

Cardinal Angelo Bagnasco, President of the Council of European Bishops' Conferences (CCEE), also recalled how "the Catholic Church is particularly committed to defending the child's right, which also includes the right – the duty of the family to educate their children according to their own religious convictions. This initiative is against religious freedom and the principles of democracy proper to a civil society".

'Prohibiting circumcision in a given country amounts to that very country publicly declaring that no Jewish community is welcome on its territory any longer,' says Albert Guigui, Chief Rabbi of Brussels and Permanent representative of the Conference of European Rabbis to the European Institutions.

Chief Imam Razawi, Scottish Ahlul Bayt Society, also says that "Forbidding a religious rite in this way would amount to banning the ability to practice faith for Muslims".

The Jewish, Christian and Muslim organisations agree that a ban on circumcision in Iceland would amount to outlawing two world religions, Judaism and Islam, and their adherents.

This law would render a xenophobic image of Iceland in a religiously and culturally diverse world. Should this proposal go through it also risks inspiring similar initiatives in other European countries and beyond.

In a climate of growing antisemitism and islamophobia this could encourage such tendencies elsewhere, increasing the pressure on often already vulnerable communities.

The organisations emphasise that they refer to male circumcision only. This compulsory religious rite must not be confused with the cruel practice of female genital mutilation that constitutes an assault on the bodily integrity of women, violating their basic human rights and dignity.

For more information or an interview, please contact:

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The Conference of European Churches (CEC) is a fellowship of some 116 Orthodox, Protestant, Anglican and Old Catholic Churches from all countries of Europe, plus 40 national councils of churches and organisations in partnership. CEC was founded in 1959. It has offices in Brussels and Strasbourg.

The Council of European Bishops' Conferences of Europe (CCEE) currently gathers 33 European Bishops' Conferences, represented by their Presidents, plus the Archbishops of Luxembourg, of the Principality of Monaco, the Maronite Archbishop of Cyprus and the Bishop of Chişinău (Moldova Rep.), the Eparchial Bishop of Mukachevo and the Apostolic Administrator of Estonia. The President is Cardinal Angelo Bagnasco, Archbishop of Genoa; Vice-Presidents are Cardinal Vincent Nichols, Archbishop of Westminster, and Msgr Stanisław Gądecki, Archbishop of Poznań. The Secretary General is Mgr Duarte da Cunha. The Secretariat is based at St Gallen (Switzerland) www.ccee.eu

LATVIAN COUNCIL OF JEWISH COMMUNITIES

Council of Jewish Communities of Latvia

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Tel/fax +371 67 285 601

Skolas 6, Riga, LV-1010, Latvia
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26 March, 2018

Judicial Affairs and Education Committee

Icelandic Parliament

Subject:
Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)

Dear Delegates of the Standing Committee,

The Council of Jewish Communities of Latvia representing more than 10,000 members is deeply concerned regarding the bill on the criminal liability for the circumcision of boys in Iceland which now is directed to the Standing Committee.

Religious circumcision of boys (brit milah) is a central requirement of Jewish law and fundamental to Jewish religious, cultural and ethnic identity. A ban of circumcision would actually mean the prohibition of the existence of Jews in Iceland.

We urge you not to pass this law.

Sincerely,

Arkady Suharenko
Chairman

Alþingi
Kirkjustræti
150 Reykjavík
26 March 2018

Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál

About me

Ágæta Alþingi, thank you for giving me the opportunity to voice my concerns regarding the proposed legislation to ban non-therapeutic circumcision (NTC). Unfortunately, I do not speak Icelandic, so I hope that you can excuse the fact that I am writing to you all in my native language (English). My name is D'Marco J. Anthony, and I am the creator of a gender equality Facebook page called *Equality for Men*. The page focuses primarily on men's issues (such as forced male genital cutting). It also embraces intersectionality, so women's issues and issues affecting the Lesbian, Gay, Bisexual, Transgender, Transsexual, Queer, Intersex, and Asexual communities (LGBTQIA) are also addressed. My page has over 1.000 likes, 5 of which are from people that live in Iceland. I also have a Twitter version of the page with almost 500 followers. I have publicly argued against NTC, and even received an award and a prize of $100 USD for an essay I wrote about the ethics regarding circumcision, which I submitted to an essay competition at my university.

I was born in the United States of America, and I, like many American males, was circumcised shortly after birth. One of the main reasons why I hate that circumcision was forced on me as a minor is that the foreskin has highly sensitive fine touch nerves which play an important role in sexual and masturbatory function.[1] Circumcised men are never able to experience these nerves once they are amputated. Even if there are some significant benefits to circumcision, there is no way that one can remove the foreskin and have the penis function the exact same way that nature intended it to function. I am not exaggerating when I say that for several years I have spent everyday thinking about how much I resent the fact that I was circumcised against my will.

Gender Equality

My understanding is that the proposed legislation would *not* protect intersex people. As a result, I hope you will consider banning *all* non-therapeutic genital cutting, which would protect every single child regardless of gender. Adding protections for intersex people would not be unprecedented, especially since Malta has already banned Intersex Genital Cutting (IGC) when there is no immediate medical reason to do so. Furthermore, the Council of Europe, which Iceland is a member of, has urged all member states to take action and protect female, intersex, and male children from

[1] Non-therapeutic circumcision of male minors - KNMG Viewpoint.

genital alterations because they are not medically necessary.[2] Circumcision is a gender equality issue, especially when you consider what the Royal Dutch Medical Association (KNMG) has to say on the matter. They point out that removing the male prepuce (foreskin) is akin to removing the female prepuce (clitoral hood). Biological sex is not a binary, it is a spectrum between females, males, and somewhere in between (intersex people). At what point should a prepuce be considered a male foreskin rather than a female clitoral hood? Wherever you draw the line, the cutoff point could be considered arbitrary. It seems much more practical to shut down any and all unnecessary genital alterations of the prepuce and otherwise. In fact, the KNMG even argues that there are milder forms of Female Genital Cutting (FGC) which involve "pricking" the clitoral hood without actually removing any tissue. How can any country justify banning a mild "prick" of the prepuce in females without also banning the more severe act of removing the entire prepuce in males?[3] And why should Iceland or any country continue to allow IGC to be legal when it is often as severe or even more severe than FGC? Many intersex people undergo a procedure akin to a cliterectomy (complete amputation of the clitoris) when they are circumcised.[4]

Medical effects

While the medical benefits and drawbacks of circumcision are widely debated, it is important to keep in mind that many European medical professionals and organizations have argued that forcing genital cutting on minors is not medically justified and can even be deemed as being harmful. They also argue that the foreskin has important functions. Many of these medical professionals against NTC happen to live in Iceland. Since circumcision is usually performed without anesthetic, it is often quite painful. Furthermore, there are physical, psychological, and sexual adverse effects including post-traumatic stress disorder. And many circumcised men feel like they have been violated, mutilated, and sexually assaulted.[5] While some people think circumcision provides hygienic benefits, it actually deprives men of important hygienic functions. The foreskin protects the head of the penis (glans) from feces and ammonia when infants wear diapers. The foreskin also protects the glans from abrasions and trauma, and it helps prevent tight erections.[6] Meatal stenosis, which rarely occurs in intact (uncircumcised) men, was observed in 5%-20% of circumcised men in a recent study.[7]

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[2] Council of Europe Resolution 1952 (2013): Children's right to physical integrity
[3] Non-therapeutic circumcision of male minors - KNMG Viewpoint.
[4] http://www.law.harvard.edu/students/orgs/crcl/vol40_1/ehrenreich.pdf
[5] https://www.ncbi.nlm.nih.gov/pubmed/22114254
[6] https://www.ncbi.nlm.nih.gov/pubmed/22924249
[7] https://www.ncbi.nlm.nih.gov/pubmed/28017691

Even medical organizations outside of Europe are aware that the medical benefits of circumcision are extremely minimal. Circumcision for penile cancer and urinary tract infection (UTI) prevention purposes are ineffective and possibly even obsolete. The number of circumcisions required to prevent a single UTI is 140; 195 circumcisions prevent a single hospitalization due to UTIs. But it is important to keep in mind that UTIs are relatively uncommon. Penile cancer is a rare disease and about 300.000 circumcisions would be needed to prevent a single penile cancer case. Consequently, an individual is way more likely to encounter a circumcision complication than receive a penile cancer prevention benefit from circumcision. It is also important to consider that one-third of penile cancer cases result from the human papilloma virus (HPV), which can easily be prevented through vaccination alone and makes circumcision even more obsolete. Minor circumcision complications include bleeding (0,8-1,8 per 1.000 circumcisions), infection (3 per 5.000 circumcisions), and injury to the penis (1 per 2.500 circumcisions). There are also more severe complications that can occur due to circumcision.[8] One estimate claims that 1 circumcision complication occurs for every 476 circumcisions.[9] There is insufficient evidence to suggest that neonatal circumcision prevents HIV in developed countries such as Iceland,[10] especially since the studies that suggest such a benefit were done on *adults* circumcised in Africa.[11] So basically, most people that are circumcised do not receive *any* UTI, penile cancer, or HIV prevention benefits.

Religious freedom

Everyone should have the right to choose whether or not they would like to adhere to a religion. Circumcising a child for religious reasons violates that child's religious freedoms. Circumcision is an irreversible procedure which *always* leaves a scar around the penis. This essentially means that circumcision can be viewed as a form of religious branding. Religious circumcisions forced on minors ensure that even if a child decides not to practice a religion that favors circumcision when they grow up, their genitals will be permanently altered. The metzitzah b'peh ritual is a religious practice which involves oral suction of blood from the circumcision wound. Babies often contract Herpes due to this ritual and sometimes even die because of it.[12] Children should be entitled to genital integrity and religious freedom, and circumcision for religious reasons deprives children of both rights.

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[8] https://www.aafp.org/about/policies/all/neonatal-circumcision.html
[9] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2788411/
[10] https://www.ncbi.nlm.nih.gov/pubmed/20844437
[11] https://www.aafp.org/about/policies/all/neonatal-circumcision.html
[12] https://www.cnn.com/2013/04/07/health/new-york-neonatal-herpes/index.html

Leading the fight

Is it possible that Iceland will face backlash for protecting minors from harmful genital cutting? Yes, of course, but it is normal for backlash to occur when a country becomes the first to enact landmark human rights protections (in this case genital autonomy for boys [and hopefully intersex children as well]). Being on the right side of history is better for Iceland in the long run, and it also has the potential to be a catalyst for similar protections being enacted elsewhere. On top of protecting the children of Iceland from genital cutting, this legislation would send a message to the world that genital integrity and basic human rights should be upheld. Furthermore, many men that despise having been forcibly circumcised would gain a lot of the dignity they lost when they found out that the harm done to them is universally accepted under the law. Circumcision should be an informed choice that an individual makes after weighing the benefits and risks of the procedure. Parents should not be able to deprive their children of this important personal and private choice. I hope that Iceland will become the first country in the world to ban male non-therapeutic circumcision of minors and the second to ban intersex non-therapeutic circumcision of minors.

Sincerely,
D'Marco J. Anthony

Frá: Daniel M [mailto:daniel20042@gmail.com]
Sent: 25. febrúar 2018 22:01
Til: Ritstjóri vefsins <ritstjori@althingi.is>
Efni: Against Circumcision of Children - Jews support bill 183

Dear Parliament of Iceland

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls.

As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israeli's to leave our children intact (not-circumcised).

Circumcision of a child unable to consent is genital mutilation. It is an irreversible surgery that robs the child of an important body part.

Thank you for having the courage to protect children and fight for this important bill.

Sincerely,

Daniel

Alþingi
Kirkjustræti
150 Reykjavík

March 26, 2018

Ágæta Alþingi / Dear Members of the Parliament

I am an American of Nordic ancestry and am writing to support the ban on cutting the genitals of children without a medical necessity.

Even though my father was an intact (not circumcised) physician born to Norwegian-American parents, I was circumcised as a newborn simply because that is what was done to the overwhelming majority of infant boys in the United States when I was born. There was no medical justification for it. As a matter of fact, my 2 older brothers were circumcised without anyone asking my parents for permission. Circumcision was as automatic as cutting the baby's umbilical cord. It was "Standard Procedure" and very few people were questioning it.

I was circumcised by a doctor in a hospital and had complications from my circumcision which I have suffered with for 65 years. My earliest memory is of not understanding why I did not look like my 2 older brothers or any other boys I saw in the locker room when we went swimming. When someone tells you that circumcision is "safe" when done properly by a doctor in a hospital or other medical setting, they are not telling the truth. Circumcision removes healthy, normal tissue which has many important functions. Even without complications, circumcision is not harmless.

It wasn't until I was 46 years old that I finally found the courage to start speaking up about what had happened to me and I found that I was not alone. There are many people - male, female, and intersex - who have been damaged physically and psychologically by medically unnecessary genital cutting. Many of them are too ashamed and embarrassed to speak up. It takes a lot of courage to admit to oneself and to others that one has been damaged in such an intimate part of their body.

I have been to Iceland (in 2014) and I took showers at the public pools in various towns around Iceland before using the pools, hot tubs, and water slides. I am aware that circumcision is almost never done in Iceland.

Very few adults ever volunteer to be circumcised. I hope that members of the Alþingi keep that in mind. Genital mutilation is done to children. If an adult won't do it to their own body, they should not allow it to be done to a

child's body.

I would like to suggest that the Alþingi watch the documentary "CUT: Slicing Through the Myths of Circumcision" which was made by an Orthodox Jewish man who opposes infant/child circumcision. You can see me speaking up on this issue in the trailer for the film at www.cutthefilm.com

This is about Human Rights. In my 19 years of public work on this issue, I have met many people - male/female/intersex, Jewish, Muslim, Christian, animist, atheist, etc. - who have all been harmed by genital cutting. You are under pressure from religious organizations and individuals to allow circumcision. Keep in mind that these people do not speak for all Jews, Muslims, Christians, etc.

I urge you to protect all children. Adults can make up their own minds about their own bodies.

Sincerely,
Daniel T Strandjord
Aurora, CO USA

Alþingi
Kirkjustræti
150 Reykjavík

22 March 2018

Ágæta Alþingi / Dear Members of the Parliament:

I am writing in support of the proposed ban on non-therapeutic infant circumcision that is now before a committee of the Alþingi.

Before I go any further, I think it important to disclose three personal but relevant facts about myself: I am male, I am Jewish, and I was subjected to circumcision without my consent as an infant - so I know whereof I speak. And what I say to this committee, to my fellow Jews, and to the world, is that I oppose all forced genital cutting of non-consenting minors for cultural and religious reasons: from the brit milah as practiced in Iceland and elsewhere, to female genital mutilation as practiced in Africa and the Middle East, to routine infant male circumcision as practiced throughout the United States, to metzitzah b'peh as practiced in a few Haredi communities in Brooklyn, to subincision as practiced in Australia. They are all of a piece and I oppose all of them on philosophical and ethical grounds. I see absolutely no moral distinction between non-therapeutic male circumcision - whether performed in the context of the brit milah or performed merely because it has become a cultural norm, as it has in the United States - and any of these other more facilely condemnable practices. They are all a violation of the most important and fundamental human right there is: the right to have the physical boundaries of one's own body respected.

There is no human right more central to contemporary notions of freedom, human dignity, autonomy and self-determination than the right to own and control one's own body. Non-therapeutic infant circumcision violates that right. To me, that notion - the inviolability of the human body - is far more consistent with my conception of Jewish ethics, Jewish tradition and the values of the Jewish Enlightenment than the opposing asserted "right" in this controversy, namely, the "right" to amputate or mutilate part of a child's genitals as an expression of his (or her) parents' personal religious or cultural beliefs. Male genital cutting goes against everything that I, as a proudly Jewish and pro-Jewish man believe in. Hence, my profound opposition to infant circumcision is not *in spite* of my Jewishness but largely *because* of it.

Throughout the history of western civilization (and, indeed, virtually all civilizations), there has been a tension between some rights and other rights. What we do - the things we say and especially the acts we commit - all have the capacity to affect not only ourselves but others. Thus, it is in the nature of things that one person's *right to commit an act* has the potential to impinge upon another person's *even more compelling right not to be harmed by that act*. That is the intrinsic conflict between opposing rights. That is why each person's right to act is circumscribed by every other person's right not to be harmed by that act, and that is why few if any rights are deemed to be absolute. The recognition that rights are often in conflict with one another and that a just and ethical balance between them must therefore be struck has been at the heart of human social, philosophical, spiritual and political development throughout history. The objective of striking an ethical and just balance between opposing rights when they are considered to be fundamental but in conflict with one another is one of the chief challenges - and achievements - of modern democracies.

The custom of male circumcision is therefore a paradigm of the intrinsic conflict between competing rights. The "right" to impose circumcision on one's child is claimed as a right of the free exercise of religious practice, which is held to be fundamental. At the same time and diametrically opposed to this is the countervailing right of the child not to have his (or her) body harmed, disfigured, scarred or surgically altered in any way (with respect to this last named, in the absence of an overwhelming, urgent medical justification for doing so and, then, only as a last resort when all other less invasive interventions have failed). I put it to you, members of the Alþingi, that the second of these two rights - the right to have the physical boundaries of one's body respected - not only is every bit as fundamental as the right of the free exercise of religion but is *more fundamental* and therefore supersedes that other right. The right to bodily integrity - to be left alone, physically unmolested, unharmed and in one piece - *must* take precedence, otherwise, any conceivable act of harm to another person or to one's child might be justified on the grounds of the right of the free exercise of religious practice.

If male genital mutilation (or, to use the euphemism, circumcision) is to continue to be inflicted on children - of any religion, ethnicity, or nationality - in the absence of an overwhelming and urgent medical justification - without the victims' consent and while legally sanctioned under the specious justification of "religious freedom," then why not female genital mutilation, as well? Why not child marriage? Why not slavery? Why not abduction and rape? Why not public stoning for the "crime" of adultery or homosexuality? Why not human sacrifice? Every one of these other practices has at one time or another been - and, several

still are in some quarters - sanctioned by religious doctrine and morally rationalized by cultures and populations that found these practices to be perfectly in accordance with their "deeply held" religious beliefs. Only yesterday we learned of the return of a hundred or so Nigerian schoolgirls who had been kidnapped a month previously by members of Boko Haram. These militants believe that "western education" and particularly the education of girls is an abomination that threatens the viability of their religion and contradicts their sincerely held religious beliefs. Does Boko Haram therefore have the right to deprive those schoolgirls of an education? Should we shrug our shoulders and concede these devout believers the right to deny girls an education simply because their will to do so is based on their sincerely held religious beliefs? Does the fundamental right of religious freedom of Boko Haram supersede the fundamental right of girls to an education? I do not suppose there are many people of any religion - including Islam - who would answer in the affirmative to any of these questions. Why, then, should male circumcision be regarded any differently? Religious freedom ends where another person's body begins. That is especially the case when the exercise of religious freedom by one person results in physical harm to someone else in violation of that second person's fundamental right not to be harmed. Amputating an erogenous, highly sensitive, normal and functional anatomical structure that is an intrinsic and essential part of the penis without the consent of the person who is subjected to the amputation is a harm in and of itself and a human rights violation.

Theodore Parker, the nineteenth-century Unitarian minister and abolitionist observed that "The moral arc of the universe is long but it bends toward justice." Sometimes taking one step back for every two steps that we take forward, human societies the world over have gradually abandoned, one after another, customs and institutions long-practiced but that have inevitably come to be regarded as inconsistent with modern notions of fundamental human rights and human dignity. Sometimes these advances have come at the cost of great internal strife within political entities such as nation-states, sometimes within religions, and sometimes even within religious denominations. Genital cutting of children, which has been practiced for millennia, is an example of a custom once widely accepted but that has increasingly come to be regarded as an anachronism that is inconsistent with contemporary notions of human rights and human dignity. But it is not the only example. Slavery, also, was once widely accepted as legitimate and it, too, persisted for millennia. Nor did the institution die a natural and peaceful death: the opposing views divided the United States geographically, politically, and the campaign to end it during the nineteenth century opened up a schism both between and *within* certain American Christian denominations, with slavery's defenders

finding support within scripture for it and abolitionists regarding slavery as fundamentally incompatible with Christine doctrine. Significantly, slavery was not ended in the United States merely by the force of "moral suasion." It took an act of Congress and passage of the Thirteenth Amendment to the Constitution of the United States to abolish once and for all the legalized practice of enslaving human beings.

Aside from the obvious analogy between slavery and involuntary circumcision, both being practices that deprive individual human beings of their fundamental human rights, there are two important parallels here. First, involuntary male circumcision is by no means any longer universally practiced, let alone embraced, by Jews. Not only have thousands, perhaps tens of thousands of Jews around the world abandoned this custom, finding it to be inconsistent with their beliefs and values as Jews, but many have actively repudiated it and are involved in the worldwide effort - like its sister campaign to eradicate female genital mutilation - to end the practice of male circumcision once and for all. The Jewish community thus is split on this topic, not unlike the way that Christian denominations were split on the subject of slavery during the nineteenth century.

It is imperative, therefore, that the Alþingi recognize that a significant portion of the world's Jews oppose circumcision. Particularly given that much of the opposition to this proposed legislation from some Jewish organizations - organizations that I otherwise admire and respect - has been couched in terms that mischaracterize the proposed circumcision ban as an attack on Jews or Judaism or even as anti-Semitic. That is not how I and who-knows-how-many other Jews around the world see it. I urge the members of the Alþingi to recognize that, on this subject, these venerable Jewish organizations do not speak for all Jews and they certainly do not speak for me. They do not speak for the thousands of Jews around the world who oppose circumcision just as vehemently as they support it. As we see it, this legislation would merely give every boy in Iceland - including every Jewish boy - the right to decide *for himself* whether to undergo circumcision when he is old enough to make that decision for himself. That is not an attack on religious freedom but an affirmation of it.

Second, as I have noted, it took an act of congress to ban slavery in the United States. Courageously, Lincoln and congress did not wait until there was unanimity on ending slavery. They recognized that governments must often lead the way toward social progress. This is particularly true of secular governments that owe special allegiance, fealty or deference to no religion or religious denomination but, instead, govern by the consent of the people and with a mandate

to enact laws that incorporate universal principles of basic human rights and dignity. I urge the Alþingi to bear this in mind when considering this legislation. I believe that, if you do, you cannot conclude otherwise than that you have not only a right to ban non-therapeutic infant circumcision but a legal and a moral obligation to do so.

Respectfully,

David Balashinsky
Binghamton, New York, U.S.A.

David. J. Biviano, Ph.D.

djbiviano@me.com
1824 10th Ave.
Spokane, WA 99204

Alþingi
Kirkjustræti
150 Reykjavík

March 27, 2018

Ágæta Alþingi / Dear Members of the Parliament,

I am pleased to have the opportunity to commend you for consideration of the bill to prohibit the circumcision of minors in Iceland, absent a medical reason.

I have long been an "Intactivist" here in the United States where we seek this same kind of legal protection for boys, as we do for girls.

I am aware that your government faces the same objection from religious sectors that practice this procedure as a ritual of initiation into a religion or adulthood.

In my considered and researched view regarding International Law and the decrees of the United Nations of the Rights of the Child, and the Right to Religious Freedom, I am convinced that one's right to religious freedom is an individual right, not one to impose on another, including one's own children, by marking it in their flesh.

It is certainly normal for a child to grow up in the religious faith and customs of his or her community, but nevertheless maintains the autonomy of choice upon reaching the age of reason or adulthood. They should not have to live with diminished genitals upon that time in their life. In other words, one's religious freedom ends at the body of another person, whose right to an intact body, bodily integrity, is sacrosanct, to use a religious word.

Thank you for the courage and conviction to inscribe this right into Icelandic Law. The affected religious communities will then have to live within the law, including International Law, rather than insisting on being an exception to it. Ancient religious customs of child sacrifice eventually gave way to the law, and so can they.

Sincerely,

David J. Biviano, Ph.D.

From: Donald Lapowich [mailto:dlapowich@hotmail.com]
Sent: 28. febrúar 2018 23:35
To: althingi@althingi.is
Subject: Why not just say you do not want Jews in Iceland so that the World will know why you wish to ban circumcision. How cowardly can you be in attackIng any group that desires to proceed with the step as a ritual and or for health reasons. Also maybe you ha...

Alþingi
Kirkjustræti
150 Reykjavík

26 March 2018

Ágæta Alþingi / Dear Members of the Parliament

I write as a male survivor of neonatal genital mutilation. As such, I might ably attest to the lifelong psychological, sexual and social harms that have arisen as a consequence of this medically unnecessary procedure. However, I would appeal to the parliament's reason, rather than seek to elicit its sympathies.

Any law which protects females—but *only* females—from genital mutilation, is unjust and arguably unlawful. Such a law discriminates on the basis of gender against one half of the population: men and boys, as well as intersex children. Anti-FGM legislation also privileges the religious or cultural practices of certain groups (e.g. Judaism) while prohibiting the practices of others (e.g. Islam).

There is simply no ethical or legal basis for differentiating "female" from any other form of non-consensual genital mutilation. Each of the human rights said to be contravened by FGM—including the right to non-discrimination, to protection from physical and mental violence, to the highest attainable standard of health, and in extreme cases, the right to life—is violated or negated by the "routine" practice of male circumcision. As reported by the International NGO Council on Violence Against Children:

> Until recently, male circumcision has generally been challenged only when carried out by non-medical personal in unhygienic settings without pain relief. But a children's rights analysis suggests that non-consensual, non-therapeutic circumcision of boys, whatever the circumstances, constitutes a gross violation of their rights, including the right to physical integrity, to freedom of thought and religion and to protection from physical and mental violence. When extreme complications arise, it may violate the right to life. It is reported that male circumcision can result in numerous physical, psychological, and sexual health problems during the surgery, afterwards, and throughout adulthood, including haemorrhage, panic attacks, erectile dysfunction, infection (in severe forms leading to partial or complete loss of the penis), urinary infections, necrosis, permanent injury or loss of the glans, excessive penile skin loss, external deformity, and in some cases even death.[1]

It follows that existing FGM legislation must be either (a) repealed or (b) amended so as to extend its protections to all children—irrespective of age, gender, or parental religion.

In dark times such as these, Iceland is currently given a unique opportunity to lead the world into a brighter future for all children, one in which genital autonomy, human dignity, and social justice might prevail. I beseech the Icelandic parliament to legislate for the advancement of universal human rights.

Yours sincerely

Dr Chris Coughran

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[1] *Violating Children's Rights: Harmful Practices Based on Tradition, Culture, Religion or Superstition. A Report from the International NGO Council on Violence against Children* (2012) pp. 21–22. https://www.crin.org/en/docs/InCo_Report_15Oct.pdf

From: Elliot [mailto:elliot@rapasport.ca]
Sent: 1. mars 2018 14:49
To: althingi@althingi.is
Subject: circumcision BAN
Importance: High

I am totally against this ban as a Jew and as infringement of freedom .

Regards

Elliot Rouah

E.Mail : elliot@rapasport.ca

Cell : 514-994 5451

Alþingi 18.3.2018
Kirkjustræti
150 Reykjavík

Ágæta Alþingi,

I heard about the planned law prohibiting child circumcision in Iceland.
Nearly six years ago there was a similar debate in my country.
And the government decided to rate religion higher than the rights of children.
What fills me with sham until today. What kind of message was that which we have sent to children and especially for boys?
That the interests of adults are above those of children, above the physical self-determination of children, above the right of sexual self-determination of children, above the health of children.
This is not a message we should give to our children.
The body of the children should only belong to them. Without restriction by gender or origin
of the child.
How should we teach equal rights to children, if we make fundamental rights dependent on the gender of the children or the religion of the parents?
How can we tell them that their body belongs only to them, if it is a lie, in the case of half of the children?

Please do not make the same mistake as my country.
Be a good example of human rights, children's rights, progress and equal rights
Defend the weak and voiceless
in this conflict, the children.

Sincerely, yours
Eric H. Masson

Plauen, Germany

EJC
EUROPEAN JEWISH CONGRESS

Parliament of Iceland (Althingi)
101 Reykjavík, Iceland

Brussels, 27 March 2018
Ref. N°. 1803100

Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)

Dear Sir/Madam:

On behalf of the European Jewish Congress (EJC), the representative umbrella organization of European Jewry, we would hereby like to express our concerns with regard to the proposed amendment to the Criminal Code no. 19/1940 seeking to criminalise male circumcision.

Religious circumcision of boys (Brit Milah) at eight days old has been a longstanding practice among Jews for more than 3.000 years, regardless of the particular level of religious observance. It is an essential element to our religion, to our cultural and ethnic identity and to our status as free and equal citizens in democratic countries.

We are concerned that the proposed amendment to the Icelandic criminal code will be a disproportionate limitation of the freedom of thought, conscience and religion of Jews in Iceland, taking into account the fact that there is no evidence that Brit Milah poses adverse effects to the health of young boys to justify criminalising an essential religious and cultural Jewish practice (see Annex 1-3). These restrictions would pose an unbearable burden on Jews in Iceland.

Furthermore, we consider it extremely problematic that the proposed amendment seems to equate male circumcision with female genital mutilation, which in terms of risks to public health are not comparable practices by any objective standards.

We fear that this approach not only muddles the debate around the practice of circumcision and around the issue of proportionality regarding restrictions on religious freedom, but that it also may have the effect of stigmatising Jewish communities.

Recalling Resolution 2076 (2015) of the Parliamentary Assembly of the Council of Europe, states should seek reasonable accommodations with Jews in Iceland with a view to guaranteeing equality that is effective, and not merely formal, in the right to freedom of religion.

Therefore, we strongly encourage you to take these concerns into account and to reject the legislative initiative to criminalise male circumcision.

Yours sincerely,

Dr. Moshe Kantor
President of the European Jewish Congress

EJC
EUROPEAN
JEWISH CONGRESS

Annex

1. American Academy of Pediatrics, Circumcision Policy Statement, 2012.
2. Canadian Pediatric Society, Position Statement, Newborn Male Circumcision, 2015.
3. Brady, M., Newborn Male Circumcision with Parental Consent, as Stated in the AAP Circumcision Policy Statement, Is Both Legal and Ethical, The Journal of Law, Medicine & Ethics, Vol 44, Issue 2, pp. 256 – 262, 2016.

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Circumcision Policy Statement

TASK FORCE ON CIRCUMCISION

KEY WORDS

male circumcision, penis, prepuce, phimosis, sexually transmitted infections, HIV, urinary tract infection, analgesia, parental decision-making, ethics

ABBREVIATION

AAP—American Academy of Pediatrics

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abstract

FREE

Male circumcision is a common procedure, generally performed during the newborn period in the United States. In 2007, the American Academy of Pediatrics (AAP) formed a multidisciplinary task force of AAP members and other stakeholders to evaluate the recent evidence on male circumcision and update the Academy's 1999 recommendations in this area. Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV. The American College of Obstetricians and Gynecologists has endorsed this statement. *Pediatrics* 2012;130:585–586

POLICY STATEMENT

Systematic evaluation of English-language peer-reviewed literature from 1995 through 2010 indicates that preventive health benefits of elective circumcision of male newborns outweigh the risks of the procedure. Benefits include significant reductions in the risk of urinary tract infection in the first year of life and, subsequently, in the risk of heterosexual acquisition of HIV and the transmission of other sexually transmitted infections.

The procedure is well tolerated when performed by trained professionals under sterile conditions with appropriate pain management. Complications are infrequent; most are minor, and severe complications are rare. Male circumcision performed during the newborn period has considerably lower complication rates than when performed later in life.

Although health benefits are not great enough to recommend routine circumcision for all male newborns, the benefits of circumcision are sufficient to justify access to this procedure for families choosing it and to warrant third-party payment for circumcision of male newborns. It is important that clinicians routinely inform parents of the health benefits and risks of male newborn circumcision in an unbiased and accurate manner.

Parents ultimately should decide whether circumcision is in the best interests of their male child. They will need to weigh medical information in the context of their own religious, ethical, and

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cultural beliefs and practices. The medical benefits alone may not outweigh these other considerations for individual families.

Findings from the systematic evaluation are available in the accompanying technical report. The American College of Obstetricians and Gynecologists has endorsed this statement.

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POSITION STATEMENT

Newborn male circumcision

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Abstract

The circumcision of newborn males in Canada has become a less frequent practice over the past few decades. This change has been significantly influenced by past recommendations from the Canadian Paediatric Society and the American Academy of Pediatrics, who both affirmed that the procedure was not medically indicated. Recent evidence suggesting the potential benefit of circumcision in preventing urinary tract infection and some sexually transmitted infections, including HIV, has prompted the Canadian Paediatric Society to review the current medical literature in this regard. While there may be a benefit for some boys in high-risk populations and circumstances where the procedure could be considered for disease reduction or treatment, the Canadian Paediatric Society does not recommend the routine circumcision of every newborn male.

Key Words: *Circumcision; HIV; HPV; HSV; Infant; STI; UTI*

The cultural and religious ritual of male circumcision has been practiced for thousands of years. Circumcision as a medical procedure arose in Britain and the United States in the late 19th century. The historical medical benefits of neonatal circumcision have included ease of genital hygiene, diminished risk of disease and avoidance of circumcision later in life. In the middle of the last century, most Canadian boys were circumcised. However, the rate of neonatal circumcision has declined over time to the current Canadian average of 32%, with significant regional variability.[1] The Canadian Paediatric Society (CPS) published a position statement in 1996 stating that circumcision was not recommended as a routine procedure for male newborns because the benefits and harms were evenly balanced. A similar viewpoint was expressed by the American Academy of Pediatrics (AAP) in 1999 and reaffirmed in 2005.[2] More recent evidence regarding the beneficial role of male circumcision in preventing urinary tract infection (UTI) in infancy and some sexually transmitted diseases (STIs) in adult life has prompted the CPS to review the current medical information on the circumcision of newborn males. The AAP updated its own policy statement in 2012.[3] The goal of the present statement is to provide guidance to health care providers and up-to-date information for the parents of newborn boys, to enable them to make informed decisions regarding circumcision.

Methods

A Medline search using the MESH heading "circumcision, male" was initially performed, which yielded 1596 articles. These articles were subsequently reviewed, as were their references when appropriate. The focus was on neonatal and infant male circumcision and its outcomes.

The hierarchy of evidence from the Centre for Evidence-Based Medicine was applied, using levels of evidence for therapy and prognosis.[4]

The foreskin and circumcision

In the male newborn, the mucosal surfaces of the inner foreskin and glans penis adhere to one another; the foreskin is not redundant skin. The foreskin gradually separates from the glans during childhood. By six years of age, 50% of boys can retract their foreskins, although the process of separation may not be complete until puberty: 95% of boys have retractile foreskin by 17 years of age.[5] Parents may be reassured by their observation of an unimpaired urinary stream in a boy with a nonretracted foreskin. Until this developmental process is complete, the best descriptor to use is 'nonretractile foreskin' rather than the confusing and perhaps erroneous term 'physiologic phimosis'.

Appropriate care for the uncircumcised penis has been well reviewed[6] and should include anticipatory guidance on hygiene and an understanding of the normal nonretractile foreskin.

Circumcision involves the partial or complete removal of the foreskin (prepuce); a number of methods are used.[6] In Canada, the majority of newborn male circumcisions are performed by medical practitioners and most of the remainder by skilled traditional providers. Whatever method is used, strict adherence to hygienic principles and the use of effective analgesia are essential.

Potential benefits of circumcision

Phimosis treatment

Phimosis is defined as a scarring and thickening of the foreskin that prevents retraction back over the glans.[7] Phimosis may occur secondary to recurrent infections, inflammation or lichen sclerosis. Phimosis needs to be differentiated from the normal nonretractile foreskin.

The foreskin can become inflamed or infected (posthitis), often in association with the glans (balanoposthitis) in 1% to 4% of uncircumcised boys.[8][9] The foreskin can also become entrapped behind the glans (paraphimosis) in 0.5% of cases. Both conditions usually resolve with medical therapy but, if recurrent, can cause phimosis.[7][10] An estimated 0.8% to 1.6% of boys will require circumcision before puberty, most commonly to treat phimosis.[7] The first-line medical treatment of phimosis involves applying a topical steroid twice a day to the foreskin, accompanied by gentle traction. This therapy serves to thin the tissue and release adhesions, allowing the foreskin to become retractable in 80% of treated cases, thus usually avoiding the need for circumcision.[11][12] Topical steroid treatment is also useful to hasten foreskin retraction in boys with nonretractile foreskins.[12] A number of steroid preparations have been used, including betamethasone 0.05% to 0.1%, triamcinolone 0.1% and mometasone furoate 0.1%.

Other dermatoses of the penis can occur in childhood and should be considered if the skin over the penile shaft, foreskin or glans is abnormal.[10][13] Such presentations may necessitate referral to a urologist or dermatologist for diagnosis and treatment, which may include circumcision.

UTI reduction

The preputial sac provides an environment for colonization of the urethra with uropathogenic organisms that can cause UTI in infant boys.[14] UTI occurs in approximately one in 100 boys in the first month of life. A meta-analysis that included one randomized trial and 11 observational studies found that UTI was decreased by 90% in circumcised infants, with a significant OR of 0.13 (95% CI 0.08 to 0.20).[15] In a more recent meta-analysis that included 14 studies, the pooled prevalence of UTI in febrile infants <3 months of age was 7.5% for females, 2.4% for circumcised

males and 20.1% for uncircumcised males. The prevalence rate of UTI in febrile males (circumcised and uncircumcised) decreased to 1.7% by six to 12 months of age, but the 10-fold difference related to circumcision status was maintained.[16] Since the publication of this meta-analysis, a further prospective cohort study, in which a series of urine cultures were obtained in boys up to 15 months of age, also found a lower incidence of UTI in individuals who had undergone newborn circumcision (0% versus 2%, P<0.001).[17] The risk of UTI declines rapidly in males after the first few months of life to an incidence of one in 1000 by one year of age.[16] Using estimates of lifetime risk for male UTI, a recent meta-analysis calculated that, over a lifetime, the RR for UTI was 3.65 for uncircumcised versus circumcised males, with 23% of all UTIs attributed to lack of circumcision.[18] However, this conclusion should be questioned because the adult data were limited to a single study of only 78 men.

It has been estimated that 111 to 125 normal infant boys (for whom the risk of UTI is 1% to 2%) would need to be circumcised at birth to prevent one UTI.[15][16] In boys at higher risk for UTI, such as those with recurrent UTI or an underlying urinary tract anomaly (eg, high-grade vesico-ureteric reflux or obstructive uropathy), circumcision may be of greater benefit. In these cases, it is estimated that only four boys would need to be circumcised to prevent one UTI.[15] However, it should be noted that contaminated urines are more common in uncircumcised males, potentially leading to overdiagnosis of UTI; thus, the number needed to treat may be considerably higher than that found in these studies. Childhood UTI leads to dimercaptosuccinic acid (DMSA)-detectable renal scarring in 15% of cases.[19] Although these scars could theoretically have an impact on long-term renal function and hypertension, there is no evidence for this effect, and most experts believe that UTIs in children with normal kidneys do not result in long-term sequelae.

STI reduction

Observational studies performed in Africa and in developed countries since the emergence of HIV/AIDS have suggested that uncircumcised men are at higher risk for HIV infection.[20][21] The inner surface of the foreskin is rich in Langerhans and other HIV target cells that are exposed to infection during sexual intercourse, which is speculated to be one mechanism leading to HIV acquisition.[22] If true, then removing the foreskin could theoretically have a protective effect against HIV acquisition. Conclusive evidence that circumcision is partially effective in decreasing the risk for heterosexually-acquired HIV infection among men in sub-Saharan Africa has been provided by three large randomized controlled trials involving men and adolescent boys in Uganda,[23] South Africa[24] and Kenya.[25] Compared with uncircumcised controls, there was a decrease in new HIV infection by 50% to 60% in the circumcised male participants. In the Kenyan study, this protective effect was sustained for at least 42 months[25] (Level of Evidence 1). Observational studies undertaken in sub-Saharan Africa have also suggested that there is a similar degree of protection when circumcision is performed in the neonatal period[20][26] (Level of Evidence 4).

It remains unclear, however, whether these conclusions can be applied to populations in developed countries, where the HIV seroprevalence rates are lower and common routes of HIV transmission include injection drug use (IDU) and men who have sex with men (MSM).[27]

The Centers for Disease Control and Prevention (CDC, Georgia, USA) recently published an analysis of the cost-effectiveness of newborn circumcision in reducing the lifetime risk of HIV acquisition in American males, assuming 60% efficacy over a lifetime and a risk of HIV acquisition varying from 0.94% for white males to 6.22% for black males.[28] The CDC estimated that the risk of lifetime acquisition through heterosexual transmission was reduced by 16% overall, ranging from 8% in white males to nearly 21% for black males. The analysis, based on a cost of USD$257 for the procedure, demonstrated cost savings in both Hispanic and black males. The number needed to treat to prevent one HIV infection varied from 1231 in white males to 65 in black males, with an average in all males of 298. The model did not account for the cost of complications of circumcision. In addition, there is a risk that men may overestimate the protective effect of being circumcised and be less likely to adopt safe sex practices.

In 2011, the Public Health Agency of Canada reported that 46.6% of new cases of HIV in Canada for which an exposure category was reported were attributed to MSM and 13.7% to IDU.[29] The proportion of new cases attributed to heterosexual transmission involving individuals not originally from a country where HIV is endemic was 20.3%, while 16.9% of new cases were in individuals originally from HIV-endemic countries. The report noted that the estimated rate of new infection in the latter group was nine times higher than in the general Canadian population. A disproportionate

number of new cases occurred in Aboriginal people (12.2%), a rate estimated to be 3.5 times higher than in the non-Aboriginal population. IDU was the main reported source of exposure (58.1%), followed by heterosexual exposure (30.2%).[29]

It is presumed that male circumcision, by reducing the burden of HIV in men, will indirectly protect women. There does not appear to be a significant role in decreasing male-to-female transmission in HIV-discordant couples.[30][31]

Evidence obtained from observational studies that male circumcision can decrease the risk of other STIs has been conflicting. Analysis of data regarding subjects enrolled in the randomized sub-Saharan African studies revealed lower rates of herpes simplex virus-2 (HSV-2) seroconversion (adjusted HR = 0.72) and acquisition of high-risk human papillomavirus (HPV) genotypes (adjusted RR = 0.65) in circumcised men during the two-year follow-up postcircumcision.[32] The rate of HPV infection was also lower in circumcised men in many other countries (OR = 0.37) [32] (Level of Evidence 2). Circumcision was not found to be protective against gonorrhea or chlamydia.[33] No studies have examined the impact of routine neonatal circumcision on STIs other than HIV.

The female partners of men circumcised in the same African studies had a lower adjusted prevalence rate of 0.52 for *Trichomonas vaginalis* infection, 0.60 for bacterial vaginosis and 0.78 for genital ulcer disease.[34]

Although circumcision can decrease the risk of acquiring and transmitting STIs, it should be emphasized that other preventative measures, including abstinence, use of condoms and other safe sex practices, must continue to be taught and practiced.

Cancer reduction

Female partners of circumcised men have a reduced cervical cancer risk, with ORs ranging from 0.18 to 1.61 depending on the sexual-behavioural risk level of their partner[35] (Level of Evidence 3). The incidence of cervical cancer in Canada ranges from nine to 17/100,000.

Penile cancer is rare in developed countries (one in 100,000 men). Squamous cell carcinoma of the penis occurs almost exclusively in uncircumcised men, with phimosis being the strongest associated risk factor (OR 11.4 [95% CI 5.0 to 25.9]).[36] This finding underscores the importance of genital hygiene and of identifying and treating cases of phimosis and residual nonretractile foreskin in all males.

There is a strong association between HPV infection and penile cancer regardless of circumcision status, with 80% of tumour specimens being HPV DNA-positive.[37] It is expected that routine HPV vaccination for girls will dramatically decrease the incidence rate of cervical cancer. The benefit may also extend to penile cancer, especially as the program is broadened to include young men.

Potential risks of circumcision

Surgical procedures, including circumcision, are painful. Even with procedural analgesia, individuals experience postprocedural pain that must be treated. Newborns who experience procedural pain have altered response to later vaccinations, with demonstrated higher pain scores.[38]

Acute complications of neonatal circumcision include minor bleeding, local infection and an unsatisfactory cosmetic result. Severe complications, such as partial amputation of the penis and death from hemorrhage or sepsis, are rare occurrences. A recent meta-analysis reporting on prospective and retrospective studies investigating circumcision found a median complication rate of 1.5% in neonates or infants. When circumcision was performed during childhood, the complication rate increased to 6%, a rate similar to that reported in studies of circumcised adolescents and adults.[39]

The most common late complication of circumcision is meatal stenosis (2% to 10%), which may require surgical dilation.[40] This condition can be prevented almost completely by applying petroleum jelly to the glans for up to six months following circumcision.[41] Partial re-adherence of the penile skin to the glans is not uncommon. Such

adhesions often resolve spontaneously by puberty but, when they are extensive, may also benefit from treatment with a topical steroid preparation. Surgical lysis is rarely required.[42]

The foreskin serves to cover the glans penis and has an abundance of sensory nerves,[5] but medical studies do not support circumcision as having a negative impact on sexual function or satisfaction in males or their partners.[43]-[45] It has been reported that some parents or older boys are not happy with the cosmetic result, but no specific data from the literature to quantify this outcome could be found.

Health care providers should be aware of potential contraindications to neonatal circumcision. Hypospadias requires an assessment by a urologist before circumcision is considered. Any risk of bleeding diathesis requires further investigation and discussion with appropriate professionals and decision makers before proceeding with circumcision.

Ethics and legalities of circumcision

Neonatal circumcision is a contentious issue in Canada. The procedure often raises ethical and legal considerations, in part because it has lifelong consequences and is performed on a child who cannot give consent. Infants need a substitute decision maker – usually their parents – to act in their best interests. Yet the authority of substitute decision makers is not absolute. In most jurisdictions, authority is limited only to interventions deemed to be medically necessary. In cases in which medical necessity is not established or a proposed treatment is based on personal preference, interventions should be deferred until the individual concerned is able to make their own choices.[46]

With newborn circumcision, medical necessity has not been clearly established. However, there are some health benefits, especially in certain populations. Furthermore, performing circumcision in older boys, who are able to provide consent, can also increase risk and costs to the individual.[39] Therefore, some parents view circumcision as being in their child's best interest. A complete discussion of ethical and legal issues associated with newborn male circumcision is beyond the scope of this statement. Readers are referred to the July 2013 issue of the *Journal of Medical Ethics* which is devoted to the topic.[47] Both parents and health care providers should be familiar with the legal issues related to consent.

Summary

Current evidence indicates that there are potential health benefits associated with male circumcision, particularly in high-risk populations. Infant circumcision reduces the incidence of UTI in young boys and eliminates the need for medical circumcision in later childhood to treat recurrent balanoposthitis, paraphimosis and phimosis. Circumcised men have a lower risk of developing penile cancer, while the incidence of trichomonas, bacterial vaginosis and cervical cancer in the female partners of circumcised men is also reduced. Circumcision in adult men can reduce the risk of acquiring an STI (specifically HIV, HSV and HPV). Minor complications of circumcision can occur, although severe complications are rare. The risk of complications is lower in infants than in older children. The complication rate decreases significantly when the procedure is performed by experienced health care professionals, with close follow-up in the days postprocedure to ensure that bleeding does not increase. It is important to remember that most data regarding the benefits and outcomes following circumcision come from countries other than Canada, which can make application to our population difficult.

Because the medical risk:benefit ratio of routine newborn male circumcision is closely balanced when current research is reviewed (Table 1), it is challenging to make definitive recommendations for the entire male newborn population in Canada. For some boys, the likelihood of benefit is higher and circumcision could be considered for disease reduction or treatment. Health care professionals should provide parents with the most up-to-date, unbiased and personalized medical information available so that they can weigh the specific risks and benefits of circumcising their son in the context of familial, religious and cultural beliefs. Having the right information will enable them to make the best decision for their boys. Decision aids based on current medical information can be helpful.

Recommendations

- The CPS does not recommend the routine circumcision of every newborn male.
- Physicians and other health care professionals caring for newborns must stay informed about circumcision and assist parents in understanding potential risks and benefits of the procedure.
- The parents of male newborns must receive the most up-to-date, unbiased and personalized medical information available about neonatal circumcision, so that they can weigh specific risks and benefits of circumcision in the context of their own familial, religious and cultural beliefs.
- Parents who choose to have their sons circumcised should be referred to a practitioner who is trained in the procedure.
- Neonatal male circumcisions must be performed by trained practitioners whose skills are up-to-date and strictly adhere to hygienic and analgesic best practices.
- Close follow-up in the early postcircumcision time period is critical. The parents of circumcised boys must be thoroughly and accurately informed about postprocedural care and possible complications.
- At the time of hospital discharge, health professionals should ensure that the parents of uncircumcised newborn boys know how to appropriately care for their son's penis and are aware that the normal foreskin can remain nonretractile until puberty.
- Quality Canadian data are required to understand the clinical and economic issues involved with neonatal male circumcision, including its potential risks, benefits and costs, in the Canadian context.

TABLE 1

Potential risks and benefits of neonatal circumcision

Outcome	**Effect size (reference)**
Potential risks	
Minor bleeding	1.5% (combined)
Local infection (minor)	NNH = 67 [39]
Severe infection	Extremely rare
Death from unrecognized bleeding	Extremely rare
Unsatisfactory cosmetic results	
Meatal stenosis	NNH 10–50 (<1% when petroleum jelly is used)
Potential benefits	
Prevention of phimosis	NNT = 67 [7]
Decrease in early UTI	NNT = 111 – 125 [16]
Decrease in UTI in males with risk factors (anomaly or recurrent infection)	NNT = 4 – 6 [15]

Decreased acquisition of HIV	NNT = 298 (65 – 1231 depending on population) [28]
Decreased acquisition of HSV	NNT = 16 [32]
Decreased acquisition of HPV	NNT = 5 [32][35]
Decreased penile cancer risk	NNT = 900 – 322,000 [36][37]
Decreased cervical cancer risk in female partners	NNT = 90 – 140 [35]

HPV Human papillomavirus; HSV Herpes simplex virus; NNH Number needed to harm; NNT Number needed to treat; UTI Urinary tract infection

Selected resources

- Canadian Paediatric Society. Circumcision of baby boys: Information for parents <www.caringforkids.cps.ca/handouts/circumcision>
- American Academy of Pediatrics. Circumcision <www.healthychildren.org/English/ages-stages/prenatal/decisions-to-make/Pages/Circumcision.aspx>

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Newborn Male Circumcision with Parental Consent, as Stated in the AAP Circumcision Policy Statement, Is Both Legal and Ethical

Michael T. Brady

Circumcision is a surgical procedure that removes the foreskin (prepuce) of the penis. While it is a minor surgical procedure, it has generated considerable controversy. There are zealous proponents and opponents of this medical practice. The medical and lay literature has numerous articles and opinion pieces discussing the risks and benefits of circumcision. Opponents of male circumcision have called it "child abuse"[1] and a "human rights violation,"[2] while proponents feel that the health benefits derived from removal of the foreskin make circumcision a "biomedical imperative"[3] and a "cost effective prevention strategy."[4] Given this tremendous dichotomy of opinion and the polarization of opponents and proponents, it is unlikely that any rational discussion will sway those who hold extreme views. For that reason, any decision about the role of newborn male circumcision in the delivery of optimal healthcare to children should not be high jacked by those who have emotional or subjective beliefs about this procedure. Rather, determination about whether newborn male circumcision is an appropriate medical option should be based on non-biased review of the evidence relating to the health risks and health benefits of newborn male circumcision.

Background to American Academy of Pediatrics Task Force on Circumcision

The American Academy of Pediatrics (AAP) has played a major role in defining policies and guidelines that have shaped optimal care for infants, children and adolescents. In 2007, the AAP convened a Task Force on Circumcision to update its recommendations on newborn male circumcision. Prior to 2007, the AAP had written three statements on newborn male circumcision in 1975,[5] 1989,[6] and 1999.[7] The purpose of update in 2007 was in large part to address significant new evidence concerning the beneficial effects of circumcision on preventing the acquisition of HIV and other sexually transmitted infections since publication of the 1999 statement. In addition, the 1999 statement provided a very lukewarm description of the identified health benefits. They were characterized as "potential" health benefits that did not provide immediate benefit to the child who was circumcised. The language in the 1999 statement prompted 18 state Medicaid programs to discontinue reimbursement of newborn male circumcision. For these reasons, the AAP brought together experts in areas that they felt would

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be valuable in developing recommendations that were evidence-based and current. Task Force members included the following areas of expertise: general pediatrics, neonatology, bioethics, infectious diseases, obstetrics, family medicine, epidemiology, urology and public health. The Task Force participants were chosen based on expertise and not whether they had preconceived opinions on the role of newborn male circumcision in healthcare delivery to children.

Any decision about the role of newborn male circumcision in the delivery of optimal healthcare to children should not be high jacked by those who have emotional or subjective beliefs about this procedure. Rather, determination about whether newborn male circumcision is an appropriate medical option should be based on non-biased review of the evidence relating to the health risks and health benefits of newborn male circumcision.

Methodology and Questions for Review

Task Force members identified eight questions that were relevant to any determination of recommendations concerning newborn male circumcision. These questions were published in the Technical Report.[8]

1. What is the current epidemiology of male circumcision in the United States?
2. What are the most common procedures and techniques for newborn male circumcision?
3. What best supports the parental decision – making process regarding circumcision?
4. What is the association between male circumcision and both morbidity and sexual function/satisfaction?
5. What is the impact of anesthesia and analgesia?
6. What are common complications and complication rates associated with male circumcision?
7. What workforce issues affect newborn male circumcision?
8. What are the trends in financing and payment for elective newborn male circumcision?

AAP contracted a professional medical librarian to search the medical literature for articles that addressed these questions. The evidence from these articles was graded using the American Heart Associations' template for evidence evaluation.[9] Searches were conducted in Medline, Cochrane Database and Embase for the time period of 1995 through 2010. A total of 1430 articles were identified. Case reports, case series, ecological reviews, opinions and articles with an evidence grade of 5 or higher were not accepted. A total of 1031 articles met prior established criteria and were reviewed by the Task Force. A contracted physician epidemiologist and at least one Task Force member with specific expertise in the area in the article reviewed each of the 1031 articles.

Task Force Recommendations

The following are the recommendations developed by the Task Force following a review of the current evidence concerning newborn male circumcision and were included in the Technical Report:[10]

1. Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks, and the benefits of newborn male circumcision justify access to this procedure for those families who choose it.
2. Parents are entitled to factually correct, nonbiased information about circumcision that should be provided before conception and early in pregnancy, when parents are most likely to be weighing the option of circumcision of a male child.
3. Physicians counseling families about elective male circumcision should assist parents by explaining, in a nonbiased manner, the potential benefits and risks, and by ensuring that they understand the elective nature of the procedure.
4. Parents should weigh the health benefits and risks in light of their own religious cultural, and personal preferences, as the medical benefits alone may not outweigh these other considerations for individual families.
5. Parents of newborn boys should be instructed in the care of the penis at the time of discharge from the newborn hospital stay,

regardless of whether the newborn has been circumcised or not.

6. Elective circumcision should be performed only if the infant's condition is stable and healthy.
7. Male circumcision should be performed by trained and competent practitioners, by using sterile techniques and effective pain management.
8. Analgesia is safe and effective in reducing the procedural pain associated with newborn circumcision; thus, adequate analgesia should be provided whenever newborn circumcision is performed.
9. Key professional organizations (AAP, AAFP, ACOG, the American Society of Anesthesiologists, the American College of Nurse Midwives, and other midlevel clinicians such as nurse practitioners) should work collaboratively to:
   - Develop standards of trainee proficiency in the performance of anesthetic and procedure techniques, including suturing;
   - Teach the procedure and analgesic techniques during post-graduate training programs;
   - Develop educational materials for clinicians to enhance practitioners' competency in discussing the benefits and risks of circumcision with parents;
   - Offer educational materials to assist parents of male infants with the care of both circumcised and uncircumcised penises.
10. The preventive and public health benefits associated with newborn male circumcision warrant third-party reimbursement of the procedure.

It is important to understand what the policy statement recommends and what it does not recommend. The policy statement does not recommend routine newborn male circumcision. The policy statement actually does not recommend circumcision of any child. But it does recommend that frank and non-biased discussions of newborn male circumcision be made between healthcare providers and parents of newborn males. These recommendations were endorsed by the American College of Obstetrics and Gynecology.[11]

While opponents of circumcision have attacked the AAP Policy Statement and Technical Report, there are a number of recommendations that should not be controversial and should be acceptable to everyone. Recommendations that should not be controversial include: (1) Parents of male newborns should receive instruction on the care of the penis whether the child is circumcised or uncircumcised; (2) Parents are entitled to factually correct, non-biased information about circumcision; (3) Physicians counseling families about elective newborn male circumcision should provide non-biased information about risks and benefits; (4) Elective circumcision should only be performed if infants condition is stable; and (5) Male circumcision should only be performed by trained and competent practitioners using sterile technique and effective pain management.

Controversial Recommendations

Recommendations that have been considered controversial include: (1) Evaluation of current evidence indicates that health benefits of newborn male circumcision outweigh the risks and benefits of newborn male circumcision justify access to this procedure for those families who choose it; (2) Parents should weigh the health benefits and risks inlight of their religious, cultural and personal preferences, as medical benefits alone may not outweigh those other considerations for those individuals families; and (3) Preventive and public health benefits warrant third-party reimbursement for newborn circumcision. These last three recommendations deserve specific attention in order to understand how the Task Force developed them.

Evidence of Benefit

The AAP was not first in stating that the medical benefits of newborn male circumcision outweighed risks. In 2007, the CDC had made this exact same statement.[12] The reason that the AAP and the CDC feel that the health benefits outweigh the risks is because there are clear evidence of significant health benefits, particularly relating to reduction in urinary tract infections,[13] HIV infection,[14] sexually transmitted infections, specifically HPV, HSV and syphilis,[15] penile cancer,[16] phimosis, paraphimosis and balanitis in young males[17] and lichen sclerosis.[18] In addition, female partners of individuals who are circumcised are less likely to be infected with HPV, to develop cervical cancer[19] and to develop bacterial vaginosis.[20] The evidence to support these health benefits is clear and supported by multiple well designed studies. These health benefits are irrefutable.

The greatest impact on reduction of urinary tract infections occurs in the first year of life.[21] Circumcised infants in the first year of life have nearly a ten-fold decreased risk of urinary tract infection as compared to non-circumcised males. While the difference in risk of acquiring a urinary tract infection between circumcised and non-circumcised males declines with increasing age, the benefit remains for life. Children

between the ages of one and 16 years and greater than 16 years who have been circumcised have 6.6 and 3.4-fold less risk of a urinary tract infection, respectively.[22] Circumcision is also protective against positive urine cultures and urinary tract infections in all ages of children with vesicoureteral reflux.[23]

One of the most compelling health benefits documented by circumcision has been the reduction in acquisition of HIV infection in heterosexual circumcised males. This evidence comes from three randomized controlled trials that were performed in Africa.[24] Opponents of circumcision state these studies were not valid because they were performed on a population that is dissimilar to the population in the United States. It is true that the prevalence of HIV-infection in the three African countries where the studies were conducted is significantly higher than in the United States. In addition, the predominant mode of acquisition by males in these African countries is different than in the US. In Africa, most acquisition of HIV infections in males is through heterosexual activity; where as in the United States it is more commonly acquired in men who have sex with men. Since the beginning of the HIV pandemic, there were numerous epidemiologic studies from the United States that identified circumcision as one of the factors associated with reduced acquisition of HIV infection in heterosexual males.[25] The three randomly controlled studies in Africa provided a proof-of-principle, i.e. these three studies clearly defined the role of circumcision in the reduction of HIV acquisition in heterosexual males. In order to assess the relevance of the African studies to a United States population, the Centers for Disease Control and Prevention (CDC) performed a modeling study looking at the efficacy and cost-effectiveness of newborn male circumcision in a population in the United States with a lower prevalence of HIV and with a lower proportion of males acquiring HIV infection through the heterosexual route.[26] While the impact of newborn male circumcision would be less in the United States than it would be in Africa, the modeling study was able to show that if all of the infants in the US who are currently not circumcised were circumcised there would be a significant reduction in HIV infections despite the differences in the US population and those in the African studies.[27] In this model, they were able to project a 15.7% reduction in lifetime risk of acquiring HIV by all males.[28] In addition, there would be a medical cost savings for all males, for African-American males, and for Hispanic males.[29] For white males, it would be cost-effective.[30] These cost savings did not take into account the impact and costs of transmission of HIV to female partners. Nor did this model take into account the costs of reducing other conditions reduced in circumcised males such as other sexually transmitted infections, urinary tract infections, penile cancer, phimosis, etc. A separate cost-effectiveness study that did include these other health benefits suggested that if the rate of newborn male circumcision in the United States was reduced to the rates seen in Western Europe it would add approximately $505 million to our healthcare costs each year.[31] Another study that looked at the impact of South Carolina Medicaid discontinuing to reimburse elective newborn male circumcision determined that for every year of decreased circumcision rates due to Medicaid defunding, there would be approximately 100 additional HIV-infection cases and an additional $30 million worth of net medical costs in this population.[32]

Complications and Risks

Circumcision is a surgical procedure that does have some risks in both the immediate post-surgical period, as well as later. Complications seen in industrialized nations such as the United States and the United Kingdom occur in about 1 in 500 or more infants who are circumcised in the newborn period.[33] The most common complication is bleeding. This occurs more commonly in children who have an underlying bleeding disorder. In more than 60% of children who have bleeding following circumcision, the bleeding can be stopped just by applying pressure. Approximately 40% will need a suture to be placed to stop the bleeding.[34] The second most common complication is infection.[35] Fortunately, the vast majority of the infections are local and most can be managed by topically applied antibiotics. Penile injury in the immediate period after circumcision can include removal of too much or too little foreskin or by surgically damaging the glans. Fortunately, penile injury is very uncommon. In longer-term studies, penile medical conditions actually occur twice as frequently in uncircumcised males than in circumcised males. Late complications are typically adhesions, meatal stenosis or an unsatisfactory cosmetic result. The risks of complications are higher when the circumcision is performed outside of an accredited medical facility, performed by an inadequate trained practitioner, performed without using sterile technique, performed on an infant who is not medially stable, performed on a premature infant or performed on an infant with a family history of a bleeding diathesis.

Impact on Sexual Health

There has been much said by the opponents of circumcision about the impact of circumcision on sexual function, sensitivity and sexual satisfaction. The litera-

ture contains numerous studies assessing sexual function and satisfaction. Unfortunately, most of the studies are extremely poor due to sampling bias or poor study design. Findings from these numerous studies reveal that circumcision results in: (1) Improved sexual satisfaction and sensitivity; (2) Diminished sexual function, satisfaction and sensitivity and (3) No change in sexual function, satisfaction and sensitivity. The limited number of reasonably designed studies with the greatest evidence suggests that circumcision does not have any significant impact on satisfaction of either the male who was circumcised or their partner. There are two randomly controlled trials that support this evidence.[36] Another well-designed study sampling men who have and have not been circumcised performed in a random fashion found no evidence of impact of circumcision on sexual health.[37]

Opponents of circumcision recommend that any decision about male circumcision be deferred until age 18 years. This deferral would allow the male to participate in the decision making process. However, many of the health benefits that can be achieved by circumcision are lost if the procedure is deferred to age 18 years.

Two recent systemic reviews/meta-analyses concludes that medical male circumcision has no adverse effect on sexual function, sensitivity, sexual sensation no sexual satisfaction.[38] Circumcision removes highly innervated erogenous tissue. However, the evidence in circumcised males suggests that residual highly innervated erogenous tissue can accommodate to maintain the expected function, sensitivity and satisfaction.

Optimal Age for Male Circumcision

Opponents of circumcision recommend that any decision about male circumcision be deferred until age 18 years. This deferral would allow the male to participate in the decision making process. However, many of the health benefits that can be achieved by circumcision are lost if the procedure is deferred to age 18 years. As stated earlier, the potential to reduce urinary tract infections is greatest prior to age 18 years. The impact of reducing acquisition and/or transmission of HIV and other sexually transmitted infections is diminished by the high frequency of sexually activity and acquisition of sexually transmitted infections by US teens.[39] Forty-seven percent of twelfth grade students have acknowledged having sexual intercourse; 24% have had more than 4 different sexual partners. In addition, complication rates and costs are significantly higher for circumcisions performed outside of the newborn period.[40]

Conclusions

The AAP and its Task Force on Circumcision felt that it would be ethical for parents to make a medical decision that they felt was in the best interest of their child. The best interest of their child would be informed by their parents' experience, culture, and by evidence and information presented to them by medical providers. Since there is strong evidence to support that health benefits of a newborn male circumcision outweigh the risks, it would be ethical if a parent decided to accept the risks because they are interested in allowing their child to benefit from the reduction in urinary tract infections, sexually transmitted infections, HIV-infection, penile cancer, and other penile disorders. There are some cultures and/or religions that either support or do not support newborn male circumcision. The AAP and its Task Force felt that parents could, in addition to non-biased medical evidence, use these values to assist them in making the decision about what is in the best interest of their child.

The AAP and its Task Force felt comfortable in its recommendations because there were some concerns that not providing parents with appropriate information concerning health benefits of circumcision would actually be unethical. So the question is would it be ethical to withhold evidence from parents relating to the health benefits and risks of newborn male circumcision. Opponents of circumcision would like parents to only know their side of the story.

Would it be ethical to prohibit parents from making a decision that they believe is in the best interest of their child if the evidence supports that health benefits outweigh the risks? Again, the opponents feel that this decision should not be left up to the parents. However, clearly parents consistently make decisions for their children based on what they believe are in the best interest of their child.

Would it be ethical to deny access to preventive health measures based on the source of health care payment? If a parent feels that their child's health would benefit by a medical procedure, the American Academy of Pediatrics and the Task Force did not believe that this healthcare decision should be denied to those individuals who could not afford to pay for it

on their own. For that reason we feel that third party payers including Medicaid should reimburse for newborn male circumcision. Cost should not be a factor in whether or not parents make their decision to circumcise or not circumcise their child.

At the present time, there is no jurisdiction in the United States that makes newborn male circumcision with parental consent illegal. While there have been attempts to create such legislation, they have failed to date. Given the clear evidence of health benefit, and a benefit that outweighs the risks, and the fact that some religions include circumcision as one of their traditional rites, it is unlikely that legislation to ban circumcision would be passed or upheld as constitutional in the United States.

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Alþingi
Kirkjustræti 150
Reykjavík

Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

26 March 2018

Ágætu þingmenn Alþingis / Dear Members of the Icelandic Parliament,

Thank you for making this proposal to protect the bodies of children from harm.

I was raised in a Jewish family, and I understand that people fear anti-semitism. Protecting all children from genital cutting is not an anti-semitic act. Protecting children from genital cutting is the act of a society that cares for its people's well being. Cutting the external genitalia of girls is part of many cultures, and your government prohibits this because your society cares about the well being and rights of its people.

Like many people born in the United States and in Jewish families, I was circumcised at 8 days old. I wish I had my whole body. Loss of the foreskin to circumcision, an important part of my body and sexuality, caused and continues to cause a tremendous feeling of loss and violation. I have met countless other people who share my feeling of violation and loss.

The foreskin is an important part of the penis. It protects the glans (head) of the penis from abrasion. Children circumcised as infants often get a condition called meatal stenosis, where the urethral opening is smaller or closes. This condition almost exclusively occurs in people who were circumcised at very young ages. There are many other risk that circumcision poses, including death from blood loss.

All the parts of the vulva are important, and there is not a correct amount that can be removed from a healthy child. The same applies to all children. There should not be surgery to modify or reduce the genitals of healthy children. You can not remove parts of the penis without affecting sex and the ability to feel sexual pleasure. How much of a healthy child's genitals are okay to remove? How much of your genitals could be removed without sex being effected?

Body modifications, like circumcision, should be for consenting adults only. Thank you for protecting girls from unnecessary modification of their genitals, and thank you for proposing to protect all children from genital cutting.

If there is anything I can do to support this proposal, please contact me.
Með kærri kveðju,

Evan Roman

Tallinn, Estonia
Mail: evanroman1@gmail.com

P.S. I have spoken about the issue of circumcision in these two videos:

Mother Apologizes to Son for Circumcision
When Evan researched circumcision he was disturbed and angered by his findings. He approached his mom Denise with his research, she too was upset with what she learned. Together they attended Genital Integrity Awareness Week in Washington DC (2013) vowing to continue their work to stop genital cutting of children.
https://youtu.be/gUFwPD8yfNU

My parents' religious rights stop where my body begins
"I'm Jewish and it happened to me. I think my parents' religious rights stop where my body begins. It removes the most sensitive parts of the penis." ~Evan, protesting with Bay Area Intactivists on Sunday, December 8, 2013
https://youtu.be/JHuwKxdqmbE

Circumcision: A Mother's Apology - 4 Years Later
Four years ago Denise Roman publicly apologized to her son Evan, for having allowed someone to cut him when he was a baby. In this interview Denise discusses her feelings since, and the responses and the public conversation that video prompted.
https://youtu.be/7bG9FtmON1Q

FÉLAG ÍSLENSKRA BARNALÆKNA

Reykjavík mars 2018

Efni: Umsögn um frumvarp til alaga um almenn hegningarlög (bann við umskurði drengja), 114. Mál.

Allsherjar og menntamálanefnd Alþingis,

Með bréfi þessu lýsir Félag íslenskra barnalækna yfir stuðningi við greinargerð yfirlækna Barnaspítala Hringsins sem hefur nú þegar borist nefndinni. Félagsmenn eru andvígir umskurði á börnum sem ekki eru á læknisfræðilegum grundvelli en efasemdir eru um refsiramma frumvarpsins.

Virðingafyllst,

f.h. Félags íslenskra barnalækna

Valtýr Stefánsson Thors, formaður

Brynja Kristín Þórarinsdóttir, ritari

Soffía G. Jónasdóttir, gjaldkeri

Óafur Heiðar Þorvaldsson, varamaður

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Reykjavík 16. mars 2018

Allsherjar og menntamálanefnd Alþingis

Umsögn um frumvarp til laga um breytingar á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja)
Þingskjal 183 – 114. mál

Félag íslenskra hjúkrunarfræðinga (Fíh) og Fagdeild barnahjúkrunarfræðinga innan Fíh bendir á að við öll inngrip í líkama barna sé mikilvægt að hafa hagsmuni þeirra að leiðarljósi við ákvarðanatöku er þau varða.

Umskurður á drengjum, í öðrum tilgangi en þegar læknisfræðilegar ábendingar liggja fyrir, þjónar ekki hagsmunum barnsins. Aðgerðin veldur varanlegum og óafturkræfum breytingum á líkama drengja og brýtur í bága við sjálfsákvarðanarétt þeirra um eigin líkama. Forhúðin verndar þvagrásaropið og gegnir hlutverki við kynörvun og kynlíf. Aðgerðin sjálf getur valdið drengjum sársauka, sérstaklega ef hún er framkvæmd án deyfingar og getur haft ýmsa fylgikvilla í för með sér.

Margir hafa viljað réttlæta umskurð með þeirri staðhæfingu að sýkingartíðni sé lægri hjá drengjum sem eru umskornir. Sú staðreynd réttlætir þó ekki umskurð á fjölda drengja sem annars aldrei hefðu haft nein vandamál tengd sýkingum eða forhúð, en innan við 2% drengja þarfnast aðgerðar vegna of þröngrar forhúðar.

Fíh vill hins vegar árétta að bann við umskurði drengja getur haft í för með sér að slíkar aðgerðir séu framkvæmdar við óviðundandi aðstæður og af aðilum með ófullnægjandi þjálfun, en við slíkar kringumstæður er tíðni fylgikvilla töluvert hærri.

Því telur Fíh að skoða þurfi betur á hvern annan hátt hægt er að vernda sjálfsákvörðunarrétt barna um eigin líkama en að setja bann við umskurði drengja sem viðbót inn í núverandi hegningarlög.

F.h. Félags íslenskra hjúkrunarfræðinga og Fagdeildar barnahjúkrunarfræðinga

Guðbjörg Pálsdóttir

Guðbjörg Pálsdóttir formaður
Félags íslenskra hjúkrunarfræðinga

Alþingi
Kirkjustræti
150 Reykjavík

Reykjavík 20. Mars 2018

Efni: Umsögn Félag múslima á Íslandi og Menningarseturs múslima um frumvarp til laga um breytingu á almennum hegingarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál

Umskurður hefur verið framkvæmdur í þúsundir ára sem partur af menningu frumbyggja í Ástralíu, Mið-Austurlöndum, Afríku og Ameríku og eru helstu ástæður umskurðar læknisfræðilegar, samfélagslegar og trúarlegar. Umskurður er mjög mikilvægur liður í Abrahamstrú þar sem trú kristinna, gyðinga og múslima er sprottin af. Múslimar og gyðingar hafa framkvæmt umskurð í þúsundir ára og samkvæmt gyðingatrú getur karlmaður ekki talist sem gyðingur nema með umskurði innan 8 daga frá fæðingu. Umskurður verður því að vera til staðar til að drengurinn sé samþykktur inn í trúna.

Íslam er ein af útbreiddustu trúarbrögðum heimsins og kallar Kóraninn, helgirit múslima, eftir því að fylgt sé gjörðum spámannsins Abraham. Í trú múslima og gyðinga er sáttmáli sem gerður var á milli Abraham og Guðs þar sem Guð fer fram á umskurð og er mjög mikilvægt að því sé fylgt eftir.
Tilfelli umskorna karlmanna í múslimalöndum eru um 90 – 100% sem sýnir hversu mikilvægur og algengur umskurður er í heiminum.

Sá misskilningur um að umskurður drengja sé sambærilegur umskurði kvenna eða Female Genital Mutilation á sér enga stoð. Ástæður, athafnir og niðurstöður eru ekki sambærilegar og er því ekki hægt að skilgreina það sem sama hlutinn. Umskurður drengja er framkvæmdur einungis með hreinlæti og heilsu í huga en umskurður kvenna, sem hefur verið bannaður í mörgum löndum, er einungis gerður til að minnka lífsánægju þeirra.

Við sem foreldrar berum ábyrgð á velferð barna okkar og á meðan umskurður drengja eykur vörn þeirra viljum við gera það sem fyrst. Það er ekki rétt sem kemur fram í frumvarpinu að múslimar umskeri drengi við 10 ára aldur, heldur er reynt að gera það sem fyrst þegar börnin eru ung eða nýfædd til að koma í veg fyrir erfiðleika sem geta komið upp ef umskorið er seinna.

Sýnt hefur verið fram á að umskurður drengja getur spornað við kynsjúkdómum og öðrum sjúkdómum og teljum við, að verði frumvarpið samþykkt muni það auka áhættu á þessum tilteknum sjúkdómum.

Umskurður hefur ekki verið vandmál á Íslandi og ekki hefur verið sýnt fram á að það muni verða í komandi tíð. World Health Organization mælir með umskurði ef hann er framkvæmdur af læknum eða þeim sem hafa reynslu og þekkingu á því.

Í kjölfar frumvarpsins hefur skapast umræða í samfélaginu sem hefur orsakað klofning og eru nú múslimar og gyðingar litnir hornauga. Helstu fórnarlömb frumvarpsins eru þó börnin þar sem þau þurfa að líða mest fyrir fordómum samfélagsins.
Við teljum að frumvarpið brjóti á trúfrelsi einstaklinga og vegna þess gagnrýnum við frumvarpið harðlega. Verði frumvarpið samþykkt mun Ísland verða fyrsta land í heiminum til að banna umskurð drengja og verður það því einnig fyrsta landið til að úthýsa múslimum og gyðingum út úr landinu.

Virðingarfyllst

Sheik Salmann Tamimi,
Formaður Félags múslima á Íslandi

Imam Ahmed Seddeeq,

Forstöðumaður Menningarseturs Múslima

Félagsráðgjafafélag Íslands

Alþingi
Nefndasvið
b.t. allsherjar-og menntamálanefndar
Austurstræti 8-10
150 Reykjavík
Sent rafrænt á nefndasvid@althingi.is

Reykjavík, 28. mars 2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja).

Félagsráðgjafafélag Íslands (FÍ) þakkar tækifærið til að gera umsögn um frumvarp til laga um breytingu á lögum á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja).

Félagsráðgjafafélag Íslands er sammála markmiði lagabreytingarinnar um almennt bann við umskurði drengja. FÍ er sammála því að ónauðsynlegar aðgerðir eigi ekki að framkvæma á börnum enda um óafturkræft inngrip í líf barns sem hefur ekki haft neitt um ákvörðunina að segja. FÍ telur að börn eigi alltaf að hafa tækifæri til að taka upplýsta ákvörðun þegar þau hafa aldur og þroska til þegar um svo alvarlegt inngrip á líkama þeirra er að ræða. Því beri að taka réttindi barns fram yfir skoðanir fullorðinna, sama hvort þær eru af trúarlegum, menningarlegum eða öðrum ástæðum. Vísum við til Barnasáttmála Sameinuðu þjóðanna máli okkar til rökstuðnings, sér í lagi greinar 3, 12. og 24.

Teljum við að lagaákvæðið eigi að eiga við um börn og fullorðna óháð kyni og leggjum til að orðalagið verði eftirfarandi:
Hver sem með líkamsárás veldur tjóni á líkama eða heilsu barns eða ~~konu~~ fullorðins með því að fjarlægja kynfæri að hluta eða öllu leyti skal sæta fangelsi allt að 6 árum.

Félagsráðgjafafélag Íslands er reiðubúið að fylgja þessari umsögn eftir á fundi allsherjar- og menntamálanefndar.

Virðingarfyllst, fyrir hönd Félagsráðgjafafélags Íslands
María Rúnarsdóttir, formaður.
Hafdís G. Gísladóttir, félagsráðgjafi.

MOSFELLSBÆR

Alþingi
b.t. nefndasviðs
Kirkjustræti

150 Reykjavík

Mosfellsbæ, 21.03.2018
nr. erindis 201803196/50.13 uvi

Efni: Umsögn fjölskyldunefndar Mosfellsbæjar um frumvarp til laga um breytingu á almennum hegningarlögum nr. 19/1940 sbr. þingskjal 183-114. mál

Fjölskyldunefnd[1] Mosfellsbæjar, 266. fundur tók frumvarp til laga um breytingu á almennum hegningarlögum nr. 19/1940 (þinskjal 183-114. mál) til umfjöllunar á fundi 20. mars 2018 sbr. erindi nefndarsviðs dags. 12. mars 2018. Svohljóðandi bókun var gerð:

> *Fjölskyldunefnd samþykkir með fjórum atkvæðum að taka undir tillöguna með vísan til meginreglu 1. gr. barnaverndarlaga nr. 80/2002.*
>
> *Bókun FFE fulltúa D-lista:*
> *Ég tek undir umsögn Embættis landslæknis um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurn drengja), 114 mál að trúarlegar og menningarlegar hliðar á þessu máli séu svo ríkar, að umskurður á forhúð drengja muni verða framkvæmdur um ófyrirsjáanlega framtíð óháð því hvaða afstöðu heilbrigðiskerfið og samfélagið að öðru leyti mun hafa til þess að leyfa þessa aðgerð. Það er því nauðsynlegt að löggjöf á þessu sviði sé gerð þannig úr garði að umskurður á drengjum valdi ekki barninu skaða.*
> *Hætta er á að umrætt frumvarp muni leiða til þess að þessar aðgerðir muni verða gerðar við aðstæður sem ekki tryggja öryggi þeirra barna sem hér um ræðir.*
> *Ég get því ekki stutt frumvarpið eins og það er sett fram.*

Virðingarfyllst,
f.h. fjölskyldunefndar Mosfellsbæjar

Unnur V. Ingólfsdóttir
framkvæmdastjóri fjölskyldusviðs

[1] Fjölskyldunefnd Mosfellsbæjar fer með málefni barna og ungmenna skv. barnaverndarlögum nr. 80/2002

28.3.2018

Umsögn um frumvarp til laga um almenn hegningarlög (bann við umskurði drengja), 114. mál.

Umskurður drengja

Lagafrumvarp um bann við umskurði drengja, að viðurlögðu 6 ára fangelsi, er verulega vanhugsað og skaðlegt.
Hér á landi er sem betur fer í gildi lagalegt bann frá 2005 við limlestingum á kynfærum kvenna. Svokallaður umskurður meybarna er grimmdar aðgerð og á rætur í drottnunarhyggju feðraveldisins. Hann veldur óafturkræfum skaða og mikilli skerðingu lífsgæða, heftingu, niðurlægingu og undirokunn konunnar.
Eðlismunur er á ofangreindu og umskurði drengja sem hefur viðgengist í um 5000 ár. Það að líkja þessu tvennu saman lýsir annaðhvort verulegri vanþekkingu eða annarlegum ásetningi. Umskurður sveinbarna en einn útbreiddasti menningar/trúarsiður sem fyrir finnst í mannlegum samfélögum. Almennt er talið að rúmur þriðjungur karla í heiminum sé umskorinn. Ástæður eru gjarnan sambland af menningar/trúararfi, hreinlætisástæðum, samkennd, jákvæðri sjálfsmynd og heiðri. Umskurður drengja er algengastur í Mið Austurlöndum en stór hluti t.d Bandaríkjamanna er einnig umskorinn. Umskurður drengja er hvergi bannaður í heiminum frekar en ungbarnaskírn okkar kristinna, né stangast framkvæmdin á við nokkur mannréttindi.

Hryllingsmynd búin til

Í lagafrumvarpinu er þetta tvennt lagt að jöfnu. Þar er dregin upp hryllingsmynd, talað um limlestingu og líkamsárás. Það sem tugir milljóna upplýstra vesturlandabúa telja mikla blessun og sæmd fyrir sig og syni sína er gert að grimdar glæp sem ber að refsa fyrir. Þar er vitnað í einhliða læknisfræðilegar upplýsingar og reynt að láta líta svo út að siðurinn stangist á við samþykktir Sameinuðu Þjóðanna sem hann gerir þó ekki. Í greinargerð virðist gengið út frá því að alltaf þegar umskurður drengja er framkvæmdur þá sé það við lífshættleg skilyrði, við þvingun og mikla kvöl. Það er alrangt.
Umskurði drengja er ekki ætlað að meiða, niðurlægja eða skerða lífsgæði með nokkrum hætti, heldur hið gagnstæða. Í jafn karl miðlægum feðraveldis menningarsamfélögum sem múslima og gyðinglegra samfélaga, þá er í raun fáránlegt að halda því fram að tilgangur umskurðar sveinbarna sé gerður til niðurlægingar eða til takmörkunnar drengja til njóta kynlífs síðar. þetta varðar sjálfsmynd, menningu/trú, ævaforna siði, heiður og hreinlæti.

Mat lækna

Til eru læknisfræðilegar rannsóknir sem mæla með umskurði drengja, m.a. talinn stuðla að auknu hreinlæti. Eins er hægt að finna læknisfræðilegar kannanir sem vara við, því það eru einfaldlega ekki krefjandi læknisfræðilegar ástæður fyrir hendi. Víst er að málið er viðkvæmt og langt frá því að vera jafn einfalt og lesa má úr greingargerð frumvarpsins.

Trúar og menningarhefðir

Hvergi í Biblíunni, Talmúd trúarritum gyðinga, né í Kóraninum er vísað til svokallaðrar umskurnar meybarna. En þó hefur sá skaðlegi siður gert vart við sig í múslimskum ríkjum þar sem slíkar hefðir voru þegar til staðar fyrir daga Islams.
En víða er fjallað um umskurð drengja. Í gyðingdómi hefur umskurður drengja á áttunda degi mikið trúarlegt og jákvætt vægi. Sjálfur Jesús var umskorinn en þó hefur siðurinn haft lítið vægi í kristindómi og er því flestum Íslendingum mjög framandi.

Hversvegna?

Hver er ástæða þess að setja íslenska refsilöggjöf um sið sem er okkur svo framandi og fjarlægur en líklegst þriðjungi mannkyns afar helgur og kær?
Með frumvarpinu erum við að senda út þau boð að Ísland, með allt sitt siðferði á hreinu, ætlar að hafa vit fyrir og siðbæta þúsunda ára hefðir gyðingdóms og Islam sem og annarra hundruð milljóna manna. En það sem heimurinn mun skynja og heyra, hróplega; „Við viljum ekki hingað til landsins þá sem stunda þennan sið“.

Mannúð

Væri ekki manúðlegra í upplýstu samfélagi að læra að virða menningarlegan fjölbreytileika og efla þroskaða umræðu við þá sem eru okkur framandi? Að sleppa fælandi refsilagasetningu en bjóða frekar upp á bestu heilbrigðisaðstæður sem völ er á, til að framkvæma umskurð hjá þeim hópum sem þess óska af menningarlegum og trúarlegum ástæðum.

Birtist sem grein í Fréttablaðinu, á ritstjórnaropnu 14.02.2018.
Hjörtur Magni Jóhannssson
Forstöðumaður og prestur Fríkirkjunnar í Reykjavík
hjorturm@frikirkjan.is, Sími 8994131

From: Gary G [mailto:garydean01@gmail.com]
Sent: 1. mars 2018 01:42
To: althingi@althingi.is
Cc: marty.york@bnaibrith.ca; daniel.koren@bnaibrith.ca
Subject: FW: Iceland?s Proposed Circumcision Ban

I agree with B?nai Brith Canada that the purpose of this circumcision ban legislation is anti-Semitic. Why does it concern the government what people do provided it does no harm? I myself have been circumcised and am doing quite all right after 58 years of steady use!!!

I know that Canada and Iceland share many common northern concerns and that people of Iceland made their way to Canada with all their traditions; especially to Manitoba. We did not prevent your people from coming to Canada because of different customs and culture so I expect the same kind of reciprocal openness, multiculturalism and acceptance from Iceland.

Jewish people have for thousands of years been welcomed in many places of the world and we are quite successful and adaptable but we do not accept being discriminated against and that is just what you are doing.

I want to see you stop this and to allow us to be who we are. It does not hurt your country and it does not hurt any individuals who experience this procedure which has been proven to be more sanitary and cuts down on certain STD?s and has other benefits - but more importantly - it is our tradition and you know what the experts say about
Tradition - https://www.youtube.com/watch?v=gRdfX7ut8gw

Gary Gerofsky

Canada

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March 27, 2018

Alþingi
Kirkjustræti
150 Reykjavík

Ágæta Alþingi / Dear Members of the Parliament:

I am writing on behalf of Intact America, a human rights organization that calls for all children to be protected from medically unnecessary surgery on their genitalia. In the United States, Intact America claims a following of more than 75,000 supporters and activists. In any given month, hundreds of thousands of individuals from around the world see our messages and materials.

Intact America is committed to advancing and protecting the rights and equality of all people – particularly, in the case of those who cannot advocate for themselves. Thus, Intact America endorses the principle of equal protection from forced, medically unnecessary and irreversible surgeries, and supports legal efforts to protect all children from genital cutting, alteration, or modification.

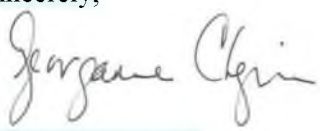
From a bioethical perspective, respect for an individual's autonomy implies that he or she has the capacity to act and decide intentionally, with understanding, and without coercion or influences that would mitigate against a free and voluntary act. "Proxy" (e.g., parental) consent is only valid for medical procedures that are intended to save the life or health of a child. Because the foreskin is a normal, healthy anatomical structure, neither parents nor guardians have no right to solicit or consent to foreskin removal on behalf of the child. Therefore, childhood circumcision, except in extremely rare cases where a pathological condition is present, violates the principles of informed consent and cannot ethically be performed by medical practitioners or in medical settings.

From the perspective of religion or "culture," Intact America recognizes the right of parents to raise their children in accordance with their own cultural and religious standards. However, this right is not limitless. Intact America holds that a child's right to bodily integrity outweighs parental preference, cultural norms, and religious rituals. Therefore, parents may not (directly, or through the agency of a medical or religious practitioner) harm a child physically and irreversibly in the name of religion or culture.

The proposed legislation in Iceland is consistent with both bioethical principles and contemporary understandings of human rights. Thus, Intact America strongly supports the bill before your legislative body.

Thank you for your opportunity to submit this letter.

Sincerely,



Georganne Chapin
Executive Director

George Hill
1323 N River Rd
Port Allen, Louisiana 70767-3303
USA

Thursday, 22 March 2018

Alþingi
Kirkjustræti
150 Reykjavík
Iceland

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágæta Alþingi / Dear Members of the Parliament,

As the acting Vice-President for Bioethics of Doctors Opposing Circumcision, I respectfully submit the attached article published in the Journal of Men's Health and Gender in September 2007. and I ask that it please be incorporated in the formal roll of submissions in support of the bill to limit circumcision of male children to cases of medical necessity.

I also would like to call your attention to the United Nations Covenant on Civil and Political Rights (1966) to which Iceland is a State-Party. Children enjoy numerous special human rights under the Convention on the Rights of the Child (1989). Unfortunately, the general human rights guaranteed to children by the Covenant on Civil and Political Rights are frequently overlooked.

The Covenant has no minimum age so it applies to children, whose general human rights are protected under this treaty. Protected rights which are violated by non-therapeutic circumcision of boys include:

- Article One – Self-Determination
- Article Seven – Degrading Treatment
- Article Nine – Security of Person
- Article Eighteen – Freedom of Religion
- Article Twenty-Four – requires protection of above rights.

I ask that you adopt the bill as law. This would make Iceland a leading nation in the advancement and protection of human rights and the protection of boys.

Yours respectfully,

George Hill

The case against circumcision

George Hill

In 2004, 57% of boys born in the United States received a medically-unnecessary, non-therapeutic circumcision at great cost before leaving the maternity hospital [1], although there are no medical indications for this amputative operation [2,3]. Alleged advantages rest on claimed, but unproved, prophylactic prevention of disease later in life. Complications and risks, however, are clear and immediate. Such circumcisions are *not* good medical practice and are injurious to the infant [4]. Because the US is the greatest offender, this paper will focus on circumcision as practiced in the US and will explore the multitude of reasons why circumcision should not be performed and why false claims of benefits are made.

Medical society position statements

Too much weight is placed on medical society position statements regarding child circumcision. Medical societies are political organizations whose purpose is to advance the interests of their physician-members. If societies were honest about the risks associated with circumcision and the certain loss of physiological function, the physician-members would lose income and be exposed to risk of lawsuits for the certain injury caused by amputation of normal functional tissue. The ethical problems associated with non-therapeutic circumcision of children are ignored or minimized. Current statements remove the burden of care from the doctor and shift the duty and legal responsibility to the parents.

Psycho-social problems also exist [5]. Circumcised doctors who perform circumcision may be unable to objectively consider the current evidence [5]. Emotional factors include avoidance of emotional discomfort from questioning one's own circumcision and protection of self-esteem by those who have performed hundreds or thousands of circumcisions [5]. Socio-political factors include a division of opinion and a desire to avoid an appearance of religious intolerance [5]. Circumcision policy statements frequently exclude discussions of sexual, psychological, human rights, ethical, and legal issues [5]. Alleged prophylactic benefits of circumcision are exaggerated and risks are minimized.

Circumcision policy statements from medical societies, therefore, are poor sources of information about child circumcision and misleading to parents. The reality is much worse than the rosy picture presented by the policy statements.

The foreskin

The foreskin is a specialized organ [6], with protective, sensory, mechanical, and sexual functions, which are destroyed by its amputation.

Protective functions

The foreskin protects the meatus of infant boys from ammoniacal diapers and prevents meatitis, meatal ulceration, and meatal stenosis [7]. Moreover, the foreskin has immunological functions that prevent infection. The most important pathogen in urinary tract infection (UTI) is *Escherichia coli*, present in feces. The muscle fibers in the foreskin form a whorl at the orifice that serves as a preputial sphincter, keeping feces away from the meatus [8] and helping to prevent UTI in infants. The subpreputial moisture contains lysozyme, which destroys pathogens [8]. For example, circumcised adult males have a higher incidence of non-specific urethritis [9] and circumcised boys

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have more *Staphylococcus aureus* in the urethra [10].

Sensory functions

The foreskin is a *specific erogenous zone* [11], which is the most highly innervated part of the penis [12]. A *ridged band*, which originates from the frenulum and encircles the opening of the foreskin, contains nerve endings arranged in rete ridges near the mucocutaneous boundary [12]. The foreskin contains the tissue on the penis most sensitive to fine-touch [13]. Circumcision degrades sensory input to the central and autonomic nervous systems and results in an increase in intra-vaginal ejaculatory latency time [14].

Mechanical functions

The foreskin is not attached to the underlying structure and is free to glide back and forth over the glans penis during intercourse [6,15]. The penis glides in the foreskin during intercourse, reducing friction, vaginal dryness and abrasion and makes intercourse more comfortable for both partners [6,15]. The force required to penetrate increases 10-fold when the foreskin is absent [16].

Sexual functions

The nerve-endings in the foreskin are stimulated by motion and stretching. Stretching of the foreskin and frenulum provides erogenous sensation and ejaculation [17]. This stretching is easily controlled by the individual. In one study, circumcision *increased* the difficulty of masturbation for 63% of the men and *decreased* pleasure for 48% [18].

The nerves of the glans penis are concentrated in the corona [19]. The foreskin glides back and forth over the glans penis during intercourse [6,15]. The foreskin, therefore, tends to protect the corona of the glans penis from direct stimulation. In the circumcised male, however, the anatomical alteration removes this protection of the corona nerves from direct stimulation. The nerves of the glandis corona may become hyper-stimulated during intercourse and trigger ejaculation before it is desired and to the dissatisfaction of both partners [18,19]. This hyper-stimulation cannot be controlled by the individual. Some circumcised men will suffer from premature ejaculation due to the loss of protection provided by the foreskin, despite the overall loss of penile sensitivity [20].

The circumcision status of the male partner also affects female sexuality. A survey of women who had experienced intercourse with both circumcised and genitally intact partners, found they had a strong preference for, and were more likely to experience orgasm with, the non-circumcised partner [21]. An Australian study found that women with circumcised partners were more likely to experience vaginal dryness, a symptom of female arousal disorder [22].

Behavioral effects

Male circumcision is (1) a traumatic operation [23] and (2) the loss of a functional body part [10]. Persons who have lost body parts must grieve their loss of function [24]. Failure to grieve the loss of the foreskin function results in a cohort of men who are in denial about their loss. Traumatized persons tend to re-enact and repeat their trauma [25]. The compulsion to repeat the trauma and the emotional need to deny the loss results in a large cohort of circumcised men who seek to perpetuate the practice of non-therapeutic circumcision. Such men become the 'adamant fathers' who insist on circumcising their sons despite medical evidence that the operation is injurious. Circumcised doctors tend to be biased in favor of circumcision. A baby is more likely to be circumcised if the father and/or attending physician is circumcised [26].

Effect on medical literature

The medical literature on circumcision is voluminous and contentious. Circumcised doctors create papers that overstate benefits and minimize harms and risks [27]. When these doctors publish such claims, other doctors come forward to refute them [28]. One medical doctor who reviewed a pro-circumcision book published by an apparently circumcised professor of molecular medical science – a discipline far removed from urology – found numerous errors of fact [29]. The result is an unending debate driven by the emotional

compulsion of circumcised men. When analyzing medical literature about circumcision, one should ask:

1. Does the author come from a circumcising culture?
2. Is the author circumcised?
3. Does the author have a circumcised son?
4. Does the author profit from doing circumcisions?
5. What is the author's true motive in writing this document?

Complications, risks, and disadvantages

In addition to the inherent injuries described above, male circumcision is a surgical operation with the usual risks of surgical mishaps, infection, and hemorrhage, as well as possible death [7,30]. Death from complications of circumcision is well documented by official coroner's reports [31,32].

Life-threatening infection with virulent community-associated methicillin-resistant *Staphylococcus aureus* (CA-MRSA) is an emerging risk for newborn circumcised boys. CA-MRSA has acquired new genes that emit tissue-destroying toxins. Outbreaks of CA-MRSA occur in newborn' nurseries on a regular basis. If a boy is colonized with CA-MRSA and then circumcised, infection through the open circumcision wound is a real and dangerous possibility. CA-MRSA causes soft tissue infections, necrotizing pneumonia, empyema, osteomyelitis, perinephric abscess, necrotizing fasciitis, toxic shock, and death [33,34]. Medical society statements regarding infant circumcision have yet to acknowledge the risks of CA-MRSA infection.

HIV

A complete discussion of the relationship of male circumcision and human immunodeficiency virus (HIV) infection is beyond the scope of this paper. The authors of a Cochrane Review (who found insufficient evidence to recommend male circumcision to prevent female-to-male HIV transmission), being aware of randomized controlled trials (RCTs) that were underway, said:

> *Circumcision practices are largely culturally determined and as a result there are strong beliefs and opinions surrounding its practice. It is important to acknowledge that researchers' personal biases and the dominant circumcision practices of their respective countries may influence their interpretation of findings* [35].

Three RCTs have now been published with enormous ballyhoo. One was led by a French team and two have been led by North American researchers. All lead authors previously had published in favor of male circumcision to prevent HIV infection, so researcher bias is overwhelmingly evident.

All three RCTs were terminated early. Studies terminated early tend to overstate the effects of intervention [36]. These RCTs consider only *heterosexual* female-to-male transmission of HIV in high risk areas of sub-Saharan Africa, where large segments of the population are HIV positive. In the US, the disease vectors primarily are homosexuality and illicit drug use [36], so these RCTs are not applicable to the US. Also the incidence of HIV infection is much lower than in Africa, so circumcision would not be an effective intervention in the US or other developed nations.

The claim that male circumcision prevents HIV infection is based on the hypothesis that Langerhans cells in the foreskin are vulnerable to HIV infection [36]. Newly published research finds that Langerhans cells produce a substance called Langerin that blocks the uptake of HIV [36]. The hypothesis, therefore, now has been overturned and the validity of the findings of the RCTs is placed in doubt [36]. A meta-analysis of the studies is needed to verify their accuracy [36].

Even if circumcision were found to be effective at preventing sexual transmission of HIV, infant circumcision would be of no value for at least 15 years [37]. More than 30 HIV vaccines are now under development [38]. Some have advanced to stage IIB trials and are likely to become available between 2015 to 2020 [38]. A child born in 2007 has an excellent chance of being vaccinated against HIV before he reaches sexual maturity, so infant or child circumcision cannot be recommended to prevent HIV infection. Neonatal circumcision to prevent HIV infection is not indicated for the US [39].

Despite the hyperbolic claims of the circumcision advocates, the high rate of prostitution, *not* lack of circumcision, is the cause of the African epidemic. When RCTs are adjusted for the sex-worker population, circumcision ceases to be a significant source of proctection [40].

Costs

The financial burden of carrying out millions of male neonatal non-therapeutic circumcisions is frequently overlooked. When an infant boy is circumcised, both mother and baby remain in hospital about 6 hours longer, driving up costs [41].

There are several components to the total cost:

1. Surgeon fee
2. Facility fee
3. Longer stay in hospital for both mother and baby [41]
4. Treatment of complications
5. Re-circumcision to repair botched circumcision
6. Other costs to society

The most recent study reports the direct costs of a neonatal circumcision to be $828.42 in 1999 dollars, [4] which, when adjusted to 2007 is equivalent to $1,027.75 [42]. Of the 4,112,052 births in the US in 2004 [43], about 0.512 or 2,177,707 were boys. If 57% of those boys were circumcised [1], there were 1,207,093 circumcisions. The total direct cost of neonatal circumcision in the US, therefore, is about $1,240,589,692.00. There are other costs but there are insufficient data with which to quantify those costs.

Male neonatal circumcision diverts $1.2 billion dollars of medical resources from medically-necessary, therapeutic services.

Law

Courts have decided three cases, two in England [44] and one in the USA [45], in which the best interests of the child were adjudicated in regard to non-therapeutic circumcision. In all three cases, the court found non-therapeutic circumcision *not* to be in the best interests of the child. Parents and medical doctors must act in the best interests of the child [46].

Non-therapeutic male neonatal circumcision fits the legal definition of child abuse and is a violation of existing laws against child abuse [47], but such laws are only rarely applied to non-therapeutic male neonatal circumcision.

Female circumcision is unlawful, but the law does not grant equal protection to boys [45,46]. Parents may not have authority to consent to non-therapeutic amputation of healthy functional tissue [46]. These and other fundamental questions of the lawfulness of non-therapeutic child circumcision have not been addressed by the courts. Questions about the power of parents to consent to non-therapeutic amputation of healthy functional body parts [9–11], about the male child's right to equal protection of the law, and other issues remain unresolved [46,47]. The case against non-therapeutic circumcision of male children being lawful is strong. When the issue finally does come to the bar, there is an excellent chance that surrogate consent for non-therapeutic circumcision will be found to exceed parental power and that the amputation will be found to be an unlawful violation of the child's legal rights to bodily integrity and special protection [44,46,47].

Human rights and medical ethics

Children possess two kinds of human rights: general human rights enjoyed by all and special human rights accorded to children due to their weakness, immaturity, and need for special protections [48]. General human rights include the right to security of the person and the right to freedom from cruel and degrading treatment [48]. Children enjoy a right to special protection due to their status as a child, such as 'rights to protection from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse' [48]. In addition, children have a right to protection from 'traditional procedures prejudicial to the health of children' [48]. Circumcision is a traditional procedure that started before the dawn of recorded history [7,30]. As reported above, male circumcision is harmful to the health of children.

Circumcision ethics has been discussed at length elsewhere [49]. The circumcision of

children fails seven ethical tests including: (1) lawfulness, (2) respect for human rights, (3) violation of all four cardinal principles of medical ethics, (4) provision of futile or ineffective treatment, (5) misuse of medical resources, (6) abuse of surrogate consent, and (7) patient exploitation [49].

Conclusion

The case in favor of male circumcision is based on specious literature largely created to satisfy the emotional compulsions of wounded circumcised men [27,35]. Similarly, the position statements of medical societies (frequently written by circumcised men) are biased in favor of circumcision [5]. Claimed health benefits are illusory and do not offset the proven risks, complications, and disadvantages that exceed any claimed benefits [4]. On close analysis, there is *no* case for non-therapeutic or prophylactic circumcision.

Male circumcision is harmful because it excises healthy tissue [12] and permanently impairs beneficial physiological functions [6,8]. Male circumcision also causes psychological problems that tend to perpetuate the cycle of abuse [24,27]. Male circumcision is a costly diversion of medical resources away from beneficial services [4]. Male circumcision violates legal rights, human rights, and ethical standards [44,46–49]. Finally, we must remember that males are the more vulnerable and sensitive of the two genders [50] and, therefore, deserve the greater degree of protection from traumatic, invasive, injurious, and unnecessary surgery. For all of these reasons the non-therapeutic circumcision of boys should *not* be performed and the genital integrity of all children should be respected and protected.

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Alþingi
Kirkjustræti
150 Reykjavík

Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Berlin, 20 march 2018

Ágætu þingmenn Alþingis / Dear Members of the Icelandic Parliament,

we,

- TERRE DES FEMMES – Human Rights for Women e.V.
- MOGiS e.V. - A voice to the Affected – people affected by assaults against sexual self determination in childhood, e.g. Circumcision
- Projekt 100% MENSCH – Project for equality for heterosexual, lesbian, gay, bisexual, transsexual, trans*, non-binar, intersexual, queer und asexual people

adress you from Germany.

You will shortly be discussing a legislative proposal to extend the existing protection of **girls** against female genital cutting in every form to **children of any gender**.

We agree absolutely with the proposal and its human rights approach.
The issue of non-medical genital surgeries to non consent-able children is not a question of religion, culture or gender.
It is about the self determination of every human being about its intimite parts.

Human rights are indivisible.

Unequal protection of children depending on the appearence of their genitals is to be rejected for ethical reasons.

We agree that this is a very sensitive issue that concerns cultural and religious traditions. We strongly object to any attempts to misconstrue efforts on behalf of the rights of all children to genital self-determination, or to misuse these efforts as a basis to profess or carry out hatred toward religious and cultural minorities.

We very much appreciate the clear phrasing of the bill proposal, that this is solely about equality, the well-being, bodily integrity, and right to self-determination of children.

We ask you seriously to agree to the proposal.
It is a peaceful sign of hope and tolerance to the whole world: every child has the right to be accepted with the complete genitals it is born with.

Please have a look at the announcment of the yearly "Worldwide Day of Genital Autonomy" on may 7th. www.genital-autonomy.de
You will find there the list of 50 organisations from 12 countries on five continents, calling for e.g.

"Legislatives initiatives worldwide that provide for the protection of ali children, regardless of gender, from non-therapeutic genitai operations."

This is exactly what your approval to the proposal can help realize.

Please notice this big support worldwide and contact us if we can assist you.

Thank you very much!

Yours,

Dr. Idah Nabateregga
TERRE DES FEMMES – Human rights for Women e.V.
Department Female Genital Mutilation
Brunnenstraße 128
D-13355 Berlin
Mail: fgm@frauenrechte.de

Victor Schiering
Chairman MOGiS e.V. – A Voice to the Affected
Kopernikusstraße 11
D-18057 Rostock
Mail: victor.schiering@mogis-verein.de

Holger Edmaier
Managing Director
Projekt 100% MENSCH
Bochumer Str. 1
D-70376 Stuttgart
Mail: kontakt@hundertprozentmensch.de

WORLDWIDE DAY OF GENITAL AUTONOMY – May 7th 2018

6th Anniversary of the Cologne Ruling

This will be the sixth anniversary of the "Cologne Ruling". In 2012, for the first time, a court explicitly granted boys the right to genital self-determination by concluding that medically unnecessary foreskin removal ("circumcision") from a boy is an offense. This decision has since become a worldwide beacon for the self-determination of children regardless of gender, ancestry or religion.

This year's main focus is:

FEMALE GENITAL MUTILATION IN ASIA

Millions of girls are victims of genital mutilation in Asia. Most of these cases are religiously motivated and are carried out by medical personnel. The people responsible are distancing themselves explicitly from African practices with regard to the form of the intervention. The 7th of May takes a closer look: because it stands for "zero tolerance" for violation of children's rights!

The "World Day of Genital Autonomy" calls for:

- **Increased measures also against so-called "less invasive" and medicalized forms of female genital mutilation, protection of the vulnerable and support for those affected worldwide.**
- **Adherence to and implementation of the UN-Convention on the Rights of the Child, Article 2 (protection against discrimination); Article 3 (precedence of children's well-being); and Article 24 Paragraph 3 (abolishment of traditional practices prejudicial to the health of children).**
- **Legislatives initiatives worldwide that provide for the protection of all children, regardless of gender, from non-therapeutic genital operations.**
- **Protection of children with atypical sex characteristics from genital surgery and intervention without absolute medical indication.**
- **An immediate stop to group or mass circumcision of minor males (boys) for alleged HIV prevention in African countries.**
- **Public research and education on the consequences of non-therapeutic genital surgery on children in its different forms and social contexts.**

Appealing for the WORLDWIDE DAY OF GENITAL AUTONOMY are:

- AKTION REGEN - Verein für Entwicklungszusammenarbeit (Austria)
- Attorneys for the rights of the child (California, USA)
- Australasian Institute for Genital Autonomy - AIGA Inc. (Australia)
- Bay Area Intactivists (USA)
- beschneidungsforum.de - das Forum zum Thema Beschneidung (Germany)
- Berufsverband der Kinder- und Jugendärzte BVKJ (Germany)
- Bundesarbeitsgemeinschaft Säkulare Grüne (Germany)
- Canadian Foreskin Awareness Project (Canada)

- Children's Health & Human Rights Partnership (Canada)
- Deutsches Kinderbulletin - jedem Kind eine Chance / Politische Kindermedizin (Germany)
- Doctors Opposing Circumcison (D.O.C.) - Physicians for Genital Integrity (Seattle, USA)
- Droit au corps (France)
- Facharbeitskreis Beschneidungsbetroffener im MOGiS e.V. - Eine Stimme für Betroffene (Germany)
- Forum Männer in Theorie und Praxis der Geschlechterverhältnisse (Germany)
- Genital Autonomy (UK)
- Genital Autonomy America (USA) (formerly NOCIRC)
- Giordano-Bruno-Stiftung (Germany)
- GSSG: Gemeinnützige Stiftung Sexualität und Gesundheit (Germany)
- (I)NTACT - Internationale Aktion gegen die Beschneidung von Mädchen und Frauen e.V. (Germany)
- IBKA - Internationaler Bund der Konfessionslosen und Atheisten (Germany)
- Ibn Rushd – Goethe Moschee (Germany)
- Initiative gegen Gewalt und sexuellen Missbrauch an Kindern und Jugendlichen e.V. (Germany)
- Intact Africa (Africa)
- Intact America (USA)
- Intact Denmark (Denmark)
- Intact Kenya (Kenya)
- Intact Switzerland (Switzerland)
- Intaction (USA)
- intaktiv e.V. - eine Stimme für genitale Selbstbestimmung (Germany)
- Jews Against Circumcision (USA)
- KAHAL (Israel)
- Lessan e.V. (Germany)
- Männer gegen MännerGewalt e. V. (Germany)
- Men Do Complain (UK)
- MOGiS e.V. - „Eine Stimme für Betroffene" (Germany)
- NOCIRC - (see Genital Autonomy America)
- NORM-UK / 15 Square (UK)
- Partei der Humanisten (Germany)
- pro familia Nordrhein-Westfalen (Germany)
- Pro Kinderrechte CH (Switzerland)
- Projekt 100% MENSCH (Germany)
- Protect the Child (Israel)
- Säkulare Flüchtlingshilfe e.V. (Germany)
- Sexpo (Finland)
- TABU International e.V. - Gegen Genitalverstümmelung, für Frauen- und Kinderrechte (Germany)
- TERRE DES FEMMES - Menschenrechte für die Frau e.V. (Germany)
- The VMMC Experience Project (Kenya, Uganda)
- Verband medizinischer Fachberufe e.V. (Germany)
- WADI e.V. (Germany)
- Your Whole Baby (USA)
- Zentralrat der Ex-Muslime (Germany)

-----Upphaflegt skeyti-----
Frá: Gideon Gourell [mailto:atlantis01@bezeqint.net]
Sent: 3. febrúar 2018 12:44
Til: Silja Dögg Gunnarsdóttir ; Ólafur Þór Gunnarsson ; Inga Sæland ; Bjarkey Olsen Gunnarsdóttir ; Ólafur Ísleifsson ; Jón Þór Ólafsson ; Guðmundur Ingi Kristinsson ; Líneik Anna Sævarsdóttir ; Björn Leví Gunnarsson ; Ritstjóri vefsins
Efni: Against Circumcision of Children - Jews Support Bill 183

Dear Parliament Member,
I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls.
As a secular Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israelis to leave our children intact (not-circumcised).
Circumcision of a child unable to consent is genital mutilation. It is an irreversible surgery that robs the child of an important body part.
Thank you for having the courage to protect children and fight for this important bill.
Sincerely,
Gideon Gourell

Ef skorin er forhúð af manni gegn hans vilja fer gerandi í fangelsi, en sé þolandinn barn er það refsilaust.

Af hverju á barn ekki rétt á sömu vernd og almennur borgari, hvar nákvæmlega kemur sá réttur inn. Er það þegar þau geta tjáð sig? Hvað þarf þolandinn að vera gamall?

Gerum ekki öðrum það sem við viljum ekki að aðrir gjöri okkur.

Hvað erum við að gera við nýbura? Sársaukinn við aðgerðina er verulegur, ef taugarnar eru sterkar getið þið hlustað á (ekki grát) heldur sársauka öskur hvítvoðungs við aðgerðina www.plutorium.com/assets/circ.wav

Hafði í kjölfar umræðu samband við móður mína laugardaginn 24. febrúar 2018 til að fá upplýsingar um hversvegna ég var umskorinn innan við tveggja ára. Hef haldið þessu leyndu í 63 ár, jafnvel systur mínar vissu þetta ekki. Felmtri slegin yfir að ég gæti munað atburð í lífi mínu frá 1955 sagði móðir mín að amma hefi látið gera þetta af nauðsyn, annars hefðu læknar á þessum tíma aldrei fallist á svona aðgerð.

Ég man enn langvarandi sviða í kynfærunum, hvernig ég þurfti að liggja til að geta sofið og hræðsluna við menn með spegla á höfðinu.

Erum við að breyta einhverju meira en bara kynfærum sveinbarna. Það er ekki útilokað að reynsla nýburans gangi dýpra í vitundina en reynsla síðari ára. Vitum við hvað við erum að gera varnarlausum börnum?

Er ekki rétt að nýburar fái öryggi og hlýju í örmum móður sinnar eftir fæðingu í stað þess að kvalir séu greyptar í vitund þeirra. Ég þekki afleiðingarnar af hinu síðarnefnda og hef ýmislegt að segja sálfræðingum hafi þeir samband við mig, reynslan vistast djúpt.

Primum non concere

Er ekki vissara að banna umskurð allavega þar til hægt er að sýna fram á að enginn langvarandi skaði hlýst af? Og aðgerðin sé sársaukalaus.

Rök fyrir að leyfa umskurð sökum þess að þetta verði þá gert utan heilbrigðistofnana eru veik. Það er engin leið að fela umskurð á drengjum, hann er augljós, og gerandinn veit að refsing bíður. Að skaðlegar aðgerðir séu löglegar vegna ótta við að þær verði skaðlegri ólöglegar er uppgjöf. Gerum svona ekki nema af illri nauðsyn.

Spurningin er ekki hvort hið veraldlega gefi undan þörfum smáhóps og leyfi umskurð, heldur eiga heittrúaðir einfaldlega að hætta þessum ósið.

Ég skora á háttvirta þingmenn að sýna þessum nýju einstaklingum okkar miskun, gerum fyrstu árin friðhelg, leyfum þeim að vaxa úr grasi í öryggi og án ótta. Tryggjum þeim þann einstaklingsrétt sem barnasáttmáli sameinuðu þjóðanna skilgreinir.

Íslendingar eru af mörgum talin hugrökk þjóð, ég hef heyrt því fleygt oftar en einu sinni erlendis. Treysti því að þið háttvirtir þingmenn gerið það sem þið vitið að er rétt og verndið einstaklingsrétt smábarna.

27.3.2018

Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Dear Althingi,

I strongly support your pending legislation that provides legal protection of genital integrity for boys. Since females are already protected from non-medical genital alteration, males should have the same rights. Please do not be dissuaded by those who claim the law would violate religious freedom. Whose freedom? Since an infant is incapable of religious beliefs, imposing an irreversible body alteration on him violates the freedom to choose his own religion as an adult. It differs from education, which can be changed.

Thank you for leading the way on bodily integrity rights – I hope that other nations will follow. All children, regardless of gender, culture or parental religion, have a fundamental right to all their healthy, functional genitalia.

Greg Hartley
State Director
Your Whole Baby of PA
www.YourWholeBaby.org
412-445-5570

I am also on the Steering Committee of Intact America: www.IntactAmerica.org

Frumvarpið tel ég vera of þröngt. Athugið með að banna einfaldlega allar aðgerðir á kynfærum barna (sem ekki eru lífsnauðsynlegar). Þar vil ég benda á eftirfarandi:

http://ruv.is/frett/thoggunin-og-feluleikurinn-gridarlegur

Það skiptir engu máli hvort einstaklingur sé talinn karl eða kvenkyns við fæðingu, né hvort læknar og/eða hjúkrunarfólk eigi erfitt með að greina hvort kynið er. Allar svona aðgerðir ætti einungis að vera gerðar á spítölum þar sem "sjúklingur" er fullráða einstaklingur sem hefur tekið ákvörðun sjálf(ur) varðandi sýn kynfæri.

virðingarfyllst,

Guðbjörg Gísladóttir
Engjasel 84
109 Reykjavík

kennitala 0208612589

„Þöggunin og feluleikurinn gríðarlegur"

17.02.2018 - 19:57
Heilbrigðismál · **Innlent**
Intersex kona, sem var fyrirskipað af læknum að halda því leyndu, spyr hvers vegna börnum sé breytt með skurðaðgerð til að aðlagast kröfum samfélagsins í stað þess að breyta samfélaginu. Ráðgjafi Evrópuráðsins segir að Íslendingar fremji mannréttindabrot með því að gera óafturkræfar skurðaðgerðir á börnum sem eru intersex og fæðast með ódæmigerð líffræðileg kyneinkenni.

Mannréttindabrot á intersex börnum

Intersex fólk á Íslandi er oft látið gangast undir óafturkræfar skurðaðgerðir eða hormónameðferðir að því forspurðu. Þetta kom fram á ráðstefnu um málefni intersex fólks í dag. Piet de Bruyn, ráðgjafi Evrópuráðsins um réttindi hinsegin fólks, segir þetta hrein og klár mannréttindabrot og að Íslendingar ættu að hætta slíkum óafturkræfum inngripum.

Piet segir mikilvægt að heilbrigðiskerfið sé í stakk búið til að sinna intersex fólki og aðstandendum þeirra. Til þess þurfi að auka fræðslu til heilbigðisstarfsfólks og annarra sem vinna með þessum hópi. Þá þurfi að banna með lögum að mismuna fólki vegna þess að það sé intersex.

En hvernig stendur Ísland miðað við nágrannalöndin varðandi réttindi intersex fólks? „Það eru engin réttindi intersex fólks," segir Kitty Anderson, formaður **samtakanna Intersex Ísland**. „Intersex fólk sem vill kvarta undan læknismeðferð sinni oft á tíðum getur það ekki vegna þess að það er tíu ára fyrningartími. Við erum ekki með neina löggjöf sem verndar intersex fólk."

Móðurinni sagt að ljúga

Kitty segir að mikil þöggun sé í gangi varðandi intersex fólk á Íslandi. „Í mínu tilfelli var mömmu fyrirskipað að ljúga að mér til þrettán ára aldurs. Okkur var sagt að við ættum ekki að segja neinum frá þessu. Læknirinn minn skammaði mig þegar ég sagði honum að ég væri farin að segja vinum mínum frá þessu. Mömmu var bannað að segja foreldrum sínum eða systrum sínum frá þessu, þannig að þöggunin og feluleikurinn hefur verið gríðarlegur. Þetta er eitthvað sem á ekki að ræða, má ekki ræða og skal ekki ræða."

Enn þá gerðar skurðaðgerðir á intersex börnum á íslenskum spítölum

Enn þann dag í dag eru gerðar skurðaðgerðir á intersex ungbörnum á Íslandi, án þess að nauðsyn beri til. Nefndir Sameinuðu þjóðanna telja þetta brjóta gegn samningi gegn pyntingum og annarri grimmilegri, ómannúðlegri eða vanvirðandi meðferð og samningi Sameinuðu þjóðanna um réttindi barnsins. „Hérna erum við ekki að tala um læknisfræðilega nauðsynleg inngrip, sem stundum þarf að framkvæma, en það er minnihluti þeirra inngripa sem eru gerð," segir Kitty. „Ástæðan sem er oft gefin er að það sé barninu erfitt að aðlagast samfélaginu ef að líffræðin þeirra er einhvern veginn öðruvísi, en af hverju erum við að skera upp börn til að aðlagast samfélaginu, af hverju breytum við ekki samfélaginu þannig að það sé pláss fyrir alla hér?"

Til nefndasviðs Alþingis

Umsögn um breytingu á almennum hegningarlögum nr. 19/1940, þingskjal 183-114. mál (umskurn drengja)

Háttvirtir alþingsmenn!
Ég vil mælast til þess að þetta frumvarp verði fellt í því formi sem það er nú. Til vara legg ég til breytingar sem koma hér að neðan.

Ég er heimilislæknir og sem fagmaður og faðir er ég í öngum mínum vegna þessa frumvarps. Er hræddur um að samfélag okkar breytst til hins verra í harðræðisátt nái það fram að ganga. Ekki er allt fyrirséð en þó má sjá eitthvað fyrir og bendi ég á 3. atriði.

1.
Í starfi mínu sé ég marga umskorna sem óumskorna karlmenn og reyndin er sú að fáir eða engir kvarta yfir umskurn sinni.
Það er staðreynd að menn koma ekki með vandamál eða kvartanir til lækna vegna umskurnar sem framkvæmd var skömmu eftir fæðingu, hvorki varðandi kynlíf, sjúkdóma í getnaðarlim, hersli, fjölda sýkinga eða annað. Þvert á móti er umskurður talinn hafa visst gildi til fækkunar sýkinga og hugsanlega fækkunar á leghálskrabbameini hjá konum þeirra manna sem eru umskornir.

2.
Sömuleiðis eru nánast óþekktar lögsóknir eða bitrar ákærur um limlestingu eða óafturkræft tjón frá hendi fullorðinna karlmanna í garð foreldra sinna sem hafa látið umskera þá eftir fæðingu. Því er erfitt eða ógerningur að dæma þetta sem limlestingu eða ofbeldisverk. Öðru vísi er farið um aðgerðir á stúlkum.

3.
Bann við umskurn á hinn bóginn hefði mjög alvarlegar afleiðingar sem eru ekki í neinu samræmi við slímhúðar-aðgerð.
Segjum að drengur hafi hlotið umskurn skömmu eftir fæðingu. Þegar hann vex upp yrði að fela umskurn hans til að forðast afskipti löggjafans. Myndi slíkt barn þora að vera á leikskóla, og væri ekki áhætta að fara í leikfimi eða sund? Barnið ætti sífellt á hættu að foreldrar hans verði sóttir til saka og fengju fangelsisdóm. Af þeim orsökum yrðu þeir sneyddir foreldrahlutverki sínu í mörg ár og teldust brotafólk.

Ég vil því leggja til breytingar á frumvarpinu.
a. Að það verði fellt og nái ekki fram að ganga.
b. Til vara að það sé heimilt að umskera drengi á fyrstu 2 mánuðum eftir fæðingu, en þá er af ýmsum ástæðum hentugast að gera aðgerðina.
c. Til vara að heilmilt verði að gera aðgerðina með því að sýna fram á að aðgerðin teljist nauðsynleg með framvísun læknisvottorðs.

Reykjavík 28 febrúar 2018.

Guðmundur Pálsson læknir, sérfræðingur í heimilislækningum. (nr 0114)

Alþingi
Kirkjustræti
150 Reykjavík

Reykjavík, 28. mars 2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurn drengja), þingskjal 183, 114. mál.

Frumvarp sem nú liggur fyrir Alþingi um að gera umskurn drengja refsiverða með allt að sex ára fangelsisdómi er atlaga að gyðingdómi. Umskurnin er ásamt hvíldardeginum mikilvægasta sérkenni gyðinga. Samkvæmt Gamla testamentinu er hún tákn sem stendur fyrir sjálfan sáttmála Guðs við útvalda þjóð sína (1 Mós 17) en það þýðir að sérhver drengur sem þar fæðist er umskorinn. Hið gyðinglega heiti er „brit milhah“ sem merkir sáttmáli umskurnarinnar.

Ýmsir valdhafar sem fyrr á öldum reyndu að uppræta gyðingdóm beindu spjótum sínum sérstaklega gegn umskurninni og bönnuðu hana eins og lesa má um í Makkabeubókunum (1Matt 1.60-61). Hið sama gildir um gyðingaofsóknir á síðari tímum. Fráleitt er að halda því fram að frumvarpið um bann við umskurn hafi ekkert með trúarbrögð að gera, jafnvel þótt flutningsmönnum þess hafi upphaflega gengið gott eitt til.

Að gera umskurn að refsiverðri háttsemi úthýsir öllum þeim gyðingum úr landinu sem taka trúarbrögð sín og grundvallareinkenni þeirra alvarlega. Allur meginþorri gyðinga lítur á umskurn sem grundvallaratriði og órjúfanlegan þátt í sjálfsmynd sinni.

Verði sú raunin að það litla gyðingasamfélag sem lifað hefur hér á landi undanfarin ár og áratugi muni leysast upp og hrekjast úr landi vegna þessa frumvarps þá skapar sú staða óneitanlega hugrenningatengsl við myrkan kafla í sögu Íslands á fjórða áratug síðustu aldar, kafla sem flestir Íslendingar vilja helst gleyma en var rifjaður upp í sagnfræðiriti Snorra G. Bergssonar sem kom út nú fyrir jólin.

Bann við umskurn og refsivæðing hennar er í þágu gyðingahaturs ekki bara hér á landi heldur einnig í nágrannalöndunum og ekki síst víðs vegar um Evrópu. Á síðari árum hefur gyðingahatur farið vaxandi á nýjan leik og er þegar orðið alvarlegt vandamál í fjölmörgum löndum Evrópu.

Bannið við umskurn beinist þó ekki bara gegn gyðingum heldur múslimum einnig sem sömuleiðis aðhyllast umskurn á trúarlegum forsendum og telja hana meðal mikilvægustu einkenna sinna.

Ég tek undir með landlækni þegar hann í umsögn sinni um frumvarpið andmælir því að umskurn drengja verði felld undir hegningarlög og „mælir með því að horft sé til reynslu Svía, þar sem bæði löggjafinn og Socialstyrelsen hafa sett fram skýrt regluverk um það hvenær, við hvaða aðstæður og af hverjum þessar aðgerðir eru gerðar“. Þó svo að taka verði tillit til þess vægis sem umskurn hefur fyrir gyðinga og múslima skiptir máli hvernig að henni er staðið og þar þarf að tryggja hagsmuni viðkomandi barna sem mest.

Það hefur verið reynt að koma á banni við umskurn í fleiri löndum á undanförnum árum en af skiljanlegum ástæðum ekki tekist. Hæstiréttur í Þýskalandi taldi t.d. bann við umskurn ekki standast stjórnarskrána fyrir nokkrum árum.

Loks skal tekið undir með þeim sem spurt hafa hvort umskurn drengja sé virkilega það sem mest brenni á íslenskri þjóð nú um stundir.

Virðingarfyllst,

Gunnlaugur A. Jónsson

prófessor í guðfræði og ritskýringu Gamla testamentisins við Guðfræði- og trúarbragðafræðideild Háskóla Íslands

Parliament of Iceland (Althingi) 101 Reykjavík Iceland

April 26th 2018

Dear memebers of the parliament

I am a Danish medical doctor, and it's been brought to my attention that you are debating a possible ban on non-medical male child circumcision.

Being born in Iran and raised in an Islamic culture the first couple om my life's decades, I was circumcised when I was a child. So was my father and his father and that goes back in centuries. No body asked why. It was just some thing every body does: a gift from our ancestors am important ritual.

However living in a different society the past few decades where this practice i not taken for granted as wellas being a medical doctor has given me a new perspective on this unethical treatment of baby boys. Today I wish I could have my foreskin back. But I can't and I never will. That right was taken away from me by others. Those who took it away were not evil, they just did it because they thought they should and if they could give it back to me, they would. The problem is that the procedure was irrversable and no matter how bad you want to get it undone, it's simply not possible any more. That is why I could never offer this to my or any other children.

Dear ladies and gentlemen

You are holding the future of those defenceless male children in your hands. Please do not fail them,specially when born in a different culture than the majority. If this procedure is not good enough for your own children, it's not good enough for other children born in a differnt culture living in Iceland either.

All cultures and religions have gotten rid of some rituals and practices througout the course of history as those rituals have become less and less compatible with what we consider a civilised behavior. Please do not stigmatize members of certain cultures as religions as inferior to yours by accepting certain level of barbaric behavior as undetachable rituals for those religions and cultures.

In fact, I think many members of those groups are waiting for some legal support to overcome the group pressure and put an end to this meaningless physical damage to their children.

Most people in the nordic countries are for the right of individuals to their own body and a ban on bodily damage to children including male circumcision untill the individual has reached a minimum age for consent. As far as I know most politicians do share the same opinion too. However most of them are waiting for some other politicians to step forwad first for them to follow and together stand against the massive pressure from outside nordic countries.

I hope you will not give in the pressure and will be the pioneers to do what is right and protect the children and we will surely follow you.

Best regards

Hadi Riazi M.D. Strandboulevarden 141, 4. tv, 2100 Copenhagen, Denmark

From: Icemb London <icemb.london@utn.stjr.is>
Date: 27 February 2018 at 3:14:42 pm GMT
To: harold.lautenberg@gmail.com
Subject: Fw: Proposed Ban on Circumcision for Boys

Dear Harold Lautenberg,

Thank you for your email of 23 February. The Icelandic Parliament is currently considering a bill placed before it by a group of MPs on childhood circumcision. Iceland is a vibrant democracy and the right of an MP, or a group of MPs, to table bills or parliamentary resolutions is an integral part of the democratic process. The bill is expected to enter committee stage in the next few weeks and anyone is free to contact the Parliament (althingi@althingi.is) to convey their views.

As this particular bill is not presented by the Government or can be seen as Government policy, the Embassy cannot comment on the content of the bill. The parliamentary process is very transparent, plenary debates are broadcast and written material is published on the Parliament?s website (www.althingi.is), including submitted evidence, providing for various and opposing views to be seen and heard.

Best regards,
Kristin H. Kristinsdottir

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http://www.iceland.is/uk

----- Forwarded by Hrefna Dís Minshull/UTN/NotesSTJR on 26/02/2018 09:56 -----

From: Harold Lautenberg <harold.lautenberg@gmail.com>
To: hrefnam@mfa.is
Date: 23/02/2018 16:05
Subject: Proposed Ban on Circumcision for Boys

Dear Ambassador,
I was alarmed to read about a proposal to ban Circumcision for Boys in Iceland.
One of the most important customs in our Jewish faith is Circumcision 8 days after birth. The baby is medically

checked and if deemed healthy, the procedure is carried
out by a competent person trained specially in this procedure.
This custom has been carried out for thousands of years.
To ban it and make it an illegal act takes away the foundation
of our faith. History showed the Greek dynasties banned
this practice as a way of undermining our heritage and
abolishing Judaism, I believe also the Nazi regime
banned this practice, certainly not for the well being of
the child, but again a means of undermining and eventual
destruction of the Jewish people.
I am certain that Iceland does not wish to follow in their footsteps
for the same reason.
I would appreciate your reply.
With Best Wishes
Harold Lautenberg

Sent from my iPad

28.3.2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágæta Alþingi / Dear Members of the Parliament,

I am a proud Muslim. Thank you very much for considering banning the brutal assault called circumcision of boys. I wrote 5 pages of research which proves that true Islam is very against routine male infant/child circumcision. I am attaching the research to this email. Hopefully it can help you to accomplish your goal and criminalize that attack on children. Because the world is now like a small village, once you outlaw that barbaric practice, once you "get the ball rolling," other countries will follow you, and the umbrella of protection will expand to cover boys in the whole world.

Best regards,
Hatem Saied

Guide to discussing banning of male circumcision with Islamic communities

This guide is directed to:

1. Muslims who believe in Islam and search for the truth of what Islam says about male circumcision.
2. Governments throughout the world in order to support them to enact strict laws to prevent this harm to children's bodies, regardless of the religion, culture, or preference of the parents; and in order to help these authorities in dealing with the Islamic groups present within its borders who would oppose the enactment of these strict laws.
3. Foreign activists and non Muslims to bring up these topics to Muslims when dialoging or debating with them regarding the banning of male circumcision.

Muslims, liberate your minds from the bondage of conformity. Think with an open mind so that you can accept these new ideas and facts regarding the topic of male circumcision. It is rare to ever hear a single voice rise in defending these poor victims.

Be cautious when evaluating religious opinions. Remember that the basis of any religion is God's natural creation. And it is not a part of natural creation to cut organs rich with nerves and blood vessels. And it is certain that there are valuable lifelong functions for the part of the anatomy which is cut off in circumcision. If you don't know it, then ask about it. And learn it. And learn also about all the various harms and accidents that result from male circumcision. If you haven't heard about it, then research it, and hear the stories of victims to increase your knowledge of the topic. This part of the body appears naturally in all boys; thus it is not a birth defect, but rather was meant to exist. God does not make mistakes in His creation. That same part of the body is present in animals as well, to serve and benefit them. Humans and animals continue with this organ all their lives. Remember that God perfected everything. And this body part is part of God's perfect creation in humans also, not only in animals.

The real Islamic religion completely denounces circumcision and indeed any wound or cut or alteration to humans or animals.

We [God referring to Himself in the plural] wrote in it [The Torah] that a soul for a soul and an eye for an eye and a nose for a nose and an ear for an ear and a tooth for a tooth and punishment for wounds. Yet for those who forgive, it is considered absolved for them. And those who do not rule by what God dictated are oppressors. Chapter: The Table, verse 45.

And God says, forbidding alteration of humans and animals, and promising those who defy to perpetual hellfire:

They call upon none but a rebellious devil whom God has cursed. And he has said, "I will surely take from among Your servants a definite portion. And I will mislead them and I will incite them and I will command them so they cut the ears of cattle, and I will command them so they will change the creation

of God." And whoever takes the devil as an ally instead of God has certainly sustained a clear loss. The devil makes promises to them and incites them. But the devil promises nothing but conceit. The habitation of those is Hell, and they find from it no change. Chapter: The Women, verse 117-121.

The animal and human body, in the teaching of these verses, is like the machine that the manufacturing company advises us not to remove any parts from. The devil, however, advises us to modify and abuse it. Circumcision is nothing but changing the creation because it is the irreversible removal of a functional organ. Some people liken circumcision to cutting nails or cutting hair, but this is a false analogy because those are keratinized extensions of the body, containing neither nerves nor blood vessels, and which can regrow.

And God said in perfecting everything:

And you see the mountains, thinking them still, but they are passing as the passing of clouds. It is the work of God, who perfected everything. He is expert with what you do. Chapter: The Ants, verse 88

And he said in describing the completion of human creation, and its beautiful perfection:

We have certainly created humans in the best sculpture. Then we returned him to the lowest of the low. Except for those who believed and did righteous deeds, so they receive uninterrupted recompense. Chapter: The Fig, verses 4-6.

God is advising in these verses that He gave everyone a wonderful body and He is helping the righteous believers to keep it that way (because they have the correct teaching from Him).

Let us now turn our attention to the stories and statements attributed to the prophet which encourage circumcision. First of all, we invite Muslims to be cautious in accepting these anecdotes because any anecdotes which come after the Quran are actually just guesses, and God warned us against following the teaching that is based on guesses.

And most people act on assumptions. Indeed, assumption is useless in the face of the truth. Certainly God knows what they do. Chapter: Jonah, verse 36.

Indeed, they act on assumption. And on what they desire. Chapter: The Star, verse 23.

These anecdotes appear in books other than the Quran. We do not need these books to complete for us the source of religion. The Quran never commanded us to accept these anecdotes. We do not need any further instruction beyond what is in the Quran because if any specific thing is not mentioned in the Quran, then we are not required to do it in a specific way. In that case, it is left for the individual to decide. The fastest growing denomination among Muslims is the one that follows the Quran alone. And the Quran, as mentioned before, prohibits circumcision completely and considers it an alteration of God's creation and an attack on the nature that God has made.

These anecdotes (more than 11,000 in the Sunni denomination alone out of more than 700,000 said to have been available at the time of the beginning of the collection) do not belong as part of the religion

because otherwise the religion would be unclear, undefined, and vague due to the abundance of its books and the contradictions present in each of them. And the religion would also be full of doubts due to **the various factors affecting the accuracy of orally transmitted stories, specifically the factor of transmission, the factor of place, and the factor of time**.

The factor of transmission refers to the errors that come in when a story is transmitted orally in a long line of storytellers. If we take, for example, ten people, and tell the first one a story, to transmit it to the next, and so on. And then if we bring the last one to hear from him what he has received, we would find the story became another story. And that happens daily.

The factor of place refers to the errors that come in when a story is transmitted orally over a long distance from its original telling or occurrence. For example if we take an accident that happened in a certain place and we go to that place in order to investigate, we would find a difference in the story. If the story involves a ram, this ram would turn into a horse, and we will get far from the truth as we get far from the place and far from the eyewitnesses.

The factor of time refers to the errors that come in when a long period of time exists between different tellings of the story. Even an eyewitness teller himself would not be a reliable source some years after the incident he is reporting. So what do you think about the one who heard a story from someone else and then repeated it after many years? And so on from the second to the third, another twenty years, to the fourth, after twenty years, and so on, until the third century after the death of the prophet; the time where the most important books that contained the anecdotes which they claim to be reliable started to appear. That is a long period of time which allows for many accidental errors to come in.

In addition, any person in the chain of storytellers might have deliberately changed the words of the stories (and invented new stories) to be in accordance with their desires, passions, thoughts, personal opinions, customs, etc. It is noteworthy that the majority of the people who collected these anecdotes, especially in the second generation of storytellers, were the servants who reported the words of their masters (first generation means those who had actually seen the prophet) after they died. Once the masters were dead, they could not negate the stories. Why do we not hear these stories from the sons instead of the servants? Many important famous storytellers from the second generation onward were foreigners in a stratified society which preferred the Arabic race over the sons of the conquered countries. Therefore, the rationale of telling anecdotes was to climb up in society, not to serve God.

These anecdotes are collected in different books, each anecdote sorted according to its weakness, which means the degree of doubt that exists about its authenticity. Each degree of doubt on the scale is named by a certain expression. Be aware, it is just an expression and listen carefully to what is coming. Those anecdotes which are highly doubtful are given an expression called "weak" and those anecdotes which are less doubtful are given an expression called "**correct**"! So it still has doubt though it is called "correct." This is a very unfortunate expression because 99.9% of the people look at the word "correct" and wrongly conclude that the prophet truly said it. The doubt has been cleverly covered up and readers have been misled. And the Quran says, commenting on misleading expressions, "They are not but names; you have named them. You and your forefathers. God did not authorize those names. Such

people act on assumption. And what the soul desires. While they already received from their Lord the guidance. Chapter: the Star, verse 23.

Scholars who have researched these anecdotes have said that if they left out the anecdotes of the deceptive storytellers, then there would be no anecdotes left. And they concur that all the anecdote storytellers are cheaters or have heard the stories from cheaters. Yet in spite of that, the anecdote scholars adopted the principle to accept all anecdotes unless cheating is evident, instead of rejecting all anecdotes unless proven free from cheating. Therefore, it is clear that honesty is absent in this anecdote branch of science.

One of the famous anecdotes is enough to make you forsake anecdotes altogether. It admits that the prophet forbade dictating his speech or writing about him in any way except for the Quran; and ordered whoever quoted him to erase what he wrote. Obviously, respecting that order for a long time is the reason why anecdote collectors didn't have manuscripts to take from and had to take from a chain of storytellers instead for every anecdote.

Anecdote scholars have said that any anecdote which contradicts the Quran or contradicts science or common sense or is otherwise impractical must be a fake anecdote and that we should not work with it, even if the chain of storytellers looks valid. In spite of these admonitions to disregard certain anecdotes, the scholars did not apply such rigorous tests to the anecdotes of Bokhary, the author of Book #1, which is the biggest and the most important book of anecdotes marked with expression "correct" for the Sunni denomination. When evaluating the stories of the most famous storytellers such as Bokhary, the scholars check only the chain of storytellers, but not the problems or issues or contradictions within the story itself. This is a grave mistake.

When we discuss these anecdotes, we still do not find them reliable on the issue of circumcision. Here is a quick overview of the four most important anecdotes related to circumcision.

1. The anecdote that says circumcision is a convention for men and an honor for women is transferred by Hagag bin Artaa. Qortoby and bin Hagr, who are ancient famous scholars, concluded that this man [Hagag bin Artaa] is not reliable.
2. There is an anecdote that says that circumcision is one of five conventions of the instinct. It has been said also in another version of that anecdote that the number of conventions is three. Then, in another version, it has been said that the number is four. Then in another version, it is said that the number of conventions is ten. None of these versions mentions circumcision. Then appeared the versions which say that the number of conventions is five. And the names of these five conventions keep changing between different sub versions. One time, circumcision appeared. Other times, it disappeared, replaced by "taking a bath." Not only that, but the book that mentioned circumcision (Moatea by Malek) was written by his disciple bin Katheer. But circumcision is not there in the same book written by another disciple El-Shybany. So how can we be sure in the face of all these contradictions that circumcision even appears in the story? Moreover, instinct is a thing done by a living being automatically without any teaching even if he/she/it is alone or removed from others. Since most men in the world are not circumcised,

then it is clear that circumcision cannot be a "convention of the instinct," and that anecdote must therefore be false.

3. There is an anecdote that says that if two circumcisions touch each other, then a shower is mandatory. In other words, if a male's place of circumcision touches a woman's place of circumcision, as in sexual activity, then a shower is mandatory. This anecdote has another version that omits the reference to circumcision (if he sat between her arms and legs and exerted himself, then a shower is mandatory), while still transferring the same meaning regarding sexual activity. This word, which means "circumcision," could also be pronounced, with a slight change in the vowels, to mean "spouses." In other words, it could be a vocal transmission error. Another possible interpretation holds that the anecdote doesn't tell you to circumcise, but just that if those parts of the anatomy which are traditionally circumcised (in male and female) touch one another, then the sexual activity penetrated to a level where a shower is mandatory. Maybe the command is only for circumcised people, and non-circumcised people would have to penetrate to a deeper level before a shower is mandatory. Even the original version does not promote circumcision but just orders people to shower in that circumstance.
4. There is an anecdote which says that Abraham was circumcised at age 80 with an axe. In order to examine this anecdote, let's look at another story first. According to the Quran, when God commanded Abraham to slaughter his son, Abraham asked his son. He didn't force him or tie him down or trick him. He allowed his son to make the decision for himself. And the son complied. Getting back to the story of Abraham's circumcision, if you believe Abraham did decide to become circumcised, then Abraham made that decision himself as a mature adult (80 years). He didn't force it on another person, just as he didn't force his son's sacrifice. So there is no reason to do it to another person, especially a youngster.

This document is made by Hatem Kamal Mohamed Saied.

This document uses information from the writings of Dr. Ahmad Subhi Mansour, Saleh Banour, Dr. Sami Aldeeb Abu-Sahlieh, and Saied Abd Elmoaty, and also from some ideas posted on the Arabic group opposing male circumcision, "Stop Circumcising Your Boys; They are Lying to You." that used to be on Facebook but no longer exists at this address https://www.facebook.com/groups/37736989287/

English translation version 1.5. Monday, June 2, 2014.

Frá: Henri KONSTAIN
Sent: 22. apríl 2018 06:05
Til: Ritstjóri vefsins
Efni: Fyrirspurn - Ábending

Please, Silja - and the rest of the responsible Icelandic politicians - don't give in to pressure from any religious groups or other organizations or countries!

Make the ban against circumcision and FGM a law, and show the way for other Christian-based countries, that logic and common sense still prevail!
Those who claim religious grounds are worthless!

Biology and natural evolution has developed male foreskin because it is natural and female vagina because it is natural.

It is not an argument that 1 of 3 males WW are circumcised and therefore it is "natural".

Go, Iceland - show the world the right way - make the ban into law!

Kind regards,
Henri KONSTAIN
Danish - living in Luxembourg.

Mál 114
Þingskjal 183
148. Löggjafarþing
Frumvarp til alga um breytingu á almennum hegningarlögum nr.19/1940 (bann við umskurði drengja)

Umsagnaraðili: Hvítasunnukirkjan Fíladelfía

Í greinagerð með frumvarpinu er réttilega bent á að árþúsundum saman hafi það tíðkast innan ákveðinna menningarheima, sem og trúarhópa, að umskera drengi.
Eins og einnig er bent á hefur umskurður drengja einnig verið mjög útbreiddur í hinum vestræna heimi, ekki síst í bandaríkjunum, óháð trúarskoðunum.

Í greinargerðinni er fjallað um skaðsemi þess þegar umskurður fer fram

1. Án deyfingar
2. Án sótthreinsunar og í heimahúsum, mögulega af vanhæfum einstaklingum
3. Að börn geti ekki látið í ljós álit sitt á athöfninni.

Varðandi fyrstu tvö atriðin liggur beinast við að benda á að mun eðlilegri viðbrögð væru að setja lög um hvernig umskurður eigi að fara fram og gera kröfur til þeirra sem framkvæma slíkar aðgerðir. Það hlýtur að liggja fyrir að í hinum vestræna heimi séu aðstæðurnar sem lýst er ekki dæmigerðar (enda eru t.d. bandarískir drengir flestir umskornir af læknum á sjúkrahúsum).

Varðandi 3. atriðið þá er í raun víðtækari spurning en bara hvort foreldrar megi ákveða að láta umskera syni sína. Það er spurning um hvort foreldrar megi áfram velja það sem þeir telja best fyrir börnin sín.
Til þess að það væri réttlætanlegt að setja slíkt bann og hér er lagt til þyrfti að sýna fram á með óyggjandi hætti að umskurður væri skaðlegur. Einnig skiptir máli að skoða hvort bann raunverulega verndi börn eða ekki. Í þeim löndum þar sem fóstureyðingar eru ólöglegar er t.a.m. mun líklegra að konur fari í hættulegar aðgerðir framkvæmdar af vanhæfum einstaklingum og leggi þannig líf sitt í hættu. Ekki hefur verið sýnt fram á að umskurður drengja sé skaðlegur og í ljósi þess hversu mikilvægur hann er fyrir stóra trúarhópa er hætta á því að slíkt bann komi ekki í veg fyrir slíkar aðgerðir.

Foreldrar taka margar óafturkræfar ákvarðanir fyrir börnin sín. Þau velja hvar þau búa, þau velja hvaða skóla börnin sækja, þau gefa þeim nafn og þau ákvarða með hvaða hætti börnin alast upp. Í dag er ákveðin hópur fólks sem berst mjög gegn bólusetningum, segja þær beinlínis skaðlegar eða í það minnsta hættulegar. Engu að síður er engum sem dettur í hug að banna foreldrum að bólusetja börnin sín, bíða þar til þau hafa aldur til að ákveða sjálf. Foreldrum er treyst til þess að velja það sem þeir telja börnum sínum fyrir bestu, meira að segja þegar þeir velja að láta ekki bólusetja börnin þó allir læknar myndu mæla með bólusetningu.

Það sem er kannski alvarlegast við þetta frumvarp er að það heggur beint gegn tveimur mikilvægum trúarbrögðum í heiminum, annarsvegar Islam og hinsvegar Gyðingdómi.
Það er mikill ábyrgðarhluti að á sama tíma og íslenska þjóðin hefur fundið til mikillar samúðar með flóttafólki frá Sýrlandi og Írak og íslenska ríkið er að bjóða fólki þaðan hæli hér, sé verið að gera trúariðkun þeirra, sem flest eru Múslimar, ólöglega. Umskurn er hluti af trúariðkun, sjálfsmynd og menningararfi Múslima.

Fyrir Gyðingum er umskurnin táknið um sáttmála Guðs við Abraham. Sá sem ekki er umskorinn á ekki hlutdeild í sáttmálanum, tilheyrir ekki hópi Gyðinga og er ekki gjaldgengur til að taka þátt í trúarlífi þeirra sem er algjörlega samofið menningu þeirra.
Með slíku banni væri verið að meina börnum að alast upp í upprunamenningu sinni. Umskurn er ekki valkvæð fyrir þessum hópum.

Árið 2010 kom út skýrsla á vegum W.H.O. um umskurn á drengjum. Niðurstaða þeirrar skýrslu var að mikilvægt sé að gæta að hreinlæti við slíkar aðgerðir og að þeir sem þær framkvæma séu vel þjálfaðir. Það örlar ekki á þeirri hugmynd þar að bann sé fýsilegur kostur, enda var ekki niðurstaða skýrslunnar að umskurn væri skaðlegt. Raunar má skilja sem svo að umskurn þyki ákjósanleg á svæðum þar sem H.I.V. er útbreiddur sjúkdómur. Í skýrslunni kemur fram að umskurn stuttu eftir fæðingu sé öruggari en ef er beðið þar til drengurinn verður eldri, þ.e.a.s. sár gróa hraðar og minni líkur eru á sýkingum eða vandamálum sem geta komið upp.
Ef umskurn á drengjum er slíkt ofbeldi að það réttlæti fangelsisvist foreldra er það mesta furða að Alþjóða heilbrigðisstofnunin skuli fjalla um umskurn á svo jákvæðan hátt. Slíkt hlýtur að teljast gáleysi í besta falli. Líklegra verður að teljast að umræðan á Íslandi hafi verið skökk.

Miðað við hversu útbreiddur umskurður á drengjum er og hversu oft og víða slíkar aðgerðir hafa verið framkvæmdar af læknum, ætti það að vera borðleggjandi og auðsýnt væri hann skaðlegur. Það er hann ekki, þó einhver dæmi séu um neikvæðar aukaverkanir eins og við allar aðgerðir. Því ber að mótmæla harðlega að umskurði drengja sé líkt við limlestingu á kynfærum kvenna. Umskurður á drengjum er lítið inngrip sem jafnvel er gripið til af læknisfræðilegum ástæðum, limlesting á kynfærum kvenna hefur mjög neikvæð áhrif á lífsgæði kvenna og engann læknisfræðilegan ávinning.

Í frumvarpinu er vísað til þess að umskurður drengja sé útbreiddur meðal gyðinga og múslima. En á sama tíma og þetta frumvarp er lagt fram fer fram mikil umræða um ört vaxandi gyðingahatur í evrópu sem og hatursfull viðhorf í garð Múslima.
Það er óhugsandi að meðferð þessa frumvarps verði ekki beintengd þeirri umræðu. Verði það samþykkt verður litið svo á að verið sé að gera Múslima og Gyðinga brottræka frá Íslandi, nema þeir leggi trú sína og siði til hliðar. Verði frumvarpið samþykkt verður því hampað af öfga-þjóðernissinnum um alla álfuna og verður vatn á myllu þeirra. Með því að gera umskurn að einhverju skammarlegu er verið að jaðarsetja þá karlmenn sem voru umskornir í æsku og setja karlmenn sem hafa verið umskornir af læknisfræðilegum ástæðum í erfiða stöðu.

Frumvarpið er lagt fram af góðum hug og af umhyggju fyrir börnum. Af sömu umhyggju fyrir börnum innflytjenda og börnum Múslima og Gyðinga verður að hafna þessu frumvarpi.
Frumvarpið jaðarsetur óumskorna drengi í þeim samfélögum sem þeir alast upp í og jaðarsetur umskorna drengi meðal íslendinga.
Með frumvarpinu er verið að gera Islam og Gyðingdóm ólögleg trúarbrögð á Íslandi.

Í nafni trúfrelsis, fjölmenningar og réttar foreldra til að velja það sem þeir telja best fyrir börn sín þarf að hafna þessu frumvarpi.

Fyrir hönd Hvítasunnukirkjunnar Fíladelfíu
Helgi Guðnason

To the government of Iceland

Dear Sirs/Madams,

We write to you because we are gravely concerned about the prospect of a potential legal ban on ritual circumcision of boys in Iceland. We fear that, whereas such a ban may not have far-reaching consequences in Iceland due to the very limited number of Muslims and Jews in that country, a legal ban could potentially have severely negative consequences for Jews and Muslims in other Scandinavian and European countries.

We note that certain claims in the proposed bill are incorrect. Firstly, the Danish Medical Association, while deeming non-medical circumcision unethical because there is no medical basis for the procedure, specifically does NOT recommend a legal ban. The reason for this is the recognition that a legal ban will have severe and unpredictable consequences.

The comparison in the Icelandic bill between male non-medical circumcision and female genital mutilation (FGM) is completely unfounded. FGM is almost universally condemned and banned, and the World Health Organization (WHO) and many other international organizations and NGO's have been working for decades to convince the practitioners of FGM to abolish the practice. Male circumcision, by contrast, is legal in every country in the world, and a third of all men on the planet are circumcised.

Several other statements in the bill appear to be founded in misunderstandings regarding the procedure itself. For instance, only very few Muslims circumcise at age 10 or older. Most Muslims circumcise boys at a much younger age, and there is an increasing tendency to circumcise early among most Muslim ethnic groups.

The former United Nations Special Rapporteur on Freedom of Religion or Belief, Heiner Bielefeldt, visited Denmark in 2015 and 2016. In his report to the United Nations' General Assembly, Mr. Bielefeldt unambiguously states that non-medical circumcision of boys as a religious ritual is included in the religious rights of the parents, as well as in the rights of the child to be raised within the religion and cultural tradition of his parents and family. Mr. Bielefeldt also states that freedom of religion is one of basic universal human rights.

In June 2016, the United Nations' Universal Periodic Review recommended that Denmark "refrain from banning or setting age limit on non-therapeutic circumcision of boys" (art. 120.143). The Danish government accepted the recommendation.
https://www.upr-info.org/sites/default/files/document/denmark/session_24_-_january_2016/recommendations_and_pledges_denmark_2016_0.pdf

The proposed bill has the potential to wreak havoc on communities and families belonging to ethnic and religious minorities in other Scandinavian countries and all over Europe by turning a mainly harmless and widespread practice into grounds for criminalization and imprisonment.

Therefore, we urge the Icelandic government to reconsider, and we highly recommend that you consult with the Jewish and Muslim communities in Iceland to clear up misunderstandings regarding the procedure. We also recommend that you consult with recognized and non-biased international medical experts, for example within the WHO.

Faithfully yours,
Ian C Skovsted, MSc, Biochemistry, tlf.29880001
Sohail Asghar, MD, Ph.D., Master of Disaster Management, tlf. 20613737

Jette Møller, chairman, SOS Racisme Danmark, tlf. 60633399
Nanna Solow, MA, History of Religion, tlf. 60921432
Dan Meyrowitsch, Ph.D., Epidemiologist, Head of Research, tlf. 60604386
www.circuminfo.dk

Schillstrasse 197
86169 Augsburg, Þýskalandi
12. mars 2018

Nefndasvið Alþingis
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Nokkrir þingmenn vilja banna umskurð drengja í forvarnarskyni. Þeir meina eflaust vel en byggja tillögur sínar á misskilningi. Við þurfum ekki að styðja umskurð á Íslandi, enda biður enginn um slíkt. En við verðum öll að hafna þessu banni sem mun engu barni hjálpa.

Mál sem snertir mig

Ég þekki þessi mál vel af eigin reynslu. Sonur okkar átti við forhúðarsýkingar að stríða ítrekað frá 7 ára aldri. Meðferð með sterakremi og sýklalyfjakremi, fyrst á Íslandi og síðar í Þýskalandi, bar ekki árangur. Læknarnir í Þýskalandi sannfærðu okkur um að forhúðin þyrfti að fara, annars gætu sýkingarnar valdið verulegum vandræðum.

Læknirinn á barnaskurðstofu spítalans sagði okkur að þeir gerðu þrjá umskurði á hverjum virkum degi. Samtals eru það meira en 600 umskurðir á ári. Flestir eru af heilsufarsástæðum eins og hjá okkur, en mjög löng eða þröng forhúð getur verið arfgeng. Aðrir umskurðir eru vegna trúar- eða menningarhefða og þá þurfa foreldrar að bera kostnaðinn.

Staðreyndir um umskurð

Eins og nær allir drengir af minni kynslóð sem eru fæddir í Bandaríkjunum – hvað sem trú eða trúleysi líður – er ég sjálfur umskorinn. Það hræddi mig því ekki að þurfa að láta umskera son minn.

Umskurður er stundum forvarnaraðgerð og stundum umskiptaathöfn (e. *rite of passage*). Í gegnum aldirnar hafa margir og margvíslegir menningahópar umskorið drengi. Umskurður er mjög algengur í dag í Bandaríkjunum, Afríku, Kóreu, og Filippseyjum og þekkist líka í öðrum engilsaxneskum löndum. Þar líta margir málsmetandi læknar á hann sem forvarnarráðstöfun sem kemur í veg fyrir þjáningu og sjúkdóma seinna á ævinni hjá ákveðnu hlutfalli stráka. Þá er umskurður hluti af íslamskri menningu, gyðingdómi sem og menningu kristinna í norðausturhluta Afríku. Forvarnargildi umskurðar er samofið menningarlegu gildi hans. Mann grunar að umskurður hafi fest sig í sessi sem hefð hjá ákveðnum trúarhópum vegna þess að hann minnkar tíðni sjúkdóma.

Hefur umskurður drengja heilsufarslega kosti nú sem fyrr? Já. Það viðurkenna jafnvel læknar sem eru á móti umskurði. Helsti kosturinn er að hann kemur í veg fyrir sýkingar í typpinu og forhúðinni (e. *balanitis* og *posthitis*). Í stuttu máli: Hefði sonur minn fæðst í Bandaríkjunum og verið umskorinn fljótlega eftir fæðingu, hefðum við ekki þurft að ganga í gegnum þetta sársaukafulla ferli þegar hann var orðinn eldri. Er hægt að meðhöndla svona sýkingar án þess að grípa til umskurðar? Oft, en alls ekki alltaf.

Og umskurður hefur fleiri kosti. Krabbamein í typpinu er sjáldgæft krabbamein, en það er algengara meðal óumskorinna karlmanna. Þá eru áreiðanlegar rannsóknir sem sýna að umskurður lækkar tíðni alnæmis (sérstaklega vegna smits við kynmök), sem og tíðni fáeinna annarra kynsjúkdóma. Vegna þessa hefur umskurður drengja orðið algengari í Afríku undanfarin ár.

Er umskurður nýfæddra drengja hættulegur eða skaðlegur? Aðgerðinni fylgir einhver hætta á sýkingum – en það á við um allar aðgerðir. Þessi hætta er þó minni háttar í vestrænum samfélögum. Augljóslega er aðgerðin sársaukafull án deyfingar. Nú til dags fer aðgerðin vanalega fram með deyfingu á spítölum. Aðgerðin sjálf, á nýfæddum drengjum og í höndum fagmanna, er frekar lítið mál. Svo hefur umskurður ekki áhrif á kynlíf (ólíkt „umskurði“ kvenna), og engin neikvæð áhrif á lífið yfirleitt. Milljónir umskorinna Bandaríkjamanna lifa góðu lífi og sakna forhúðar sinnar ekki neitt.

Vega kostir eða gallar þyngra?

Stór spurning í umræðunni um umskurð er hvort heilsufarslegir kostir umskurðar seinna í lífinu (sem eru, tölfræðilega, minniháttar) vega þyngra en ókostir aðgerðarinnar (sem eru líka minniháttar).

Hlutlægt svar við þessari spurningu er erfitt að finna. Það er hægt að færa rök með og á móti og skoðanir lækna virðast oft fara eftir uppruna og tilfinningum, hérlendis sem annars staðar. Margir læknar segja að jákvæðar afleiðingar umskurðar réttlæti það að umskera alla drengi eftir fæðingu. Aðrir segja að ávinningur þess að umskera sé ekki nógu mikill. Þegar tilgangurinn er að hræða fólk segja þeir stundum hryllingssögur um staka umskurði sem mistókust, en þessar sögur líkjast þeim sem við heyrum frá andstæðingum bólusetningar. Allir geta líka gúglað hryllingsljósmyndir um forhúðarsýkingar.

Kanadíska heilbrigðiskerfið gerði fyrir nokkrum árum ítarlega og vandaða skýrslu um umskurð drengja. Í lokaorðum þeirrar skýrslu er komist að þeirri hófstilltu niðurstöðu að kostir og gallar þess að umskera jafnast meira eða minna út. Kanadískir foreldrar eigi því að ákveða hvað þeim finnist best fyrir börnin sín, en kerfið ætti ekki að þrýsta á þá til að gera annað eða hitt. Þessi stefna er reist á vísindalegum rannsóknum og hefur þann aukakost að hún skapar ekki andúð þeirra menningarhópa sem eru með langa hefð fyrir umskurði.

Þessi umræða bendir til mótsagnar í frumvarpinu. Flutningsmenn þess vilja banna umskurð nema „af heilsufarslegum ástæðum.“ En sumir læknar telja að heilsufarsástæður mæli *alltaf* með því að umskera nýfædda drengi.

Andstaða við umskurð á Norðurlöndum

Síðustu ár hefur átt sér stað herferð gegn umskurði drengja á Norðurlöndum. Mig grunar að vanþekking, misskilningur og sleggjudómar leiki hér stórt hlutverk. Fáir karlmenn á Norðurlöndunum eru umskornir og fáar konur hafa þekkt umskorna karlmenn. Fólk virðist upplifa umskurð sem eitthvað mjög framandi og ógnandi, og virðist ekki skilja muninn á „umskurði“ drengja og stúlkna.

Öfl sem höll eru undir útlendingaandúð og/eða þjóðernishyggju láta oftar en ekki rödd sína heyrast hæst í þessum efnum. Umræðan nú ber því miður þjóðernissinnaðan keim, sem ég tel hættulegan. Í frumvarpinu sem nú liggur fyrir Alþingi er til dæmis vísað til „gyðinga og múslima“ en þess er ekki getið að að flestir drengir í Afríku eða Bandaríkjunum eru umskornir, af ástæðum sem tengjast ekki trú. Fjölmargir drengir sem tilheyra hvorki trúfélögum múslima né gyðinga eru umskornir á hverju ári. Samt setur RÚV aftur og aftur ljósmyndir af rétttrúuðum rabbínum við fréttir um umskurð.

Viðhorfið til umskurðar innan heilbrigðisstéttarinnar á Íslandi virðist frekar þröngt. Það hefur til dæmis lengi verið grein á Vísindavefnum eftir hjúkrunarfræðing sem leggst eindregið gegn umskurði. Í greininni er tekið mjög djúpt í árinni en myndin sem þar er dregin upp samrýmist engan veginn minni upplifun (ekki frekar en milljóna umskorinna karlmanna um allan heim). Hún verður að flokkast sem áróður frekar en miðlun vísinda. Höfundur hennar virðir fjölda vísindalegra greina og rannsókna beinlínis að vettugi.

Háttvirtu Alþingismenn, ég hvet ykkur til að sækjast eftir dýpri, víðsýnni og hlutlægari þekkingu á umskurði drengja. Þetta kann að virðast ykkur einfalt og lítið mál, en svo er ekki – langt í frá.

Hvað eigum við að gera?

Fyrir tveimur árum lagði þingmaður fram fyrirspurn um umskurð til heilbrigðisráðherra (sjá 145. löggjafarþing, 539. mál). Ráðherrann var þeirrar skoðunar að það ætti alltaf að nota deyfingu við umskurð á nýfæddum drengjum, og einnig að umskurður ætti ávallt að fara fram á spítölum, ekki í heimahúsum. Þetta er hófstillt skoðun sem nánast allir geta tekið undir. Svona eru reglurnar víða, til dæmis í Þýskalandi.

Regla af þessu tagi er í eðlilegu samræmi við vísindalegar framfarir. Á tuttugustu öld töldu heiðarlegir læknar, í góðri trú, að umskurður væri best framkvæmdur án deyfingar. Þeim fannst skammvinnur sársauki ásættanlegt verð fyrir heilsufarskosti umskurðar. Í dag eru vísindamenn meðvitaðri um sársaukann sem nýfæddir drengir upplifa við aðgerðina. Ef við höldum að sársaukinn sé of mikill, þá eru réttmæt viðbrögð ekki að banna umskurð. Við eigum frekar að

krefjast þess að sársaukanum sé haldið í lágmarki þegar aðgerðin fer fram. Í rauninni er þetta þegar gert hérlendis.

Að öðru leyti eiga íslenskir foreldrar sem ákveða að umskera drengi sína að vera lausir við áhyggjur um að lenda á Litla-Hrauni. Þeir sem hafa illan bifur á umskurði þurfa hvorki að umskera börnin sín né styðja umskurð að öðru leyti.

Ég er ekki að segja að Íslendingar ættu að byrja að umskera drengi sína, jafnvel þótt það feli í sér kosti. Ég var (og er) alveg sáttur við að það er engin hefð fyrir umskurði á Norðurlöndunum. Sem faðir fylgdi ég íslenskum venjum og lét ekki umskera nýfæddan son minn. En ég myndi ekki heldur lýsa umskurði sem hræðilegum, óskiljanlegum, eða óréttlætanlegum.

Umskurður nýfæddra drengja er hvort eð er svo sjaldgæfur á Íslandi að bann við honum væri táknrænt. Þeir örfáu foreldrar sem kjósa að umskera drengi sína eftir fæðingu fara til útlanda til þess, og myndu halda því áfram væri bann í gildi.

Óskynsamleg rök á móti

Ég las frétt þar sem sagði að umskornir drengir „geti upplifað kvíða og einangrun“ á Íslandi vegna þess að þeir eru ólíkir öðrum. En þetta eru ónothæf rök á móti umskurði. Jafnvel þótt við bönnum umskurð án heilsufarsástæðna verða sumir strákar á Íslandi alltaf umskornir, annaðhvort vegna sýkinga eða vegna þess að þeir fæddust erlendis. Það kallar ekki á að banna umskurð og þar með stigmatísera þessa stráka enn meir, heldur á smá fræðslu um að líkamar eru margvíslegir – og að það er í lagi að ekki séu allir eins!

Sú hugmynd að umskurður brjóti „gegn réttindum ungra drengja“ og að við eigum að „virða sjálfsákvörðunarrétt barna og banna umskurð á drengjum nema í þeim tilvikum sem drengur, sem náð hefur nægilegum aldri og þroska til að skilja hvað felst í aðgerðinni, veitir samþykki sitt“ er sjálfsagt vel meint en ekki minni rökleysa fyrir það.

Einn vandinn við þessa hugmynd er að ákvörðun fullorðins karlmanns um að láta umskera sig er allt annars eðlis en ákvörðun foreldra um nýfæddan son sinn. Hjá nýburum er aðgerðin minna mál og drengirnir muna ekki eftir henni. Aðgerðin á eldri börnum eða fullorðnum fer fram í fullri svæfingu og krefst þess að tekið sé frí frá skóla eða vinnu í allt að viku. Ef við bönnum umskurð nýfæddra drengja, þá erum við, í nafni sjálfsákvörðunarréttar, í rauninni að reyna að útrýma umskurði og banna þá heiðarlegu skoðun að hann bæti lýðheilsu.

Að umskera eða umskera ekki er auk þess ekki eina ákvörðunin sem foreldrar taka, óhjákvæmilega, um líkama barna sinna. Með því að umskera nýfæddan dreng eru foreldrar að „brjóta gegn réttindum hans“ á svipaðan hátt og þeir gera með því að bólusetja hann, láta fjarlægja hálskirtla, setja rör í eyru, gefa lyf sem hafa mögulegar aukaverkanir, gefa börnum vatn eða tannkrem með flúor, eða kaupa lýsi. Allar þessar ákvarðanir eru umdeilanlegar og hafa kosti og galla. Í öllum slíkum tilfellum eru foreldrarnir þó að reyna að *veita* barninu réttindi til að lifa

með minni áhættu á alvarlegum sjúkdómum eða fötlunum. Þess vegna tökum við foreldrar áhættu af þessu tagi. Og af þeim sökum gengur frumvarpið alltof langt með því að segja að umskurður sé einfaldlega „brot á mannréttindum drengja."

Auk þess bendir ekkert til að þeir þingmenn, sem vilja banna umskurð á grundvelli sjálfsákvörðunarréttar, telji rétt að banna líka aðrar líkamsbreytingar á ósjálfráða börnum. Að gata eyrun hefur ekkert heilsufarslegt gildi en felur í sér talsverða hættu á fylgikvillum. Að lengja háls ungra stúlkna með málmhringjum (eins og í norðvesturhluta Tælands) bætir ekki heilsu þeirra og er ekki óalgengara á Íslandi en umskurður nýfæddra drengja. Að einblína á umskurð drengja og jafnvel refsa með sex ára fangelsisvist (meira en brennuvargar eða bankastjórar fá!) bendir til þess að fordómar og útlendingaandúð séu frekar á ferð hér en gagnrýnin hugsun.

Lokaorð

Umskurður drengja er löglegur í öllum löndum heims. Svo virðist sem sumir hérlendis taki því með sérstöku stolti að Ísland verði hugsanlega fyrst ríkja til að samþykkja bann. Slíkt væri þó mun meiri hneisa fyrir Ísland heldur en margur hér virðist gera sér grein fyrir. Hin Norðurlöndin og Þýskaland hafa hafnað tilraunum til að banna umskurð. Í Noregi var það aðallega Framfaraflokkurinn (flokkur hægriöfgamanna sem er á móti innflytjendum) sem beitti sér fyrir banni. Ef Ísland verður eina landið til að banna umskurð, mun það ekki sýna okkur Íslendinga í góðu ljósi.

Frekar hófsamur læknir að nafni Andrew Freedman birti pistil í tímaritinu *Pediatrics* árið 2016 um umskurð. Hann ráðlagði þeim sem eru á móti umskurði að nálgast málið ekki með reiði, dómsmálum, átökum, lagafrumvörpum, fordómum, bönnum, eða ýkjum. Þeir sem vilja vinna gegn umskurði drengja ættu frekar að nota orku sína á jákvæðan hátt. Þeir mættu reyna að hafa áhrif á þá sem vilja halda í umskurð með uppbyggilegum hætti og gagnkvæmri virðingu, ekki sleggjudómum og glæpavæðingu. Ef það er vinsælt að hafa forhúð, þá mun fólk halda í hana. Á Íslandi hefur forhúðin alltaf verið vinsæl og sigur hennar örugglega í höfn.

Í rauninni efast ég um að umskurður drengja sé nokkurt vandamál á Íslandi. Til hvers er frumvarpið þá? Alþingi ætti að sinna málum sem raunverulega herja á íslensk börn og foreldra og grafa undan réttindum þeirra á hverjum degi. Það væri óskandi að jafn öflug og dýnamísk umræða færi fram um raunveruleg brot gegn börnum og sú sem nú hefur logað á Íslandi um umskurð drengja.

Virðingarfyllst,

Ian Watson

Höfundur er dósent við NTNU, norska tækni- og vísindaháskólann.
Þessi umsögn birtist einnig sem grein í Kjarnanum (kjarninn.is).

Alþingi
Nefndarsvið
Austurstræti 8-10, 150 Reykjavík

Ágæta Nefndarsvið Alþingis,

Umsögn Intact Iceland um frumvarp til laga er varða breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja), 148. löggjafarþing - þingskjal 183 - 114. mál.

Intact Iceland er fylgjandi 18 ára aldurstakmarki á umskurði drengja án læknisfræðilegrar ástæðu, þannig að þeim verði tryggt jafnrétti á við stúlkur. Okkur finnst það sjálfsögð mannréttindi að fólk geti sjálft tekið ákvarðanir varðandi óþarfar og óafturkræfar aðgerðir á eigin líkama.

Í stjórnarskrá lýðveldisins Ísland nr. 33/1944 segir: "Börnum skal tryggð í lögum sú vernd og umönnun sem velferð þeirra krefst". Börn, þá sérstaklega ómálga ungabörn, geta ekki borið hönd fyrir höfuð sér og eru þess vegna háð forráðamönnum til ákveðins aldurs. Æðsta hlutverk forráðamanna er að standa með börnunum og gæta réttinda þeirra. Stundum stangast þau réttindi á við sannfæringu forráðamanns varðandi trú og hefðir – það getur reynst foreldrum mjög erfitt. Þó þeir vilji börnum sínum allt það besta, getur verið erfitt að standast félagslegan þrýsting eða að fara móti eigin sannfæringu um nauðsyn einhvers er snýr að barninu. Dæmi um slíkt er blóðgjöf barna í þeim tilfellum þegar trú foreldra bannar slíkt. Annað dæmi er misnotkun eða ofbeldi innan fjölskyldu, þar sem ekki er brugðist við af þeim fullorðnu sem hafa vitneskju um málið, vegna eigin hagsmuna. Við slíkar aðstæður beita yfirvöld sér fyrir því að réttindi barnsins séu höfð í forgangi, óháð því hver á í hlut. Börn eru nefnilega fullgildir einstaklingar með sjálfstæð réttindi, óháð réttindum fullorðinna, samkvæmt Barnasáttmála Sameinuðu þjóðanna, sem varð hluti af íslenskri löggjöf í febrúar 2013.

Hvar skal draga mörkin á meðan sumum foreldrum er leyft að setja eigin sannfæringu um ónauðsynlegar aðgerðir framar sjálfsákvörðunarrétti barnsins? Er verið að mismuna börnum vegna trúar eða sannfæringar foreldra þeirra með þessu? Hefur það í för með sér að sum börn njóti ekki sömu mannréttinda og önnur sökum lífsskoðana eða sannfæringu foreldra þeirra? Eiga börnin ekki alltaf að njóta vafans? Myndum við sjálf samþykkja skerðingu á okkar mannréttindum vegna hagsmuna annarra og hefðum ekkert um það að segja? Í 1. hluta 2. gr. Barnasáttmálans, er það tekið fram að aðildarríki verði að sjá til þess að barni sé ekki mismunað á neinn hátt.

Sumir segja að umskurður hafi kosti í för með sér meðal annars hvað varðar hreinlæti og varnir gegn kynsjúkdómum eins og HIV. Ef hættan er raunveruleg, væri hún þó fyrst fyrir hendi þegar aðili byrjar að stunda kynlíf og því er hún ekkert sem hægt er að nota í rökstuðningi varðandi barn. Hreinlæti er heldur ekkert sem ætti að reynast neinum erfitt á Íslandi árið 2018, þar sem góður aðgangur er að hreinu vatni. Réttast væri að barnið sjálft geti valið hvort því finnist rökin fyrir umskurði, nokkuð sem auðveldlega er hægt að ná fram á annan hátt en með aðgerð, séu það góð að það borgi sig að missa forhúðina. Forhúðin hefur hlutverk og hjá litlum drengjum ver

hún getnaðarliminn gegn óhreinindum og sýkingum. Forhúð fullorðinna karlmanna er kynnæmur vefur sem inniheldur þúsundir taugaenda sem auka tilfinningar og ánægju í kynlífi.

Umskornir einstaklingar þurfa að lifa alla ævi með þeim breytingum sem gerðar voru á líkama þeirra án læknisfræðilegra ástæðna. Dæmi eru um að drengir uppgötvi fyrst að þeir hafi verið umskornir, við kynfræðslu í grunnskólum. Viðbrögð þeirra eru misjöfn. Sumir upplifa reiði og sorg yfir að hluti af þeim hafi verið skorinn af án þeirra samþykkis. Þeir velta því fyrir sér hvernig það væri að hafa forhúð og hvað þeir hafi misst. Aðrir fá loksins skýringu á þeim vandamálum sem hafa hrjáð getnaðarlim þeirra allan barndóminn. Við viðurkennum að sumir kunna að vera ánægðir með að hafa verið umskornir sem ungabörn, sem er auðvitað gott mál, en þeim var aldrei boðinn annar möguleiki. Eins eru þeir sem hafa verið umskornir vegna vandamála, með góða upplifunin af umskurði, enda læknisfræðileg ástæða að baki og léttir að fá vandamál leyst. Þessar staðreyndir breyta þó ekki upplifunum eða slæmri reynslu þeirra fjölda drengja og manna sem finnst á sér brotið eða hafa þjáðst, sumir gífurlega, vegna umskurðar sem þeir höfðu ekkert að segja um. Því til stuðnings bendum á þær umsagnir sem þegar hafa borist Alþingi frá fórnarlömbum umskurðar og hvetjum þingmenn til að fara vel yfir þær umsagnir.

Niðurstöður nýlegrar rannsóknar[1] benda til að tíðni fylgikvilla eftir umskurð á drengjum, sem voru framkvæmdir á skurðstofu við bestu aðstæður, er hærri en áður var haldið eða í um 11,5% tilfella innan tveggja ára frá aðgerð. Samkvæmt niðurstöðunum eru ekki orsakatengsl milli annarsvegar aldurs barnsins og staðsetningar aðgerðarinnar (spítali eða utan) og hinsvegar tíðni fylgikvilla. Við umskurð á litlum sveinbörnum, er forhúðin rifin laus til að hægt sé að skera í hana, eða klemma hana af, til að stoppa blóðflæði, svo húðin falli af. Það fer eftir hver framkvæmir aðgerðina, hvort og þá hvaða deyfing er notuð en deyfing og svæfing í sjálfu sér getur verið hættuleg. Þó svo aðgerðin geti verið hættuleg þá er hún ekki það eina sem barnið þarf að komast í gegnum. Eftir aðgerðina er t.d sýkingar- og blæðingarhætta og dæmi eru um að börnum hafi blætt út í bleyju án þess að tekið væri eftir því, vegna þess að ungabörn þurfa ekki að missa mikið blóð til að missa meðvitund. Er þetta áhætta sem forráðamaður barns á að hafa leyfi til að taka fyrir hönd barnsins?

Lagasetningin getur verndað fleiri en eingöngu þau börnin sem að um ræðir. Stundum sjá foreldrar eftir að hafa látið undan félagslegum þrýstingi. Sumir foreldrar hafa talað um að hafa átt erfitt með að standast þrýsting annarra fjölskyldumeðlima og að þau hefðu viljað óska þess að geta borið slíku banni fyrir sig. Við vitum um mörg dæmi þess að konur á Íslandi hefðu viljað geta sagt að umskurður væri bannaður á Íslandi, til að bjarga börnum sínum frá þessari óþörfu aðgerði. Foreldrar sem tilheyra mismunandi menningarheimum geta einnig verið ósammála um hvort umskera eigi sveinbörn sín og annað foreldrið lifað í ótta um að drengurinn verði umskorinn án þeirra vitneskju. Öðrum foreldrum finnst þau hafa verið svikin þar sem þeim var ekki gerð grein fyrir því nákvæmlega hvernig aðgerðin var gerð eða hvaða afleiðingar hún hefur í för með sér. Rannsóknir og reynslusögur heilbrigðisstarfsmanna hafa einnig sýnt fram á að

[1] **Identification of circumcision complications using a regional claims database.** Glen Lau, Jaewhan Kim og Anthony Schaeffer fra Salt Lake City í Bandaríkjunum. Niðurstöðurnar, sem kynntar verða á ráðstefnu Societies for Pediatric Urology í San Francisco, í Bandaríkjunum, í maí á þessu ári.

það geta orðið erfiðleikar við brjóstagjöf og tengslamyndun sveinbarna sem hafa verið umskorin. Börnin finna nefnilega bæði til sársauka og óþæginda eftir umskurð, þ.a.m. við að liggja á ákveðinn hátt við brjóstagjöf. Þetta getur reynst erfitt fyrir foreldra og aukið streituálag á fyrstu vikum barnsins. Barnið getur ekki tjáð sig um hvað hrjáir þau í slíkum aðstæðum – það er því mjög erfitt fyrir foreldra að horfa upp á barn sitt gráta og geta ekki róað barnið. Umskurður getur þannig komið í veg fyrir að vel takist með brjóstagjöf, sem auk þess að styrkja tilfinningaleg tengsl milli móður og barns, minnkar t.d. líkur á sykursýki, exemi, krabbameini og offitu seinna á lífsleiðinni.

Verði sett 18 ára aldurstakmark, getur einstaklingur valið að láta umskera sig þegar hann hefur þroska til að mynda sér sjálfstæða skoðun varðandi aðgerðina. Þeir sem ekki aðhyllast trú foreldra sinna eða telja ávinning engan af aðgerðinni geta þá valið að láta ekki umskera sig. Það er kostur við 18 ára aldurstakmark að það er auðveldara að umskera þá sem hafa náð þeim aldri þar sem að forhúðin er orðin laus, bleyja er ekki lengur til staðar og hægt að gefa góða svæfingu án sömu áhættu. Þar að auki getur aðilinn sagt betur til um hvort þörf sé á frekari verkjalyfjum eða látið vita ef eitthvað er að. Hafa ber í huga að heilbrigð börn eru gerð að sjúklingum þegar að þau fara í aðgerðir án læknisfræðilegrar nauðsynjar. Það hefur enginn dáið vegna forhúðar, en það hafa mörg börn dáið vegna umskurðar.

Árið 2015, varð lítið land, Malta, fyrsta landið í heiminum til að setja lög sem vernda réttindi intersex barna fyrir læknisfræðilegum aðgerðum, án þeirra samþykkis. Malta sýndi þar fordæmi sem mörg lönd sækja í sem innblástur við eigin lagasetningar.

Verður Ísland fyrsta landið til að vernda mannréttindi drengja?

Virðingarfyllst fyrir hönd Intact Iceland

Íris Björg Þorvaldsdóttir
Steinunn Ketilsdóttir
Pétur Ingi Egilsson
Linda Magnúsdóttir
Thor Viðar Jónsson
Magnús Einarsson Smith
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Regína Stefnisdóttir
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Jórunn Viðar Valgarðsdóttir
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Alþingi
Kirkjustræti
150 Reykjavík

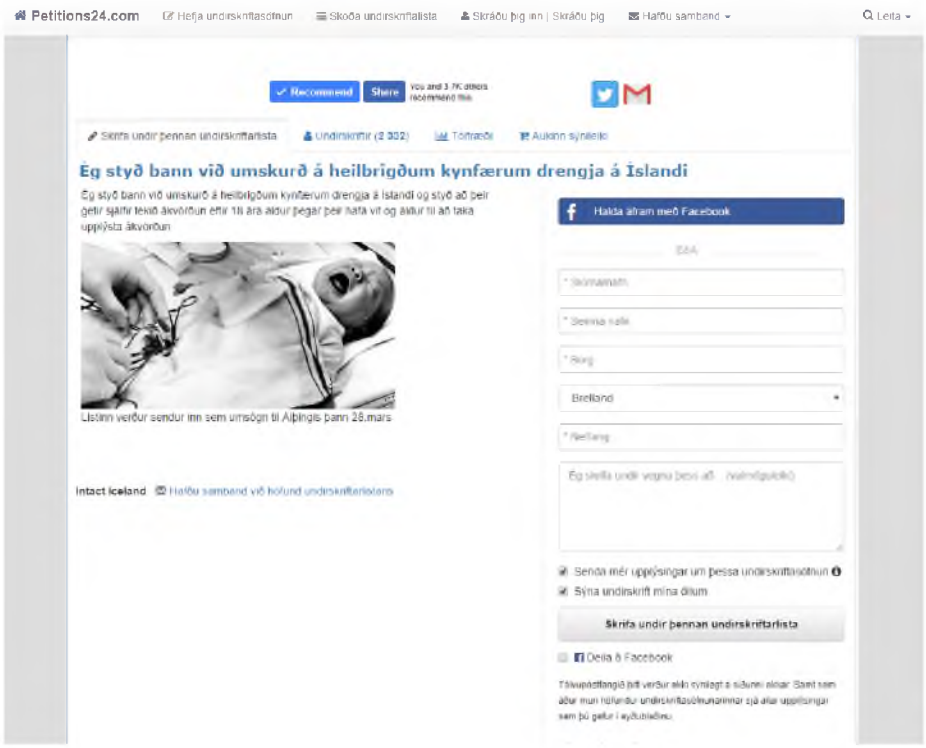
Reykjavík, 28. mars 2018

Ákall frá íslensku þjóðinni!

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágæta Alþingi,

Þann 9. mars 2018 hóf Intact Iceland undirskriftarsöfnun fyrir almenning á Petitions24.com. Á 19 dögum skrifuðu 2.332 íslendingar undir "Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi". Listinn verður áfram opinn þar til lög um aldurstakmark verður sett á umskurð á drengjum á Íslandi. Listi yfir nöfn þeirra 2.332 einstaklinga sem skrifuðu undir var afhentur Alþingi útprentaður þann 28. mars 2018. Einnig er hægt að sjá listann á https://is.petitions24.com/bann_vi_umskur_a_heilbrigum_kynfarum_drengja



Athugasemdir þeirra sem voru búnir að skrifa undir 28. mars 2018:

1. Ég vil tryggja að drengirnir hafi sama jafnrétti til að taka ákvarðanir gagnvart eigin líka og stelpurnar. Að auki vegna þess að þetta er sársaukafull aðgerð, með sársaukafulla daga eftirá og ALGJÖRLEGA ónauðsynleg!
2. Ég styð mannréttindi drengja.
3. Þetta er svo sjálfsagt mál að það ætti ekki að þurfa að ræða það

4. Að þetta er hreint og klárt ofbeldi
5. Það þarf að stoppa þessa níðslu á sveinbörnum! Mannréttindi þeirra verður og á að virða að fullu.
6. Kreddum og forneskju trúarbragðanna á ekki að troða á ómálga börn,og rista með því nafn ósýnilegs vinar foreldranna í barnið með eggvopnum.
7. Allar ónauðsynlegar aðgerðir á kynfærum barna eru óásættanlegar.
8. Ég vil ekki að það sé brotið á fólki og alls ekki börnum.
9. Umskurður er barnaníð. Bæði á drengjum og stúlkum.
10. Fátt er sjúklegra en að skera í typpin á littlum drengjum.
11. Enginn á að hafa rétt til að skaða líkama barna hvorki með umskurði né á annan hátt.
12. Óafturkræf aðgerð ("skemmd") gerð á ómálga barni, án þess að fyrir því sé nokkur nauðsyn. Nei, trú er *EKKI* nauðsyn á svona limlestingu. Þegar viðkomandi er orðinn sjálfráða, þá má hann ráða því hvort hann vilji láta klippa af sér bút, eða ekki. En ómálga, ósjálfstætt... barn, sem treystir á sitt nánasta fólk, til að sjá um sig? Þetta er barasta BARNA-NÍÐ!
13. Umskurður hvítvoðunga er villimannsleg mannvonzka.
14. Ég reyndar skil ekki afhverju það þarf þetta sérstaka bann, ég hélt að limlestingar á börnum (reyndar á öllum) væru almennt bannaðar á Íslandi.
15. Ég skrifa undir vegna þess að ég virði mannréttindi barna til að fá að velja um umskurð sjálf þegar þau verða fullorðin.
16. Það á ekki að líðast að skera burt líkamshluta af óvita barni
17. Var umskorinn eftir sex áratugi man ég sársaukan vel og þekki eftirköstin vel, bið ykkur um að valda börnum ekki þjáningum og skaða að óþörfu, treysti því að miskun og mennska ráði eins og svo oft áður ákvörðun Íslandinga.
18. Því þetta er ofbeldi á börnum. Þau geta tekið þessa ákvörðun seinna meir ef þau vilja.
19. Ég skrifa undir vegna þess að limlestingar barna eiga ekki að líðast
20. Ég skrifa undir vegna þess að mér finnst fráleitt að foreldrar geti ákvarðað fyrir börn sem þau hafa í sinni umsjón í 18 ár eftir fæðingu hvort börnin hafi alla sína útlimi óskaddaða. Það er ekki val foreldranna. Þó börn fæðist foreldrum hafa foreldrar engan rétt til að meiða börn sín undir nokkrum kringumstæðum, hvað þá orsaka varanlega limlestingu barnanna í nafni trúar eð annarra kredda.
21. Ég stið ekki barnanýð
22. Því ég er á móti ofbeldi
23. Barn getur ekki samþykkt þessa aðgerð sem er ekki tekin til baka og er eingöngu gerð í þágu truar bragða foreldra, trú getur verið iðkuð án mysþirminga barns
24. því limlestingar á barni eru siðferðislega rangar og það er ákvörðunarréttur einstaklingsins hvort hann vilji seinna meir gangast undir þessa aðgerð eður ei.
25. Ég vil ekki sjá þessa illmennsku leyfða her á landi. Það er skref 1400 ár aftur í tímann. Við eigum ekki að taka upp glæpi gegn börnum til að þóknast öðrum trúarbrögðum. Það er heimska.
26. Verjum mannréttindi barna. Forðum börnum frá ónauðsynlegum aðgerðum sem setja heilsu þeirra í hættu og geta minnkað lífsgæði þeirra. Verjum rétt fólks til að taka ákvarðanir er varða eigin líkama. Börn eru ekki eign foreldra, þetta eru manneskjur sem eiga sjálfsákvörðunarrétt yfir eigin líkama. Látið kynfæri barna í friði!

27. Af mannréttindaástæðum
28. Umskurður barns er limlesting án samþykkis.
29. Það er fáránlegt að gera óafturkræfra aðgerð á einstakling sem ekki hefur veitt samþykki sitt fyrir henni í nafni trúar!
30. Því þetta á að vera val þegar þú hefur þroska til
31. Vegna þess að ég tel að þetta eigi ekki að eiga sér stað á landinu okkar að börn sé látin þjást vegna trúar foreldra sinns. Einstaklingarnir geta tekið ákvörðun um það sjálfir þegar þeir verða 18 ára.
32. Mannréttindi barna
33. Ég skrifa undir til þess að vekja athygli á því að ýmislegt er látið viðgangast í nafni trúar og/eða hefðar sem stríðir á móti almennri skynsemi
34. Börn eiga rétt á því að ákveða þetta þegar þau eru komin með aldur til.
35. Ég styð bann við umskurð og að þeir geti tekið ákvörðun þegar þeir hafa vit og aldur til að taka upplýsta ákvörðun
36. Ég tel ekki að neinn eigi að geta tekið ákvörðun um að frakvæma ónauðsynlega og óafturkræfa aðgerð á öðrum einstakling þar sem hluti líkama viðkomandi er fjarlægður.
37. Að thetta er ógeðslegt og ekki boðlegt fyrir ung börn.
38. Mér finnst drengir eigi að ákveða þetta sjálfir þegar þeir eru sjálfráða.
39. Er á móti því að átt sé við heilbrigð kynfæri.
40. Drengir fæðast með forhúð, hún er til að vernda og koma í veg fyrir sýkingar. Stöndum vörð um Barnasáttmálann.
41. Ég skrifa undir því þetta er ómannlegt og drengir eiga að fá að ákveða þetta sjálfir
42. Ég hafna því að misþyrmingar á börnum séu í lagi...
43. 'Eg skrifa undir vegna þess ef heilbrigði er fyrirog eins mér finst að trúar brögð komi þessu ekkert við Börnin eiga að hafa val eftir 18 ára aldur
44. Drengir eiga að velja sjálfir við fullorðinsaldur hvort vilja umskurð
45. Trúarbrögð eru rót viðbjóðs í heiminum, umskurður á börnum er mannvonska vegna ógeðis trú...
46. Það er klárlega ekki börnum bjóðandi að skemma fullkomlega heil kynnfæri. Og þetta getur ekki staðist barnaverndarsáttmála Sameinuðu þjóðanna
47. Finnst þetta fáránlegt þetta á að vera einstaklings val
48. Það er bannað að meiða börn.
49. Þetta er auðvitað ómanneskjulegt
50. Segir sig sjálft.
51. Banna skal allar aðgerðir á börnum þar sem líkamshlutir eru fjarlægðir nema vegna læknisfræðilegra ástæða.
52. Finnst þeir eiga geta tekið ákvörðun sjálfir um og eftir 18 ára aldur
53. þetta er ofbeldi af verstu sort
54. Það er algjörlega ólíðandi að setja drengi í lífshættu af trúar eða menningarlegum áatæðum.
55. Forhútið HEFUR TILGANG, og hún er akki hlutur sem er galli á líkama ungra drengja,
56. það er engan vegin réttlætanlegt í upplýstu nútíma samfélagi að óafturkræf aðgerð sé gerð á barni af trúarlegum ástæðum.
57. Ég er á móti svona aðgerð í trúarlegum tilgangi

58. Villimennska í skjóli trúar gagnvart ungabörnum á ekki að líðast í siðuðu þjóðfélagi árið 2018
59. Þetta á að vera val einstaklinganna sjálfra við lögræðisaldur
60. Þetta er viðbjóður
61. Þetta er ónauðsynlegt inngrip á saklausu barni. Ef einstaklingur er trúaður getur hann gengist undir aðgerðina þegar hann hefur vitsmuni til að samþykkja hana.
62. Ég tel umskurð vera ofbeldi gegn barni og það sé ekki hægt að vísa í hefðir og trú foreldra til að réttlæta ofbeldi. Ég tel að umskurður sé nú þegar ólöglegan, þar sem hann brýtur gegn Barnasáttmálanum og 27.grein laga um réttindi sjúklinga. Í barnasáttmálanum er fjallað um rétt barna til verndar og ávalt séu teknar ákvarðanir sem eru þeim fyrir bestu. Rétt barna til að njóta bestu mögulegu heilsu. Ég tel það einstaklega fáránlegt að fólk noti trúarfrelsi sem rökstuðning fyrir því að leyfa aðgerðir sem þessar þar sem Barnasáttmálinn tryggir börnun jafnt sem foreldrum persónulegs félaga- og trúfrelsi. Umskurður snýst um trúfrelsi en hann snýst um trúfrelsi barnsins ekki foreldranna og það er að mínu mati gróft brot á trúfrelsi einstaklings að gera óþarfa, óafturkræfa, sársaukafulla og mögulega skaðlega aðgerð í nafni trúar foreldra þess. Ég tel hann vera brot á lögum um réttindi sjúklinga, en í 27.grein þeirra laga stendur: Hlífa ber börnum við ónauðsynlegum rannsóknum og aðgerðum.
63. Þetta er ónauðsynleg misþyrming á ómálga börnum og vand séð hvað þetta kemur trú við
64. Umskurður a ómálga barni er ekkert annað en ofbeldi og limlesting.
65. Ég skrifa undir af því að ég vil að umskurði á kynfærum drengja verði bönnuð.Þessi aðgerð er óþörf að mínu mati og er skýrt mannréttindabrot. Umskurður er óþarfa grimmd og svívirðing við unga drengi sem eru of ungir til að samþykkja eða neita þessari aðgerð.Mér finnst persónulega séð að þessi aðgerð sem er varanleg niðurlægjandi fyrir karlmenn.Þetta eru ekki miðaldir heldur 2018,sýnum öllum virðingu!
66. Umskurður er læknisfræðilega tilgangslaust og viðbjóðslegt níðingsverk á varnarlausum börnum og ætti að sjálfsögðu að vera bannað með lögum.
67. Sé ekki ástæðu til að gera ónauðsynlegar aðgerðir á nýburum. Drengir eftir 18 ára geta valið sjálfir hvort þeir vilji þetta en nýburi hefur ekkert vald. Öllum aðgerðum fylgir áhætta og ætti því að vera bannað að framkvæma ónauðsynlegar aðgerðir á nýburum og börnum.
68. Þetta ætti banna fyrir löngu.
69. Réttur barna vegur hærra en lífs- og trúarskoðanir foreldra þeirra.
70. Umskurður á börnum er ofbeldi.
71. Drengir eiga að fá að ráða því sjálfir hvort þeir eru umskornir
72. Það á ekki að gera neitt óafturkræft við börn/ungabörn til að uppfylla hefðir, trúarskoðanir og eða útlitslegt val foreldranna. Þetta er alvarlegt inngrip og mikill sársauki og hefur áhrif á lífsgæði barnsins til frambúðar. Og óásættanleg aukaverkun er að heilbrigð fædd sveinbörn hafa dáið eftir þessa ónauðsynlegu athöfn. Það sama á við stúlkubörn sem hafa verið umskornar við misjöfn skilyrði og sýkingarhætta þá mikil.
73. Ungabörn hafa margfalt næmari taugaenda en við, og er þessi villimannalega "hefð" því einfaldlega pyntingar á saklausustu einstaklingum okkar samfélags. Vísa rannsóknir líka til þess að umskornir menn njóta ekki kynlífs eins vel og aðrir, þar sem taugaendarnir í kóng þeirra eru ekki jafn næmir.
74. Mér er annt um börn og umskurður er út í hött.

75. Algjörlega tilgangslaust. Árás á òmálga barn sem getur ekki varið sig eða gefið álit eða skoðun á málinu.
76. Þetta er með öllu ósiðlegt, hver og einn skal hafa rétt til eigin ákvarðana.
77. Þetta er misþyrming á ómálga börnum og kemur trúarbrögðum ekkert við. Þetta er aldargömul bábylja.
78. Bann við umskurði beggja kynja
79. Þarft málefni
80. Það brýtur gegn sjálfsákvörðunarrétti að gera óþarfa og óafturkræfa breytingu á líkama manneskju sem er ófær um að veita samþykki. Sjálfsákvörðunarréttur er ófrávíkjanlegur (unalienable) réttur.
81. Börn eru frjálsbornir einstaklingar,foreldrar eru leiðbeinendur og gæta þeirra til fullorðinsára.
82. Þetta er helvítis sori
83. Það er mín skoðun að enginn hafi rétt til að framkvæma óafturkræfar aðgerðir á ungabörnum, hvorki í nafni trúar, haturs eða af neinum ástæðum.
84. Ég er alfarið á móti ónauðsynlegum og óafturkræfum aðgerðum á ómálga börnum sem geta skaðað þau fyrir lífstíð!
85. Á að vera val á fullorðinsárum.
86. Limlestingin er rökrétt útaf þúsund ára gamalli bók. Á sér enga stoð í raunveruleikanum árið 2018.
87. Því þetta er mannvonska !
88. Ég er á móti misþyrmingum á börnum.
89. Heilbrigð skynsemi.
90. Líkami nýfæddra drengja er þeirra eigin, ekki eitthvað sem foreldrar ættu að mega breyta vegna persónulegra skoðanna sinna án læknisfræðilegrar ástæðu. Ég á tvo litla drengi og hef engan áhuga á að hafa svo víðtækan rétt yfir þeim.
91. Mér finnst það vera mannréttindi að menn fái að taka þessa ákvörðun sjálfir þegar þeir hafa aldur og þroska til.
92. Sé ekki læknisfræðileg þörf á að umskera þá er það líklega vilji foreldra út af trúarlegum ástæðum, þess vegna á þetta að vera Val einstaklingsins. Barnið ætti að geta tekið þessa ákvörðun sjálft þegar það er orðið 18 ára
93. umskurður er viðbjóður. Fólk að skipta ser að kynfærum barna? Svo verður kynlíf verra fyrir folk sem er umskorið það er tilfining sem fer við þetta svo það er verið að skipta sér að því hversu mikla löngun fólk hafi fyrir kynlífi. Bull og vitleysa og eldgömul hefð sem á að deyja.
94. Við erum lagalega skuldbundin til að uppræta forneskjulegar hefðir sem eru skaðlegar heilbrigði barna. smbr. Barnasáttmáli Sameinuðu þjóðanna 24.gr. 3.liður
95. Mér finnst að þetta eigi að vera val barnsins "drengsins"
96. Er á móti ofbeldi ,svo ég tali nú ekki um á litlum börnum .
97. Fólk á að hafa val um varanlega aðgerð sem þessa, þegar það hefur aldur til.
98. Þetta er algjörlega óþörf aðgerð og getut valdið drengjum miklum erfileikum allt lifið. Gyðingar gera þetta af trúarástæðum og ætti þeir að gangast undir þessa aðgerð þegar þeir hafa vit og þroska ti að taka ákvörðun. Bandarikjamenn byrjuðu á þessu eftir að hermenn komu heim ur stríði og þeir voru með miklar sýkingar undir forhúðinni sem sagt kynsjúkdóma eftir nauðganir og viðbjóð sem fylgir stríðum, síðan varð þetta hefð hjá þeim.

99. Umskurður er rangur sama hvaða kyn á í hlut
100. Heilbrigð kynfæri drengja eiga að vera látinn vera og má sá sem á kynfærinn fara sjálfur í umskurð ef hann er orðinn lögráða, náð 18 ára aldri
101. Ekki á að leyfa foreldrum eða trúarsöfnuðum að taka óafafturtækar ákvarðanir fyrir ungabörn
102. Viðbjóður
103. Umskurður drengja fer gegn því að vernda börn. Þetta er óþörf aðgerð sem getur leitt til dauða!
104. Mér finnst þetta vera mjög rangt og manneskjan á að fá að ráða sjálf þegar hún verður eldri hvort hún ætli að taka þátt í svona trúarrugli.
105. Allir eiga rétt á að ráða líkama sínum sjálfir!
106. Við erum komin lengra en þetta sem mannkyn að afmynda líkama barna vegna trúa eða hefða.
107. Ofbeldi gegn börnum sem ekki á að líða!
108. Ég vill að barnið hafi tækifæri á að taka sjálft ákvörðun um málið.
109. Þetta er viðbjóður og ekkert barn á að lenda í þessu
110. Barnaníð er aldrei réttlætanlegt þó það séu einhverjir sem vilji halda í einhverjar hefði sem eru komnar úr fornöld
111. Þetta er þeirra val og þeir eiga að fá að hafa skoðun á þessu
112. Þessu þarf að útrýma eins og öðrum hindurvitnum.
113. Ég er umskorinn 25 ára af læknisfræðilegum ástæðum, ég get ekki séð af hverju nokkur maður ætti að vilja vera umskorinn ef fúsum og frjálsjum vilja nema hafa verið með of þrönga forhúð eins og ég
114. Ég styð sjálfsákvörðunarrétt einstaklings þegar kemur að læknisfræðilega ónauðsynlegu og óafturkræfu inngripi í líkama viðkomandi.
115. Umskurður er viðbjóður, ekkert á að vera gert við líkama á manneskju ef sú manneskja getur ekki mótmælt því.
116. Ég er á móti umskurði á kynfærum ungra drengja á Íslandi..
117. Limlestingar af trúarlegum undirrótum án samþykkis hluteigansi eiga ekki rétt á sér. Sama hverjar þær eru eða á hverjum þær eru framdar hvort sem er á drengjum, stúlkum, fullorðnum eða málleysingjum. Og eiga í ÖLLUM tilfellum að vera refsiverðar.
118. Ég er á móti umskurði án samþykkis þess sem á að umskera!
119. Ég vil að kraftar heilbrigðisstarfsmanna séu nýttir til að lækna sjúka og meidda en ekki skemma það sem heilt er.
120. Umskurður á heilbrigðum kynfærum er 100% óþarfur til að halda fullu hreinlæti. Umskurður getur verið mjög hættulegur og valdið sýkingum, tilfinningarmissi, getuleysi og jafnvel dauða. Aðgerðin er mjög kvalafull, svo enginn ætti að þurfa að ganga í gegnum hana nema velja það sjálfur þegar hann er orðinn sjálfráða.
121. Börn eiga rétt á að velja sjálf
122. Umskurður barna er brot á þeirra mannréttindum
123. Drengir eiga að áhveða þetta sjálfir þegar þeir verða sjálfráða
124. Móti öllu ofbeldi, menn geta valið af láta um skera sig þegar þeir verða fullorðnir.
125. Að ráðast á smábörn og meiða þau í nafni trúar á ekki að eiga sér stað. Það er ljótt og ómanneskjulegt.

126. Ég skrifa undir vegna þess að umskurður á barni er ofbeldi!
127. Réttur fólks til trúfelsis gefur því ekki leyfi til að skera hluta af líkama annarrar manneskju.
128. Er á móti umskurði
129. Ég skrifa undir vegna þess að mér þykir það sjálfsagt og eðlilegt og ég er almennt á móti fullkomlega ónauðsynlegum aðgerðum - sérstaklega þar sem börn eiga í hlut.
130. Ég vil að strákar hafi val þegar þeir eru 18 ára
131. Því að þetta er ofbeldi gegn börnum.
132. Ég skrifa undir vegna þess að vernda þarf rétt drengja til að taka ákvarðanir um eigin kynfæri þegar þeir eru fullorðnir.
133. Sem heilbrigðisstarfsmaður get ég ekki séð nein haldbær rök fyrir því að umskera heilbrigt barn.
134. Umskurður er tímaskekkja
135. Þessi aðgerð leiðir til þess að "kóngurinn" missir næmni vegna stöðugs núnings. Hvað varðar heilbrigðissjónarmið þá sé ég ekki hvernig forhúð á að hafa áhrif á krabbameinsmyndun og hvað varðar hreinlæti þá þarf að hreinsa umskorin typpi alveg eins og óumskorin. Þessi aðgerð á ekki rétt á sér og þó það seú vandamál vegna of þröngrar forhúðar þá er nóg að vkera smá til að víkka en algjör óþarfi að taka allt. Karlmenn eiga að hafa val þegar þeir verða einmitt fullorðnir karlmenn.
136. Ég skrifa undir vegna þess að ég styð við mannréttindi barna til þess að taka þessa ákvörðun sjálf við 18 ára aldur!
137. Ungabörn þurfa vernd, ekki pyntingar og likamsafskræmingar.
138. Árásir á kynfæri ættu alltaf að vera bannaðar!
139. Þetta er ógeðslegt
140. Þetta er ómannúðlegt og misnotkun svo ekki sé meira sagt!
141. Vegna þess að barnaníð er viðbjóðslegt og getur aldrei haft eitthvað með trú að gera
142. Ég er á móti umskurð drengja..
143. Tilgangslaus, sársaukafull og hættuleg aðgerð án samþykkis
144. Drengir eiga sjálfir að fá að ráða þessu þegar að þeir hafa aldur til hvort þeir vilji láta gera þessa aðgerð á sér eða ekki.
145. Kynfæralimlestingar barna eiga að vera bannaðar. Líka á drengjum.
146. Finnst þetta misþyrming
147. Hér er verið að grípa inn í líkama ungra drengja af engri ástæðu. Ekki eru þeir veikir nei heldur er orsökin trúarbrögð foreldra. Þetta er algjörlega ólíðandi. Ég styð frumvarpið heilshugar.
148. Ég styð bann á umskurði drengja vegna þess að þer eiga sjálfir að hafa val um hvort þeir vilji láta umskera þig. Þetta er jù þeirra lìkami en ekki annara
149. Einfaldlega vegna þess að þeir sem kjósa að búa á Íslandi skulu fara eftir okkar hefðum og við gerum ekki svona við lítil börn, Ég lít á umskurð drengja alveg jafn mikla líkamsárás eins og umskurður kvenna
150. Þetta er val sem einstaklingar eiga sjálfir að geta tekið eftir 18 ára aldur.
151. Tímaskekkja
152. Ég skrifa undir vegna þess að það er ekkert rétt við að skadda börn að óþörfu.
153. Engin trú á að réttlæta aðgerð án samþykkis þolanda

154. Ég skrifa undir þennan lista því ungir menn eiga að fá að velja þetta sjálfir ef þeir vilja. Það ætti aldrei að gera óþarfar aðgerðir á mannslíkama barna eða unglinga.
155. Ef viðkomandi vill umskurn þá tekur hann sjálfstæða ákvörðun um það eftir að hafa náð 18 ára aldri.
156. Þetta er hrikalegt ofbeldi á saklausum börnum
157. Við erum siðmenntað þjóðfélag sem samþykkjum ekki pintingar á ungabörnum.
158. Vegna þessa að mér finnst að bæði drengir og stúlkur eigi að taka sjálf ákvörðun um umskurð þegar þau hafa haldur til eða um 18 ára aldur.
159. Við eigum að vernda hjálparlaus, lítil börn gegn ofbeldi, alltaf.
160. Að það á að verja öll börn í heiminum fyrir pyntingu og fleirru. Svona lagað á aldrei að líða.
161. Barnið á sjálft að fá að taka ákvörðun um þetta þegar að það verður fullorðið.
162. það er verið að skerða sjálfsákvörðunarrétt barna.
163. Ég skrifa undir vegna þess að ég vil taka þátt í eðlilegum þjóðfélagsbreytingum.
164. Það er réttur barnsins að það sé barist fyrir réttindum þess.
165. Það er löngu tímabært að þessi villimennska sé stoppuð.
166. Mér finnst þetta barnaníð
167. Mér þykir það óeðlileg að gefa einstaklingum ekki val um sinn eigin líkama. Þetta er ekki ákvörðun sem foreldrar eða aðrir eiga að taka fyrir barn sitt.
168. Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi og styð að þeir getir sjálfir tekið ákvörðun eftir 18 ára aldur þegar þeir hafa vit og aldur til að taka upplýsta
169. Ég skrifa undir vegna þess að ég er alfarið móti ofbeldi gagnvart börnum, sama undir hvaða formerkjum ofbeldið er framið. Það réttlætir ekkert ofbeldi, hvorki trúarskoðun annara (t.d. foreldra) né aðrar afsakanir!
170. Umskurður á stúlkum er bannaður og því ætti líka að banna umskurð á drengjum, út frá jafnréttissjónarmiðum. Mér finnst að réttur barna eigi að vera rétthærri en réttur foreldra. Undantekning er að það þurfi að framkvæma umskurð af læknisfræðilegum ástæðum.
171. Þetta þarf ekki einu sinni að ræða, banna þetta strax!
172. Mér finnst þetta bara sjúkt. Að skera skinn af typpinu á ungum drengjum. Á engin orð til að lýsa því hvað þetta er fáránlegt.
173. Það ætti ekki að vera trúfrelsi ef trúarlegar aðgerðir fela í sér sársauka, þjáningu eða dauða dýra eða manna.
174. Vegna þess að mér finnst að ofbeldi geti ekki falið sig á bak við trúarbrögð og að við eigum að vernda börn fyrir hvers kyns ofbeldi sem þau geta ekki varið sig sjálf gegn.
175. Trú er ekki gild afsökun til að meiða fólk.
176. að þetta er ofbeldi
177. Mér finnst þetta rangt
178. Vegna þess að ég tel umskurð vera rangan og vilji menn þetta, verði þeir að bíða þar til ná amk sjálfræðisalri sem nú er 18 ára. Læknum á síðan að vera heimilt að neita slíkri aðgerð þrátt fyrir að menn nái 18 ára aldri, ekki að gera þá skilduga að gera aðgerð þegar ekkért er að sem krefst þess læknisfærðilega séð.
179. Litlir börn eiga fá að alast upp hér á landi í friði og öryggi. Njóta verndar íslenskra laga. "Heilbrigð sál í hraustum líkama "
180. umskurður er óafturkræf en þjáningarfull og heilsufarslega séð tilgangslaus aðgerð.

181. Foreldrar eiga ekki að hafa vald til þess að senda börn sín í óþarfa aðgerð, til þess eins að skera burt skin
182. 18 ára aldurinn er gott viðmið
183. Ég tel þetta vera brot á réttindum drengja til þess að fá að veæja og hafna sjálfir.
184. Trúfrelsi veitir ekki frelsi til limlestinga annara.
185. Do no harm.
186. Er á móti umskurði á heilbrigðum kynfærum drengja.
187. Ég skrifa undir vegna þess að Ég er a móti því að það eru gerðar óþarfa læknisaðgerðir á börnum.
188. Ég er á móti því að níðingsverkum á saklausum og varnalausum börnum.
189. Ég tel umskurð á ómálga heilbrigðum börnum vera alvarlegt ofbeldi. Enginn hefur í mínum huga rétt til þess að limlesta á nokkurn hátt eða umbreyta annarri manneskju.
190. Eg a dreingi og finst þetta viðbjoður
191. Að varðveita rétt einstaklingsins til að taka sjálfstæðar ákvarðanir er stór hlekkur í jafnrétti, sjálfstæði og ábyrgð.
192. Ég skrifa undir þetta því að karlar eiga að geta tekið eigin ákvarðarnir þegar það kemur að líkamspörtum þeirra
193. Mannréttindi barna vega hærra en trúarskoðun foreldra þeirra. Ákvörðun um umskurð á að vera í höndum hvers og eins eftir að sjálfræðisaldri hefur verið náð.
194. Ég tel að umskurður á heilbrigðum börnum brjóti mannréttindi þeirra og mannhelgi.
195. Að skera af hluta kynfæra drengja er mannréttindabrot, sama hvaða ímyndaði Guð segir að svo eigi það að vera.
196. Þetta er mannréttindabrot!
197. Ég skrifa undir vegna þess að mér finnst að það eigi að vera í höndum hvers og eins einstaklings að velja hvort hann gengur undir ónauðsynlegar aðgerðir eða ekki.
198. Ég vil ekki að barnið mitt þjáist útaf einhverju sem myndi ekki endilega þurfa að gera.
199. Þeir eiga að hafa val þegar þeir eru orðnir 20 ára eða svo
200. Sumar heðir og venjur eru bara fáránlegar!
201. Mannréttindi eru æðri trúartengdum réttindum. Margir gyðingar og eflaust aðrir hópar líka láta eingöngu umskera drengi sína vegna félagslegs þrýstings. Ef Ísland (og trúlega líka Danmörk) bannar slíkt verður auðveldara fyrir fólk að standast þann þrýsting.
202. Reglulega er þörf á því að staldra aðeins við og spurja hvort það sé í raun þörf á því sem fólk er að gera í nafni hefða. Þetta er eitt af þessum aðgerðum, árið 2018, trúarlegt eður ei, sem eru gjörsamlega tilgangslausar og eru þar með grimmdarleg.
203. Vegna réttar hverjar manneskju á að fá að ráða yfir líkasímanum og lífi. Inngrip í líf barna á ekki að vera gert á líkama barna. Human rights
204. Mér finnst að hver og einn einstaklingur eigi að fá að velja fyrir sig hvort viðkomandi vilji umskurð eður ei.
205. Umskurður á barni er ekki trúfrelsi ,það er limlesting á einstaklingi í nafni trúar sem það hefur ekki sjálft valið.
206. Mannúðarsjónarmið
207. Þetta á ekki að eiga sér stað, aldrei!

208. Að gera þetta án læknisfræðilegrar ástæðu sem sýnir fram á að þetta sé nauðsyn er ekkert annað en misþyrming á börnum.
209. Eg skrifa undir því mer finnst að sá sem þarf eða vill þarf hann að vera orðinn sjalfráða og getur þá tekið þessa ákvörðun sjálfur
210. Drengir eiga að ráða sjáldir yfir sínum kynfærum. Geta umskorið eftir 18 ára aldur ef þeir vilja
211. Vil banna umskurð drengja og stúlkna.
212. Umskurður er barnaníð. Bæði á drengjum og stúlkum.
213. Þetta er kvöl fyrir lítið barn og verið að ganga á rétt barnsins, ómannúðlegt.
214. Ég vil að Ísland sýni fordæmi í því að heimila ekki lýtaaðgerðir á kynfærum barna.
215. Þeir sjálfir eiga rétt á að velja hvort þeir vilja þetta eða ekki!
216. vegna þess að eg stið ban við umskurði a drengjum a islandi
217. Umskurður á að vera val þegar einstaklingurinn hefur aldur og þroska til að taka þessa ákvörðun
218. Þetta er mannréttindabrot og sársaukafullt fyrir barnið.
219. Þetta er ekkert annað en ofbeldi
220. Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi. Beitum dómgeind. Verum mannleg. Sýnum kærleikann í verki.
221. Þeir eiga að hafa val.
222. Mér finnst mikilvægt að inngrip sem umskurður er sé ákveðið af einstaklingnum sem um ræðir , þegar hann hefur aldur til.
223. Börn njóti vafans.
224. þetta er ekkert annað en villimenska og afskræming
225. Ég tel að drengir eigi að fá að taka sjálfir ákvörðun hvort þeir fari í úrskurð eða ekki þegar þeir hafa aldur til. Og þá með deyfingu eða svæfingu.
226. Ég er nokkuð viss um að það væri barnaverndarmál ef einhver tæki upp á því að skera aðeins af eyrunum af 8 daga gömlu barni. Ég líka bara neita að trúa því að foreldrar sem væru ekki undir trúarlegum eða samfélagslegum þrýstingi frá fjölskyldu eða einhverjum klerkum útí bæ færu að taka ákvörðun um að limlesta kynfærin á ungabarninu sínu. Lagasetning um þetta myndi ekki bara vernda börnin heldur líka foreldrana.
227. Þetta er hryllingur, martröð, ofbeldi og brot á mannréttindum.
228. Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi og styð að þeir getir sjálfir tekið ákvörðun eftir 18 ára aldur þegar þeir hafa vit og aldur til að taka upplýsta ákvörðun.
229. Þetta er ekkert annað en misþyrming á litlum börnum - hafi þetta eitthvað með trú að gera eiga þeir að taka þá ákvörðun sjálfir þegar þeir hafa vit til.
230. Umskurður drengja er algjör óþarfi ef ekki er læknisfræðileg ástæða til þess. Umskurður drengja er eins og umskurður stúlkna... þetta þjónar engum tilgangi!
231. Þetta er hryllileg meðferð á börnum
232. ég styð þetta frumvarp heilshugar
233. Gott ef Ísland getur gengur fram með fordæmi í þessum málum og harðbanna þessa limlestingu á ungbörnum. (sennilega fyrst landa?) Allir eru sammála um bann við umskurði kvenna, af hverju ekki drengja? .

234. Allar ónausynlegar og óafturkræfar aðgerðir á börnum ættu að ver bannaðar! Intersex-börnum þar á meðal!!!
235. eg styd bann a umskurdi drengja !!
236. Þetta er rangt
237. eg styd bann vid umskurdi drengja ! thetta er barnanid!
238. Thetta er vidurstyggilegt ofbeldi af haestu gradu.
239. Vegna þess að það er ekki rétt að umsekera krakka!!!!!
240. Ég skrifa undir vegna þess að ég tel umskurð vera misþirmingu á barni.
241. Ungabörn eiga ekki fara undir róttækar aðgerðar , mikil sýkingarhætta
242. Það er engin þörf á þessari aðgerð og það á eingöngu að gera aðgerðir á börnum sem bæta líf þeirra. Og í sambandi við trú þá get ég ekki skilið að maðurinn þurfi að bæta sköpunarverk Guðs.
243. Til þess að vernda barnið fyrir óþarfa að gerðum á líkama þess. Aðgerðum sem eru sársaukafullar og gerðar til einskis. Ef guð (hvaða Guð sem er) er góður vill hann ekki að börn gangi i gegnum sársauka og ofbeldi til að vera honum þóknanleg.
244. Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi og styð að þeir getir sjálfir tekið ákvörðun eftir 18 ára aldur þegar þeir hafa vit og aldur til að taka upplýsta ákvörðun.
245. Strákar eiga að hafa val hvort þeir vilja umskera sig eða ekki.
246. Auðvitað ætti þetta að vera þeirra val, þetta er þeirra líkami
247. Þetta fynnnst mér ekki í lagi
248. Þetta er misnotkun og barnanýð
249. Hver og einn hefur einungis sjálfur val og aðgang að sínum eigin líkama, allavega ætti það að vera svoleiðis. Hægt væri að líkja umskurði við að brjótast inn og stela einhverjum dýrum gripum alveg eins og að ganga að líkama manneskju án leyfis. Þessir tveir hlutir eru ekkert mikið ósvipaðir. Meira að segja er seinni valkosturinn verri vegna þess að við höfum aðeins einn líkama sem við göngum í alla ævi en getum hinsvegar skipt út húsgögn og slíku fyrir nýtt.
250. Ég er andvígur limlestingum á börnum. Drengir geta farið í umskurð þegar þeir eru orðnir 18 ára.
251. Ungabarn ætti alltaf að njóta vafans fram yfir hefðir eða trúarbrögð
252. Ég skrifa undir vegna þess að ég er a móti því að drengir fái ekki að ákveða sjálfir örlög kynfæra sinna.
253. ég vil að hver og einn geti tekið sýna eigin ákvörðun um sinn eiginn líkama
254. Í mínum huga er umskurður á heilbrigðum kynfærum barna ofbeldi og skal ekki líðast. Bann við ófögnuði þessum, samþykkt á lýðræðislegan hátt, gæti styrkt baráttu fyrir réttindum barna meðal þjóða sem lifa við aldagamlar trúarkreddur. Dropinn holar steininn. Refsirammann þarf að þróa með tilliti til hagsmuna barnanna.
255. Ég vil stoppa umskurð drengja á íslandi.
256. Mér finnst að þetta eigi að vera ákvörðun einstaklingsins eftir 18 ára aldur. Mér finnst þetta vera ofbeldi og þar af leiðandi rangt.
257. Hefð er ekki nógu góð afsökun fyrir limlestingum ungbarna.
258. Þetta er ránkt!!!!

259. Börn eiga að fá að ráða sínum líkaman sjálf!
260. Þetta á að vera val þeirra þegar þeir eldast.
261. Því að umskera einstakling án upplýst samþykkis hans er hlutlægt rangt
262. Það er verið að láta litla stráka þjást á fyrstu sekúndum líf síns fyrir ekkert
263. Út með hina ,,útvöldu".
264. Óþarfa aðgerð sem veldur varanlegu tjóni
265. Það á undir engum kringustæðum að misþyrma börnum.
266. Ég skrifa undir vegna þess að mér finnst mikilvægt að það sé á hreinu í lögum að aldrei sé gefinn afsláttur á réttindum barna/mannréttindum/jafnrétti kynjanna í skjóli menningarlegra- eða trúarlegra athafna, sé skaði fyrir hendi- sem ég tel vera í tilfellum umskurðar. Held að slíkur afsláttur í nafni trúar sé merki um stefnu í ranga átt og varasamt fordæmi.
267. Ég er á móti því að framkvædar séu óafturkræfar aðgerðir á ólögráða börnum
268. Rangt er að umskera börn af trúarlegum ádtæðum!
269. Barnið á að ráða hvort það vilji svona inngrip í líkamann er hefur aldur til
270. Ég skrifa undir vegna þess að umskurður heilbrigra kynfæra drengja er óþarfur og óafturkræfur og er brotið á mannréttindum þess sem umskurðurinn er framinn á, þar sem barnið getur ekki veitt samþykki fyrir aðgerðinni.
271. Umskurður barna er óásættanlegur. Ef þau vilja umskurð þegar þau eru eldri og hafa vit til að velja þá er það þeirra mál, en aldrei þegar þau hafa ekkert val.
272. Það á ekki að framkvæma óþarfa skurðaðgerðir á heilbriðgum, nýfæddum drengjum eingöngu útaf einhverju sem á að heita heðir. Það er alltaf hægt að umskera sig seinna á lífsleiðinni, þegar menn hafa val um það.
273. Einungis hugmyndin að umskera ungabörn er óhugnaleg!
274. Finnst algjörlega ótækt að níðast á börnum, sama hvaða form það tekur á sig.
275. þetta er ómannkegt
276. Ég styð bann á umskurði a börnum
277. þessi afskræming tilheyrir fornöld og er ekki til góðs. Kindur eru eyrnamerktar, ekki börn !
278. Ég styð bann við umskurði á kynfærum drengja á Íslandi
279. Vegna þess að einstaklingar hafa rétt á að vita hvað er gert við þá, ungabörn hafa ekki hugmynd
280. Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi og styð að þeir getir sjálfir tekið ákvörðun eftir 18 ára aldur þegar þeir hafa vit og aldur til að taka upplýsta ákvörðun.
281. ég á ekki orð um þessa meðferð á litlum drengjum sem geta sig hvergi varið. það að þetta sé ákveðið "norm" er algerlega út í hött. Banna þetta strax!
282. Fólk á að geta haft val um sinn eigin líkama og ekki á að gera óafturkræfar aðgerðir á börnum sem ekki eru nauðsynlegar fyrir heilsu þeirra.
283. Drengir eiga rétt á að taka þessa ákvörðun sjálfir þegar að þeir hafa aldur og vit til
284. Ég get ekki séð annað en að réttur einstaklingsins sé hér undirsettur rétti trúarbragðanna. Það er mér óskiljanlegt. Ef einstaklingur vill av trúarlegum ástæðum láta umskera sig - er ljóst að hann getur farið til "fegrunar"læknis, borgað uppsett gjald og gert þetta - þegar hann er 18 ára (fullráða). Umskurn á kynfærum sveinbarna er ofbeldi. Ef ekki er talin bráð nauðsyn af læknisfræðilegum ástæðum að framkvæma umskurn, á að láta

það vera. Réttur einstaklings yfir eigin líkama er æðri en réttur trúarbragða, menningaráhrifa eða siðvenja.

285. Umskuðrir eru siðferðislega rangir.
286. Mér finnst þessi aðgerð fyrir neðan allar hellur
287. Það er rétt að standa í vegi fyrir ofbeldi.
288. Ég treysti umsögnum lækna og hjúkrunarfólks á Íslandi um að þessi aðgerð á líffærum ungbarna geti verið þeim skaðleg. Gamlar trúarkreddur eiga í okkar samfélagi að víkja fyrir heilbrigðri skynsemi.
289. Inngrip í líf einstaklings..
290. Drengir geti sjálfir ákveðið þetta um18.ára aldurinn.
291. Umskurður ungbarna er áhættusöm og getur haft slæmar afleiðingar fyrir barnið, bæði andlega og líkamlega
292. Strákar eiga að fá að ráða þessu sjálfir.
293. Sjálfsagt að banna óþarfa, óafturkræfar aðgerðir á heilbrigðum börnum sem geta ekki rönd við reist. Upplýst samfélag, takk. Árið er 2018.
294. Þetta er barnaníð
295. Fáranlegt
296. Drengir eiga að geta haft möguleika á því að ráða því sjálfir
297. Siðferðislega er þetta ekki í lagi.
298. Óafturkræft inngrip í líf kornabarna er viðbjóður og galið ef trúarbrögð eiga að vega þyngra.
299. Umskurður tengist ekki trú og á að vera val hvers og eins.
300. Ég er sammála þess að það ætti að banna umskurð á heilbrigðum kynfærum drengja!
301. Mer finnst mikilvægt ad einstaklingurinn fái ad velja
302. Þetta er traumatiserandi og óþörf aðgerð á kynfærum nýfæddra drengja!
303. Þetta er óþarfi og getur leitt til vandræða seinna fyrir einstaklinginn sem var umskorinn.
304. Það er það eina rétta!
305. Fyrir börnin og þeirra rétt til eigin líkama
306. Umskurður er mjög forn og gamaldags venja sem er alveg óþörf á tímum þegar hreinlæti kemur jafnvel að betra gagni. En í fornöld og á miðöldum var auðvitað ekki alltaf góður aðgangur að góðu vatni í þeim löndum þar sem skortur var á því.
307. Finnst þetta ekki vera trúar mál þar sem barn fæðist ekki trúað heldur er það uppeldi og lifskoðanir sem myndast í gegnum árin sem stjórna því. Þeir sem vilja gangast undir svona aðgerð velja sér það þá þegar þær að kemur
308. Mannréttindi að fá að ráða svona sjálfur
309. þetta er ekkert nema ofbeldi gegn saklausum börnum.
310. Það er fáránlegt að það viðgangist að framkvæma óþarfar aðgerðir á börnum sem ekki geta veitt samþykki sitt.
311. Limlestingar á drengjum eru mannréttindabrot sem þarf að stöðva án tafar
312. Það er hið rétta.
313. Vegna þess að það á ekki að skera líkamsparta af nýfæddum börnum í þágu trúarbragða. Ef einstaklingur velur það sjálfur þegar hann er orðinn sjálfráða þá er það hans val.
314. Finnst þetta vera ofbeldi

315. Óþarfa limlestingar á kynfærum ómálga barna í nafni trúar ættu ekki að viðgangast. Flest öll rök með þessu eru byggð á löngu úreltum "vísindum" og setur þetta hefðir ofar velferð barna. Umskurður á að vera upplýst val.
316. Þetta er ógeðslegt og ætti að vera bannað helst fyrir löngu síðan!
317. Umskurður drengja er augljóslega líkamsárás. Hann er úrelt hefð sem hefur engan réttlætanlegan eða lógískan tilgang. Auðvitað á að gera hann refsiverðan eins og annað ofbeldi.
318. Finnst að það eigi að vera val hjá þeim einstaklingum, sem þetta á við, þegar þeir hafa vit til, en ekki foreldra.
319. Mér finnst líkaminn eigi að vera eins og hann er skapaður, foreldrar eiga ekki að hafa vald til að breyta líkama barnanna án þess að börnin hafi neitt um það að segja.
320. Ég er á móti því að beita börn ofbeldi og valda þeim sársauka.
321. Ég skrifa undir vegna þess að ég er á móti óþarfa lilestingum sér í lagi á börnum
322. Einstaklingur á skilið val
323. Ég stið frumvarpið heilhugar
324. hver og ein ræður yfir sínum líkama Ef hann vil umskurð getur hann gert það þegar hann hefur aldur til að taka slíka ákvörun sjálfur
325. Því ég tel það siðferðislega rangt að gera ómálga börnum þetta. Þetta er óþarfa aðgerð og er ekkert annað en limlesting ungbarna. Nei takk.
326. þetta er ekkert annað en ofbeldi gagnvart varnarlausum börnum.Merkilegt hvað líðst í nafni ákveðinna trúarbragða, það myndi eitthvað heyrast ef heiðnir menn fórnuðu geit en þykir sjálfsagðasta mál að gyðingar og múslímar ráðist á nýfædda drengi með eggvopnum. Að þetta skuli vera leyft í hinum vestræna heimi er einfaldlega skandall og til skammar fyrir þau samfélög sem hlut eiga að máli.
327. Drengir eiga að ráða þessu sjálfir
328. Ég skrifa undir af því að þetta er svo rangt að grípa inn í líkaman við erum sköpuð með allt sem er eðlilegt og það er einhver ástæða fyrir því að við erum með alla þessa líkamshluti það hlítur að þjóna einhverjum tilgangi .
329. Þetta er rangt sama hvernig á það er litið.
330. Mér finnst þetta vera ofbeldi gegn barninu og ef það er þetta sem þarf fyrir trúna þarf að endurskoða trúarbrögðin. Allur vafi á að vera barninu í hag.
331. Sú athöfn að skera heilbrigðan part af líkama barna er gróft ofbeldi sem enginn ætti að samþykkja eða taka þátt í. Trúfrelsi og menning skipta engu máli þegar við erum að tala um slíkt því að engin ástæða/réttlæting er gild til þess að horfa framhjá þjáningu barns.
332. Einstaklingur sem stjórnar sýnum líkama sjálfur.
333. Eg er á móti umskurdi
334. Ég get ekki stutt við barnaníð og það er akkúrat það sem þetta er. Burt séð frá trúanrögðum þá er þetta og verður alltaf barnaníð.
335. Að mér finnst þetta eigi að vera ákvörðun hvers og eins þegar viðkomandi er búinn að ná sjálfstæðisaldri.
336. Látið tippin í friði!!!
337. Þetta á að vera drengurinn sem á að ráða þessu 18 ára

338. Ég styð bann við umskurð á heilbrigðum kynfærum drengja á Íslandi og styð að þeir getir sjálfir tekið ákvörðun eftir 18 ára aldur þegar þeir hafa vit og aldur til að taka upplýsta ákvörðun.
339. mannréttind yfir trúarbragðakreddur
340. Því það er ekkert sem réttlætir þessar pintingar
341. Það á engan vegin við að skera líkamshluta af börnum nema það sé eitthvað að þeim líkamlega og lækningar þurfi við.
342. Eg skrifa undir vegna þess að eg vil vernda ungabörn fyrir fornaldartrúarbrögðum sem vilja limlesta þau. Líka í leiðinni henda inn að banna Child Rapists International (kaþólskakirkjan) á Íslandi
343. Kynlíf umskorinna karla er þeim meiri þraut, en almennt er talað um.
344. Fólk á að hafa val um lýtaaðgerðir á sjálfum sér
345. Engin haldbær rök hafa verið lögð fram afhverju þetta ætti að meiga í öðrum tilgangi en læknisfræðilegum.
346. Mér finnst þetta mannréttindabrot! Drengir eiga fá að ráða þessu sjálfir
347. Ég er þeirrar skoðunar að inngrip í líkama barna sé aldrei réttlætanlegt nema um læknisfræðileg atvik sé að ræða.
348. Trúarvenjur eiga ekki að trompa barnaverndarlög og ráðleggingar menntaðra heilbrigðisstarfsmanna.
349. Ég styð bann við umskurð kynfæra á drengjum Ísland því að mér finnst að þeir ættu að taka áhvörðun um mað sjálfir þegar þeir eru 18 ára eða eldri.
350. Umskurður nýfæddra drengja er ekkert annað en misþyrming og á engan vegin rétt á sér.
351. Þetta er frumstæð trúarvillimennska!
352. Mér finnst þetta villimennska að misþyrma barni á þennan hátt
353. Í gömlum norrænum bókum var umskurður kallaður hreinlífismark: hann markaði sik sjálfan því hreinlifis marki, Ver. 14 (of the circumcision). Að hann skyldi gera þetta sjálfur er vissulega aðdáunarvert en eitthvað held ég nú samt að hnífurinn hafi skolfið í höndum honum. En að slíkar afturúrlistir fortíðar skuli ennþá vera stundaðar á nýfæddum börnum er auðvitað barbarismi og furðulegt að guðsfólk skuli taka upp hanskann fyrir slíkt rugl, þar sem slíkar manneskjur halda því daglega fram að guð skapaði manninn í sinni mynd, en svo er allt í einu kominn hnífur á loft til að skera forhúðina af. Situr guð þá þarna uppi með hettuböll sinn (útsk. penis hvis Forhud helt dækker Penis (mods. stingböllur)) og kveinkar sér við hverja forhúð sem fýkur af sveinbarni? Eða er honum - einsog flestum núorðið - nokk sama um karlmenn og réttindi þeirra? Ég veit það ekki, hef ekki hitt þann skeggbraga. En líklega segir hann einsog flestir: Þetta er hefð, þetta er allt annað en umsurður stúlkna, læknasamband BNA mælir með þessu, Egyptar vissu hvað þeir sungu, Gyðingar eiga eftir að fordæma okkur, verðum að virða trú annarra... Vissulega er margt til í þessu öllu saman, en fjandinn hafi það, ég er á móti þessu rugli, forhúðin er ekkert ostagerðarform (smegma) sýkla, þetta er þarna til að gera heiminn friðvænlegri. Alls staðar þar sem þetta er stundað lifir reiðin góðu lífi, og auðvitað er þetta sagt í hálfkæringi - en þetta gæti hugsanlega verið satt, þó ég efist um það. Ég gæti samt ekki verið án minnar forhúðar, hvernig ætti ég annars að geta komið konunni á óvart um páskana með svona litlum upprúlluðum málshætti, falinn undir húðinni góðu: Lítið þarf lipran að keyra.

354. Mannréttindi trompa trúfelsi
355. annað er óeðlilegt!
356. Mér finnst þetta vera ómannúðleg meðferð og lífsgæðaskerðing á ósjálfbjarga börnum.
357. Mig hrikkir við þessum misþyrmingum á ómálga drengjum
358. Brot á mannréttindum! Ekki samþykki bsrnsins!
359. Þetta á að vera val drengjanna
360. Þetta á að vera val barnsins
361. Umskurður er viðbjóður
362. Ég skrifa undir vegna þess að þetta er óþörf aðgerð og kvalafull.
363. strákar eiga að fá að velja þetta sjálfir
364. mér finnst að strákar eiga sjálfir að geta tekið þessa ákvörðun.
365. Ég skrifa undir vegna þess að ég styð ekki pyntingar.
366. Þetta á bara að vera réttur hvers og eins að taka ekki foreldra
367. Umskurður á litlum börnum er barnaníð.
368. Ómannúðlegt og siðlaust
369. umskurður á börnum er eitthvað sem á ekki að viðgangast á 21öldini
370. brot á mannréttindum ungra barna
371. Ég skrifa undir vegna þess að mr finst að þeir eigi að ráða þessu sjálfir !
372. Ef allt er í lagi á þetta að vera val þess sem mun lifa með þessu
373. Umskurðir eru óþarfa líkamsbreytingar sem gerðar eru á börnum. Það er verið að svipta barn ákvörðunarrétti á einhverju sem mun hafa endanlegar breytingar í för með sér og ekki er aftur snúið. Þetta er einfaldlega ómannúðlegt
374. Þetta skal hætta!
375. Þetta er bara rangt og ljótt að gera svona við lítil börn!!!
376. Þetta er bara rangt og Það er bara hræðilegt að vera að brjóta svona á líkama drengja, þeir eiga að fá að ákveða það sjálfir hvort þetta sé gert við þá!að gera svona við lítil börn!!!

Alþingi
Kirkjustræti
150 Reykjavík

Subject: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágætu þingmenn Alþingis / Dear Members of the Icelandic Parliament,
as a charitable non-governmental organization speaking up for genital integrity and autonomy as an essential human right, we are very pleased to see your introduction of a bill to ban non-therapeutic amputations of boys' foreskins ("circumcisions"). Many of our members are men affected by circumcision, who justifiably feel impinged upon their rights of bodily integrity, as well as their freedom of personality and religion. Men affected by circumcision often experience themselves severely limited in their sexual sensation and some even feel mutilated due to the amputation of their foreskin. The procedure of circumcision itself is frequently undergone as a totally traumatic event, even if carried out under anaesthetic.
Thus, we want to encourage you to be the first country to act on the commitment to the UN-Convention of the Rights of the Child regarding the issue of male infant circumcision.
A short overview of the most essential information about "circumcision" can be found in our leaflet at https://intaktiv.de/wp-content/uploads/2017/10/Leaflet_intaktiv-MGM_V2e_10-2017.pdf
Kind regards,
intaktiv e.V. - A Voice for Genital Autonomy
--
intaktiv e.V.
Postfach 2449
55014 Mainz, Germany
vorstand@intaktiv.de
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Umsögn um umskurðarfrumvarpið

Í tilefni þess að Alþingi hefur nú tekið til umfjöllunar frumvarp til laga þar sem umskurður drengja yrði bannaður og gerður að saknæmu athæfi viljum við í Stofnun múslima á Íslandi koma eftirfarandi á framfæri.

Við styðjum af heilum hug yfirvegaða og ígrundaða umræðu um þann sið að umskera drengi en þar er um viðtekinn sið að ræða víða um heim sem snýr í senn að trúarlegri sannfæringu og heilbrigði. Alþingi verður að taka mið af slíkum sjónarmiðum í umfjöllun sinni um frumvarpið og gæta þar að vægi trúfrelsis, rétti barna til fullrar aðildar að samfélagi síns fólks á grundvelli sjálfsmyndar þess og sjónarmiðum þeirra fjölmörgu lækna og heilbrigðissamtaka m.a. á vettvangi Sameinuðu þjóðanna sem ýmist sjá ekkert athugavert við umskurð eða telja hann mikilvægan fyrir heilbrigði og velferð viðkomandi drengja. Ennfremur andmælum við því að umskurður drengja sé brot á barnasáttmála Sameinuðu þjóðanna eða í andstöðu við læknaeiðinn.

Trúarlegt vægi umskurðar

Ísland er ríki sem vill standa vörð um mannréttindi og byggir siðferðilegar rætur sínar á kristinni trúarhefð eins og hún er varðveitt hjá lúthersku þjóðkirkjunni. Bakgrunnur kristinnar trúar og Nýja testamentisins er Gamla testamentið en þann grunn eiga kristindómur og íslam sameiginlegan með gyðingdómi. Í Gamla testamentinu er að finna trúarlegar ástæður þess að gyðingar telja umskurð ófrávíkjanlegt skilyrði (1 Mós 17) og við múslimar teljum sömuleiðis að fylgja beri fordæmi spámannanna sem allir hafi verið umskornir. Umskurður drengja á sér því margra alda rótgróna hefð í trúarbrögðum íslams og gyðingsdóms og skipar þar stóran sess.

Mikilvægi trúfrelsis

Í VI. kafla stjórnarskrár lýðveldis Íslands er skýrt kveðið á um trúfrelsi:

> ■ **63.gr.**
> ☐ Allir eiga rétt á að stofna trúfélög og iðka trú sína í samræmi við sannfæringu hvers og eins.
> Þó má ekki kenna eða fremja neitt sem er gagnstætt góðu siðferði eða allsherjarreglu.

Þessi grein stjórnarskrárinnar er í samræmi við VII. kafla hennar sem er mannréttindakaflinn. Mikilvægur hluti trúariðkunar múslima og gyðinga er að láta umskera syni sína og hefur sá siður hvergi verið talinn brjóta gegn góðu siðferði eða allsherjarreglu fram til þessa, hvorki hér á landi né annars staðar í heiminum. Að þrengja svo mjög hið góða siðferði að umskurður drengja yrði gerður glæpsamlegur stríðir gegn öðrum ákvæðum stjórnarskrárinnar um mannréttindi eins og trúfrelsi og er slíkt alls ekki í þágu allsherjarreglu samfélagsins.

Umskurður er hluti af sáttmála manns við Guð og hefur fylgt trúarbrögðum okkar frá upphafi. Fylgjendur íslams líta svo á að það sé heilög skylda okkar við Guð að veita sonum okkar umskurð. Við teljum að það sé óásættanlegt inngrip að banna umskurð drengja með lögum enda séu forsendur trúfrelsis í landinu brostnar með slíku banni. Í samfélagi okkar íslamstrúarmanna hér á Íslandi sem og annars staðar hefur þetta verið hluti af menningu okkar frá því að elstu menn muna. Við erum umskornir, feður okkar eru umskornir, afar okkar voru umskornir og þannig eins langt aftur og skráðar heimildir ná.

Við teljum að þetta frumvarp einkennist af djúpstæðri vanþekkingu á trúarbrögðum bæði gyðinga og múslima. Við teljum ennfremur að þeir sem leggja þetta frumvarp fram geri sér ekki grein fyrir afleiðingum þess að banna umskurð drengja og þeirri djúpstæðu skömm sem því fylgir fyrir karlmenn úr röðum múslima að vera ekki umskornir allt frá æsku. Þetta er nokkuð sem við getum ekki samþykkt enda myndi það meina okkur um að fá að lifa frjálsu lífi og öðlast þá lífshamingju sem varið er í stjórnarskránni. Samfélag múslima er minnihlutahópur á Íslandi og við upplifum þetta þannig að verið sé að níðast á tilveru okkar. Slíkt bann myndi setja okkur í þung spor í tengslum við ættingja okkar í öðrum löndum og múslima almennt. Vissulega erum við í minnihluta hér á landi en í heiminum öllum aðhyllist 1,8 milljarður íslamstrú og gyðingar eru 14,3 milljónir að auki. Með því að banna umskurð myndi Ísland setja verulegar skorður á trúfrelsi þessa fólks og stíga langt skref í því að úthýsa því.

Mörg okkar erum í dag íslenskir ríkisborgarar og langflest teljum við Ísland vera heimili okkar. Það myndi særa okkur öll djúpt ef að slík lög yrðu samþykkt sem myndu í raun úthýsa okkur sem múslimum frá þessu kæra heimalandi okkar enda væri búið að gera trúarskyldu okkar glæpsamlega. Við yrðum þvinguð til að gera upp á milli heimalands okkar og sambands okkar við Guð. Það er til of mikils ætlast og að öllu leyti andstætt mannréttindum og stjórnarskránni að þvinga fólk til að gera upp á milli heimalands síns og trúar sinnar.

Við biðjum því löggjafarvaldið fyrir alla muni að taka tillit til þessara sjónarmiða í vinnu sinni.

Mikilvægi umskurðar fyrir heilbrigði

Þó svo að trúarlegt vægi umskurðar sé ótvírætt bæði innan íslams og gyðingdóms eru heilbrigðisforsendur hans sömuleiðis verulegar. Vægi umskurðar einskorðast því engan veginn við trúarbrögð. Í Bandaríkjunum er stór hluti karlmanna umskorinn óháð trúarbrögðum og sömuleiðis í Afríku. Í mörgum löndum er þetta gert vegna þess að læknar og heilbrigðisyfirvöld telja að umskurður drengja dragi úr líkum á ýmsum sýkingum og sjúkdómum, svo sem kynsjúkdómum, og er það stutt af m.a. Alþjóðaheilbrigðismálastofnun Sameinuðu þjóðanna (WHO) og Alþjóðabankanum.

Við hjá Stofnun múslima á Íslandi gerum ríkar kröfur til framkvæmdar við umskurð drengja og teljum að umskurður ætti eingöngu að eiga sér stað hjá faglega menntuðu starfsfólki heilsugæslustofnana og þá helst læknum. Innan íslams er engin krafa um að umskurður sé framkvæmdur sem hluti af trúarathöfn og hér á Íslandi höfum við fram til þessa verið í góðri samvinnu við heilsugæsluna um framkvæmd hennar.

Við myndum hiklaust styðja lagasetningu þar sem eðlileg framkvæmd umskurðar yrði skilgreind og aðkoma heilbrigðisstarfsfólks á borð við lækna yrði sett sem skilyrði en við erum algerlega mótfallin því að þessi trúarlegi og heilsufarslegi siður sé gerður að refsiverðu athæfi.

Þá bendum við á að umskurður drengja er ekki í andstöðu við læknaeiðinn, hvorki hér á landi né annars staðar svo við vitum til. Það telst grundvallaratriði að hindra sjúkdóma enda er forvörn betri en lækning. Genfaryfirlýsing Alþjóðafélags lækna bindur lækna með orðunum: „Ég mun hafa heilsu sjúklinga minna að leiðarljósi framar öllu öðru.“ Og í Alþjóðasiðareglum lækna er því lýst yfir að læknar skuli aðeins gera það sem er sjúklingnum fyrir bestu, þegar þeir veiti læknisþjónustu. Loks er ekkert í Helsinki yfirlýsingunni sem er gagnstætt umskurði en hún snýr að læknisfræðilegum rannsóknum.

Við sem tilheyrum samfélagi múslima á Íslandi teljum að þar til börn hafi náð sjálfræðisaldri sé það á ábyrgð foreldra þeirra að taka ákvarðanir fyrir þau. Á hverjum degi sinna foreldrar uppeldi og trúariðkun barna sinna, láta þau borða og sofa, senda þau í skóla og á margvíslegar æfingar og leitast við með öllum tiltækum ráðum að tryggja öryggi þeirra, heilbrigði og velferð. Þetta er hluti að eðlilegum samskiptum á milli barns og foreldris.

Í frumvarpinu sem beint er gegn umskurði drengja er því haldið fram að hann sé brot á barnasáttmála Sameinuðu þjóðanna sem þegar hafi verið lögfestur hér á landi. Þessari rangfærslu um barnasáttmálann andmælum við og bendum á að ekkert í honum sé andstætt umskurði drengja heldur þvert á móti standi sáttmálinn vörð um hann á grundvelli velferðar viðkomandi barna. Barnasáttmálinn hefði aldrei verið samþykktur á vettvangi Sameinuðu þjóðanna ef honum hefði verið beint gegn umskurði drengja með einhverjum hætti og þar með gyðingdómi og íslam. Það er ennfremur ljóst af stuðningi Sameinuðu þjóðanna við umskurð drengja í gegnum t.d. Alþjóðaheilbrigðismálastofnunina WHO að þær telja hann alls ekki brot á barnasáttmálanum.

Að lokum

Við biðjum Alþingi að taka tillit til alls þessa og ekki gera trúarlegar og samfélagslegar skuldbindinar okkar glæpsamlegar í þessu landi.

Stofnun múslima á Íslandi lýsir sig reiðubúið að taka þátt í frekari umræðu um þessi mál og bjóða fram alla þá aðstoð sem við getum veitt.

Virðingarfyllst,

Fyrir hönd Stofnunar múslíma á Íslandi
Mr. Karim Askari
Framkvæmdastjóri Stofnunar múslíma á Íslandi

2.mars 2018

Stuðningur við frumvarp á almennum hegningarlögum nr. 19/1940, þingskjal 183-114. mál (umskurn drengja)

Ágæta nefndasvið Alþingis,

Meðfylgjandi er yfirlýsing með undirskriftum frá 1.325 hjúkrunarfræðingum og ljósmæðrum sem vilja koma á framfæri stuðningi sínum við frumvarp um breytingu á almennum hegningarlögum nr. 19/1940, þingskjal 183-114. mál (umskurn drengja).

Við undirrituð í viðhengi, íslenskir hjúkrunarfræðingar og ljósmæður, lýsum yfir stuðningi við frumvarp til breytinga á almennum hegningarlögum þar sem umskurður drengja er bannaður nema læknisfræðilegar ástæður liggi til grundvallar. Sjá; https://www.althingi.is/altext/148/s/0183.html

Siðareglur hjúkrunarfræðinga kveða á um að hjúkrunarfræðingar eigi að vera málsvarar skjólstæðinga sinna og standa vörð um sjálfsákvörðunarrétt þeirra.
Í siðareglum ljósmæðra er kveðið á um að í umönnun sinni fyrir konum og fjölskyldum þeirra virða ljósmæður sjónarmið ólíkra menningarheima en reyna jafnframt að útrýma heilsuspillandi aðferðum sem þar eru viðhafðar.

Í ljósi þess vilja hjúkrunarfræðingar og ljósmæður styðja þetta mikilvæga frumvarp. Umskurður án læknisfræðilegrar ástæðu, er brot á réttindum allra barna og samræmist ekki Barnasáttmála Sameinuðu þjóðanna. Umskurður af trúarástæðum er ónauðsynleg aðgerð sem hefur í för með sér þjáningu, hættu á blóðmissi, sýkingu og veldur óafturkræfum breytingum á líkama barnsins.

Við umskurð er forhúðin fjarlægð. Forhúðin á litlum drengjum verndar getnaðarliminn fyrir óhreinindum og sýkingum. Hún er mjög næm þar sem í henni eru mörg þúsund taugaenda. Á Íslandi hafa þessar aðgerðir alltaf verið gerðar í svæfingu. Það á því miður ekki við í öllum löndum þar sem þekkt er að aðgerðin er víða framkvæmd í engri

eða ófullnægjandi deyfingu og ekki bara á sjúkrahúsum heldur einnig í heimahúsum og framkvæmd af trúarleiðtogum en ekki læknum. Aðgerðin getur því verið mjög sársaukafull eins og gefur að skilja. Eftir aðgerðina finna börnin líka sársauka sem þau skilja ekki og geta ekki tjáð sig um.

Öllum aðgerðum fylgir viss áhætta og umskurði geta fylgt alvarlegir fylgikvillar sem hafa áhrif á líf einstaklinganna alla ævi. Það er mikilvægt að réttur barns til heils líkama sé virtur og að hann vegi þyngra en réttur foreldra til taka ákvarðanir byggðar á trúarlegum eða menningarlegum hefðum. Kjósi drengir síðar að fylgja hefðum geta þeir gengist undir aðgerðina þegar þeir hafa náð 18 ára aldri og gera sér grein fyrir eðli aðgerðarinnar. Það er þá alfarið þeirra val.

Á Íslandi hafa þegar verið sett lög (nr.19/1940, með síðari breytingum) sem banna hverskyns limlestingar á kynfærum kvenna. Nú viljum við sjá að drengjum verði með lögum tryggð sama vernd og sömu réttindi.

Virðingarfyllst,
fyrir hönd undirskrifenda
Íris Björg Þorvaldsdóttir, hjúkrunarfræðingur og sundhedsplejerske
Katrín Sif Sigurgeirsdóttir, hjúkrunarfræðingur og ljósmóðir

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
2/26/2018 17:09:35	Ósk Geirsdóttir, hjúkrunarfræðingur og ljósmóðir
2/26/2018 17:16:48	Erna Margrét Arnardóttir, hjúkrunarfræðingur
2/26/2018 17:24:04	Marta Jónsdóttir hjúkrunarfræpingur
2/26/2018 17:28:02	Arna Magnúsdóttir svæfingahjúkrunarfræðingur
2/26/2018 17:31:34	Svanhildur Sigurjónsdóttir, hjúkrunarfræðingur
2/26/2018 17:31:57	Hulda Dagmar Reynisdóttir, hjúkrunarfræđingur
2/26/2018 17:32:16	Helga Guðmundsdóttir, hjúkrunarfræðingur
2/26/2018 17:33:43	Kristín Greta Bjarnadóttir hjúkrunarfræðingur og ljósmóðurnemi
2/26/2018 17:34:48	Sandra Friðriksdóttir hjúkrunarfræðingur
2/26/2018 17:39:43	Ásta Kristín Andrésdóttir, hjúkrunarfræðingur
2/26/2018 17:40:19	Gerður Sif Skúladóttir, hjúkrunarfræðingur.
2/26/2018 17:43:14	Ástríður Hannesdóttir hjúkrunarfræðingur
2/26/2018 17:43:51	Tómas Eldjárn Vilhjálmsson Hjúkrunarfræðinemi
2/26/2018 17:45:08	Helga Ágústa Eggertsdóttir Hjúkrunarfræðingur
2/26/2018 17:47:06	Björk Tryggvadóttir Hjúkrfr/ljósmóðir
2/26/2018 17:47:20	Sigrún Rósa Vilhjálmsdóttir, ljósmóðir og hjúkrunarfræðingur
2/26/2018 17:48:19	Guðrún Guðbjartsdóttir Ljósmóðir
2/26/2018 17:48:48	Guðrún Svava Stefánsdóttir hjúkrunarfræðingur
2/26/2018 17:49:18	Maria Rebekka Þorisdottir, ljósmóðir
2/26/2018 17:54:25	Hildur S. Ragnarsdóttir
2/26/2018 17:56:57	Hrafnhildur Lóa Guðmundsdóttir Ljósmóðir og Hjúkrunarfræðingur
2/26/2018 17:59:17	Sólveig Gunnarsdóttir, hjúkrunarfræðingur
2/26/2018 18:08:22	Theodóra Hauksdóttir Hjúkrunarfræðingur
2/26/2018 18:17:13	Unnur Gunnarsdóttir, hjúkrunarfræðingur
2/26/2018 18:17:16	Brynja Ingadóttir, hjúkrunarfræðingur
2/26/2018 18:23:39	Sigurlinn Svafnisdottir ljosmoðir
2/26/2018 18:26:08	Gerður Eva Guðmundsdóttir, ljósmóðir og hjúkrunarfræðingur
2/26/2018 18:29:08	Rannvig Þorvarðardóttir, skurðhjúkrunarfræðingur.
2/26/2018 18:32:47	Hafdís Björg Sigurðardóttir, hjúkrunarfræðingur
2/26/2018 18:42:16	Sólveig Steina Þorleifsdóttir, hjúkrunarfræðingur
2/26/2018 18:43:48	Jórunn Þórðardóttir hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
2/26/2018 18:46:18	Sigríður Stefánsdóttir, hjúkrunarfræðingur
2/26/2018 19:10:03	þórstína Unnur Aðalsteisdóttir, hjúkrunarfræðingur og ljósmóðir.
2/26/2018 19:10:13	Soffía Steingrímsdóttir, hjúkrunarfræðingur
2/26/2018 19:26:31	Harpa Ragnarsdóttir hjúkrunarfræðingur
2/26/2018 19:28:07	Gígja Grétarsdóttir, hjúkrunarfræðingur
2/26/2018 19:28:00	Gígja Grétarsdóttir, hjúkrunarfræðingur
2/26/2018 19:29:14	Anna Sigríður Brynjólfsdóttir, hjúkrunarfræðingur
2/26/2018 19:29:41	Ásta Ásgeirsdóttir, hjúkrunarfræðingur
2/26/2018 19:29:54	Elísabet Harles, hjúkrunarfræðingur
2/26/2018 19:31:28	Guðrún Valdimarsdóttir, skurðhjúkrunarfræðingur
2/26/2018 19:33:36	Berglind Harpa Svavarsdóttir, hjúkrunarfræðingur.
2/26/2018 19:40:51	Inga Sigríður Árnadóttir Ljósmóðir/Hjúkrunarfræðingur
2/26/2018 19:55:24	Jenný Guðmundsdóttir hjúkrunarfræðingur
2/26/2018 20:10:09	Rósa Bragadóttir Ljósmóðir
2/26/2018 20:17:01	Hólmfríður Margrét Bjarnadóttir Hjúkrunarfræðingur
2/26/2018 20:29:46	G. Erna Valentínusdóttir ljósmóðir og hjúkrunarfræðingur
2/26/2018 20:35:19	Steinunn Bergs hjúkrunarfræðinemi
2/26/2018 20:54:07	Kristín Hulda Óskarsdóttir, hjúkrunarfræðingur
2/26/2018 21:07:38	Stella I. Steinþórsdóttir, ljósmóðir
2/26/2018 21:30:56	Kolbrún Þorsteinsdóttir
2/26/2018 22:03:54	Rut Eiríksdóttir, hjúkrunarfræðingur
2/26/2018 22:27:11	Guðbjörg Vallaðsdóttir Ljósmóðir.
2/26/2018 22:27:43	Jóhanna M Sveinsdóttir, svæfingahj.fr
2/26/2018 22:29:42	Edda Traustadóttir Deildarstjóri
2/26/2018 23:39:39	Arna Borg Einarsdóttir Hjúkrunarfræðingur
2/26/2018 23:49:02	Anne María Steinþórsdóttir, hjúkrunarfræðinemi
2/26/2018 23:54:08	Sigríður Eva Magnúsdóttir
2/27/2018 8:54:55	Guðlaug Erla Vilhjálmsdóttir, ljósmóðir
2/27/2018 10:03:58	Hafdís Rúnarsdóttir ljósmóðir
2/27/2018 10:12:06	Helga R.Höskuldsdóttir ljósmóðir

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
2/27/2018 10:20:23	Berglind Ósk Sigurðardóttir, hjúkrunarfræðingur
2/27/2018 10:38:35	Lilja Jónsdóttir Hjúkrunarfræðingur
2/27/2018 10:42:52	Nanna Ólafsdóttir hjúkrunarfræðingur
2/27/2018 10:44:47	Erla Þorvaldsdóttir hjúkrunarfræðingur
2/27/2018 12:06:30	Sigríður Ósk Lárusdóttir hjúkrunarfræðingur
2/27/2018 12:10:10	Oddný Ösp Gísladóttir, ljósmóðir og hjúkrunarfræðingur
2/27/2018 12:27:01	Telma Ýr Sigurðardóttir
2/27/2018 13:43:25	Jónína H Haflidadottir sérfræðingur í hjúkrun
2/27/2018 14:47:08	Hanna Kolbrún Jónsdóttir. Hjfr.
2/27/2018 14:53:36	Vala Guðmundardóttir hjúkrunarnemi
2/27/2018 16:14:45	Oddfríður Jónsdóttir, hjúkrunarfræðingur
2/27/2018 16:36:19	Bjarnheiður M Ingimundardóttir, hjúkrunarfræðingur
2/27/2018 17:07:39	Bjarney Hrafnberg, ljósmóðir og hjúkrunarfr.
2/27/2018 17:49:14	Margrét Guðmundsdóttir ljósmóðir
2/27/2018 19:10:30	Hildur Guðrún Elíasdóttir hjúkrunarfræðingur
2/27/2018 19:44:59	Ólafía Sigurðardóttir Hjúkrunarfæðingur
2/27/2018 19:50:32	Jóhanna Sigtryggsdóttir, hjúkrunarfræðingur
2/27/2018 20:19:18	Steingerður Örnólfsdóttir Hjúkrunarfræðingur
2/27/2018 20:32:54	Kristín Guðjónsdóttir, hjúkrunarfræðingur
2/27/2018 20:55:03	Amalia Vilborg Sörensdóttir hjúkrunarfræðingur
2/27/2018 22:42:07	Steina Árnadóttir Hjúkrunarfræðingur
2/27/2018 22:42:59	Helga Jòhanna Hrafnkelsdottir .Hjùkrunarfræðingur
2/27/2018 23:27:54	Dröfn Kristmundsdóttir deildarstjóri
2/28/2018 7:47:57	Björg Skúladóttir hjúkrunarfræðingur
2/28/2018 8:27:17	Guðrún Sigríður Ólafsdóttir, ljósmóðir og hjúkrunarfræðingur
2/28/2018 13:32:08	Ingibjörg Guðmunda Sveinsdóttir - Hjúkrunarfræðingur
2/28/2018 15:40:28	Fanný Berit Sveinbjörnsdóttir ljósmóðir
3/1/2018 11:57:04	Sigríður Kristinsdóttir hjúkrunarfræðingur
3/2/2018 10:59:02	Hrafnhildur Björk Brynjarsdóttir, svæfingahjúkrunarfræðingur
	Íris Björg Þorvaldsdóttir Hjúkrunarfræðingur og sundhedsplejerske

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan	
	Katrín Sif Sigurgeirsdóttir Hjúkrunarfræðingur og Ljósmóðir	
	Linda Björk Snorradóttir Hjúkrunarfræðingur	
	Halldóra Hafdís Arnardóttir Hjúkrunarfræðingur	
	Jóhanna Þórey Sveinþórsdóttir Hjúkrunarfræðingur	
	Helen Valdís Sigurðardóttir Hjúkrunarfræðingur	
	Elísabet Heiðarsdóttir Hjúkrunarfræðingur og Ljósmóðir	
	Áslaug Hauksdóttir Ljósmóðir/Hjúkrunarfræðingur	
	Gréta María Björnsdóttir Hjúkrunarfræðingur	
	Guðrún Ösp Theodórsdóttir Bráðahjúkrunarfræðingur	
	Lilja Einarsdóttir Hjúkrunarfræðingur	
	Edda Rún Kjartansdóttir Hjúkrunarfræðingur og ljósmóðurnemi	
	Sigrún Þórisdóttir Hjúkrunarfræðingur	
	Bergþóra Einarsdóttir Hjúkrunarfræðingur	
	Íris Gísladóttir Hjúkrunarfræðingur	
	Sigrún Stefánsdóttir Hjúkrunarfræðingur	
	Hulda Birgisdóttir Hjúkrunarfræðingur	
	Halldóra Karlsdóttir Hjúkrunarfræðingur og Ljósmóðir	
	Aðalheiður Harðardótir Hjúkrunarfræðingur	
	Guðlaug María Sigurðardóttir Ljósmóðir	
	Signý Scheving Þórarinsdóttir Ljósmóðir og Hjúkrunarfræðingur	
	Steinunn Helga Sigurðardóttir Hjúkrunarfræðingur	
	Ella Björg Rögnvaldsdóttir ljósmóðir og hjúkrunarfræðingur	
	Snjólaug Gunnarsdóttir, hjúkrunarfræðingur	
	Ilmur Dögg Níelsdóttir Hjúkrunarfræðingur	
	Lára Viðarsdóttir Hjúkrunarfræðingur	
	Hugrún Jóna Hilmarsdóttir Hjúkrunarfræðingur	
	Þórunn Einarsdóttir Hjúkrunarfræðingur	
	Halla Sigrún Arnardóttir Hjúkrunarfræðingur	
	Margrét Hrönn Svavarsdóttir, Hjúkrunarfræðingur.	
	Jóhanna Þorvarðardóttir Hjúkrunarfræðingur	

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan	
	Jóhanna María Þórhallsdóttir Hjúkrunarfræðingur	
	María Ósk Gunnsteinsdóttir Hjúkrunarfræðingur	
	Nanna Kristín Johansen Hjúkrunarfræðingur	
	Hildur Á. Ármannsdóttir Ljósmóðir	
	Anna Soffía Guðmundsdóttir Hjúkrunarfræðingur	
	Rebekka stefansdóttir. Hjúkrunarfræðingur	
	Gerður Ósk Jóhannsdóttir, Hjúkrunarfræðingur	
	Gunnar Pétursson, hjúkrunarfræðingur	
	Björk Tryggvadóttir hjúkrunarfræðingur og Ljósmóðir	
	Birna Gestsdóttir. hjúkrunarfræðingur	
	Lydía Stefánsdóttir Ljósmóðir/hjúkrunarfræðingur	
	Ástrós Ingvadóttir Hjúkrunarfræðingur	
	Kristrún Ástvaldsdóttir hjúkrunarfræðingur	
	Anna Margrét Magnúsdóttir Hjúkrunarfræðingur	
	Sigrún Erla Sveinsdóttir hjúkrunarfræðingur	
	Soffía Hauksdóttir skurðhjúkrunarfræðingur	
	Björg Guðmundsdóttir Hjúkrunarfræðingur	
	Theodóra Reynisdóttir hjúkrunarfræðingur	
	Sigrún Kristjánsdóttir, Ljósmóðir	
	Áslaug Björnsdóttir, Hjúkrunarfræðingur	
	Sæbjörg Lára Másdóttir, hjúkrunarfræðingur	
	Elísabet Ester Sævarsdóttir Hjúkrunarfræðingur	
	Kristín Theodóra Nielsen Hjúkrunarfræðingur og ljósmóðir.	
	Inga María Hlíðar Thorsteinson, hjúkrunarfræðingur og ljósmóðurnemi	
	Baldvina Ýr Hafsteinsdóttir Hjúkrunarfræðingur	
	Hafdís Ólafsdóttir Hjúkrunarfræðingur og ljósmóðir	
	María Guðrún Þórisdóttir Hjúkrunarfræðingur og ljósmóðir	
	Sigurborg Eyjólfsdóttir Hjúkrunarfræðingur	
	Áslaug Salka Grétarsdóttir Hjúkrunarfræðingur	
	Rakel Ösp Hafsteinsdóttir Hjúkrunarfræðingur og Ljósmóðir	

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Valgerður Lísa Sigurðardóttir Ljósmóðir og hjúkrunarfræðingur
	Sunna K. Jónsdóttir Hjúkrunarfræðingur
	Kristín V. Þórðardóttir Hjúkrunarfræðingur
	Elín María Sigurðardóttir Hjúkrunarfræðingur
	Anna Guðríður Gunnarsdóttir Hjúkrunarfræðingur
	Rut Guðnadóttir hjúkrunarfræðingur
	Hildur María Kristbjörnsdóttir Hjúkrunarfræðingur
	Guðbjörg Hulda Einarsdóttir Hjúkrunarfræðingur
	Kristín Lilja Svansdóttir Hjúkrunarfræðingur
	Þórdís Borgþórsdóttir Svæfingahjúkrunarfræðingur
	Stefanía B. Arnardóttir Sérfræðingur í hjúkrun á sviði heilsuverndar
	Hildur Helgadóttir Hjúkrunarfræðingur og Ljósmóðir
	Hrafnhildur Ólafsdóttir Hjúkrunarfræðingur og Ljósmóðir
	Sigrún Skúladóttir Hjúkrunarfræðingur
	Anna María Þórðardóttir Hjúkrunarfræðingur
	Þórdís Hulda Tómasdóttir Hjúkrunarfræðingur
	Vaka Kristjánsdóttir Hjúkrunarfræðingur
	Ásta Dröfn Björgvinsdóttir Hjúkrunarfræðingur
	Signý Sveinsdóttir Hjúkrunarfræðingur
	Hanna Jóna Ragnarsdóttir Hjúkrunarfræðingur
	Jóhanna Hildiberg Harðardóttir hjúkrunarfræðingur
	Guðrún Lísbet Níelsdóttir Hjúkrunarfræðingur
	Guðrún Svava Guðjónsdóttir Hjúkrunarfræðingur
	Jósefína Elín Þórðardóttir Hjúkrunarfræðingur
	Signhildur Sigurðardóttir, hjúkrunarfræðingur.
	Elín Birna Skarphéðinsdóttir, hjúkrunarfræðingur.
	Rósa Einarsdóttir, hjùkrunarfræðingur
	Guðrún Ingibjörg Rúnarsdóttir, hjúkrunarfræðingur
	Heiða Björk Jóhannsdóttir, Hjúkrunarfræðingur og Ljósmóðir
	Borghildur Ragnarsdóttir,hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Anna Lilja Másdóttir, hjúkrunarfræðing
	Tanja Jóhannsdóttir, hjúkrunarfræðingur
	Brynja Viktorsdóttir, hjúkrunarfræðinemi
	Guðný Björg Sigurðardóttir, hjúkrunarfræðinemi
	Margrét Þ. Jónsdóttir, hjúkrunarfræðingur
	Edda Garðarsdóttir, hjúkrunarfræðingur
	Þórdís Edda Hjartardóttir, hjúkrunarfræðingur
	Anna Samúelsdóttir, hjúkrunarfræðingur
	Ásta Jónsdóttir hjúkrunarfræðingur
	Fríða Pálmadóttir Hjúkrunarfræðingur
	Sigþór Jens Jónsson, hjúkunarfræðingur
	Erla Rún Sigurjónsdóttir, hjúkrunarfræðingur og ljósmóðir.
	Sólrún Auðbertsdóttir, hjúkrunarfræðingur
	Unnur Guðjónsdóttir, hjúkrunarfræðingur
	Hólmdís Hjartardóttir hjúkrunarfræðingur
	Helga Margrét Ingvarsdóttir Hjúkrunarfræðingur
	Bergljót Kvaran, hjúkrunarfræðingur
	Berglind St. Eysteinsdóttir, hjúkrunarfræðingur
	Rakel Ásgeirsdóttir Ljósmóðir og hjúkrunarfræðingur.
	Klara Stefánsdóttir, hjúkrunarfræðingur.
	Hildur Pálsdóttir, hjúkrunarfræðingur
	Þórey Kara Helgadóttir, hjúkrunarfræðinemi.
	Ólöf Másdóttir hjúkrunarfræðingur
	Ólöf Gunnhildur Ólafsdóttir hjúkrunarfræðingur
	Fanney Friðþórsdóttir, hjúkrunarfræðingur
	Ingibjörg Ingólfsdóttir, hjúkrunarfræðingur
	Unnur H. Sigurðardóttir, hjúkrunarfræðingur
	Sunna María Schram, hjúkrunarfræðingur
	Margrét Sigurgeirsdóttir, hjúkrunarfræðingur
	Eiríka Benný Magnúsdóttir hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Kristín Auður Halldórsdóttir hjúkrunarfræðingur
	Kolbrún Kristiansen sérfræðingur í hjúkrun
	Anna Jakobína Guðjónsdóttir, hjúkrunarfræðingur
	Brynja Pála Helgadóttir ljósmóðir og hjúkrunarfræðingur.
	Lára Bryndís Björnsdóttir hjúkrunarfræðingur
	Gunnar Bergmann Steingrímsson, hjúkrunarfræðingur
	Ólafía Sólveig Einarsdóttir, ljósmóðir og hjúkrunarfræðingur
	Andrea Ýr Jónsdóttir, hjúkrunarfræðingur
	Sigrún Ína Ásbergsdóttir, hjúkrunarfræðingur
	Hulda Gísladóttir, hjúkrunarfræðingur
	Jóhanna Jónsdóttir, Hjúkrunarfræðingur
	Sigrún Lovísa Sigurðardóttir, hjúkrunarfræðingur
	Vilborg Guðmundsdóttir hjúkrunarfræðingur
	Anna Sigríður Halldórsdóttir, Skurðhjúkrunarfræðingur
	Oddný Eva Böðvarsdóttir hjúkrunarfræðingur
	Betsý Arna Kristinsdóttir, hjúkrunarfræðingur
	Solveig Unnur Eysteinsdóttir hjúkrunarfræðingur
	Anna Birna Guðlaugsdóttir, hjúkrunarfræðingur
	Sunna Brá Stefánsdóttir, hjúkrunarfræðingur
	Sigurósk Edda Jónsdóttir, hjúkrunarfræðingur, Fagstjóri hjúkrunar Heilsugæslu Grv.
	Eva Hilmarsdóttir, hjúkrunarfræðingur.
	Anna Ólafsdóttir hjúkrunarfræðingur
	Matthildur Pálsdóttir hjúkrunarfræðingur.
	Linda Björk Loftsdóttir, hjúkrunarfræðingur
	Jóhanna Skúladóttir,hjúkrunarfræðingur og ljósmóðir
	Tryggvi Hjörtur Oddsson, hjúkrunarfræðingur
	Unnur Ósk Björnsdóttir, hjùkrunarfræðingur
	Kristín Úlfarsdóttir, hjúkrunarfræðingur
	Ingibjörg Bernhöft hjúkrunarfræðingur
	Bryndís Oddsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Júlíana Magnúsdóttir, hjúkrunarfræðingur
	María Ottesen, hjúkrunarfræðingur
	Lilja Jónsdóttir, hjúkrunarfræðingur
	Anna Lára Jóhannesdóttir, hjúkrunarfræðingur
	Anna Tómasdóttir, hjúkrunarfræðingur
	Elva Ásgeirsdóttir, skurðhjúkrunarfræðingur
	Anna Gyða Gunnlaugsdóttir, hjúkrunarfræðingur
	Sigrún K. Barkardóttir, hjúkrunarfræðingur
	Hrafnhildur Lilja Jónsdóttir, sérfræðingur í bráðahjúkrun
	Íris Alma Össurardóttir, hjúkrunarfræðingur
	Sara R. Guðjónsdóttir, hjúkrunarfræðingur
	Aðalbjörg Rósa Sigurðardóttir, hjúkrunarfræðingur
	Júlíana Viðarsdóttir,hjúkrunarfræðingur
	Halla Bjarklind, hjúkrunarfræðingur
	Íris Rut Hilmarsdóttir Hjúkrunarfræðingur
	Sigríður Helga Axelsdóttir Hjúkrunarfræðinemi
	Rannveig Björk Gylfadóttir, hjúkrunarfræðingur
	Ingibjörg Helga Þórhallsdóttir hjúkrunarfræðingur
	Sara Björk Hauksdóttir Hjúkrunarfræðingur og ljósmóðir
	Sæunn Gunnur Pálmadóttir Hjúkrunarfræðingur
	Hildur Ýr Hvanndal, hjúkrunarfræðingur
	Hrund Guðmundsdóttir hjúkrunarfræðingur
	Heiðrún Káradóttir, hjúkrunarfræðinemi
	Gerður Guðmundsdóttir, hjúkrunarfræðingur
	Margrét Björk Ólafsdóttir, hjúkrunarfræðingur
	María Davíðsdóttir hjúkrunarfræðingur
	Sigríður María Atladóttir barnahjúkrunarfræðingur
	Helga Reynisdóttir, hjúkrunarfræðingur og ljósmóðir
	Sólveig Sveinbjörnsdóttir, hjúkrunarfræðingur
	Unnur Berglind Friðriksdóttir hjúkrunarfræðingur og ljósmóðir

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Eydís Birta Jónsdóttir, barnahjúkrunarfræðingur
	Hallfríður Kristín Jónsdóttir, hjúkrunarfræðingu og ljósmóðir
	Ragnheiður Harpa Hilmarsdóttir, hjúkrunarfræðingur
	Aníta Elínardóttir Hjúkrunarfræðingur
	Karen Eik Sverrisdóttir , Hjúkrunarfræðinemi
	Sigrún Sigurðardóttir, hjúkrunarfræðingur
	Guðlaug Gunnarsdóttir hjúkrunarfræðingur
	Kristín Edda Búadóttir, hjúkrunarfræðingur
	Birna Katrín Hallsdóttir, hjúkrunarfræðingur
	Bjarnrún Jónsdóttir, hjúkrunarfræðingur
	Þórný Alda Baldursdóttir, hjúkrunarfræðingur
	Hulda Dagmar Reynisdòttir, hjúkrunarfræðingur
	Hafrós Lind Ásdísardóttir, hjúkrunarnemi
	Sólveig Klara Káradóttir, hjúkrunarfræðingur
	Hafdís Hjaltadóttir, hjúkrunarfræðingur
	Jónína Lýðsdóttir, hjúkrunarfræðingur
	Harpa Þöll Gísladóttir, hjúkrunarfræðingur
	Berglind Guðrún Chu sérfræðingur í hjúkrun
	Sigurfinnur Líndal Stefánsson, hjúkrunarfræðingur
	Þórunn Hreggviðsdóttir, skurðhjúkrunarfræðingur.
	Lóa Maja Stefándóttir hjúkrunarfræðingur
	Sædís Guðrún Bjarnadóttir hjúkrunarfræðingur
	Rut Vestmann, hjúkrunarfræðingur.
	Ingibjörg Torfadóttir, hjúkrunarfræðingur
	Anna María Bjarnadóttir, hjúkrunarfræðingur.
	Sólbjörg G. Sólversd. Vestergaard, hjúkrunarfræðingur
	Anna Herdís Pálsdóttir, hjúkrunarfræðingur
	Erla Björk Sigurðardóttir hjúkrunarfræðingur og ljósmóðir
	Arna Vígdögg Einarsdóttir hjúkrunarfræðinemi
	Þóra Gunnarsdóttir hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Guðrún Kristinsdóttir hjúkrunarfræðingur		
	Arna Garðarsdóttir, hjúkrunarfræðingur		
	Anna Birna Ragnarsdóttir, hjúkrunarfræðingur.		
	Linda Jónsdóttir hjúkrunarfræðingur		
	Petra Sif Sigmarsdóttir hjúkrunarfræðingur		
	Arndís Bjarnadóttir, hjúkrunarfræðingur		
	Hulda gestsdóttir, hjúkrunarfræðingur		
	Rut Valsdóttir, hjúkrunarfræðingur		
	Soffía Steingrímsdóttir, hjúkrunarfræðingur		
	Gréta Hrund Grétarsdóttir ljósmóðir og hjúkrunarfræðingur		
	Hrönn Önundardóttir, hjúkrunarfræðingur		
	Guðrún María Þorsteinsdóttir, hjúkrunarfræðingur		
	Sesselja K S Karlsdóttir hjúkrunarfræðingur		
	Katrín Edda Snjólaugsdóttir hjúkrunarfræðingur		
	Fríða Ólöf Gunnarsdóttir skurðhjúkrunarfræðingur		
	Lilja Dís Snæbjörnsdóttir, hjúkrunarfræðingur		
	Kristveig Halla Guðmundsdóttir, hjúkrunarfræðingur		
	Kristjana Sigurveig Sveinsdóttir - hjúkrunarfræðingur		
	Steinunn Þórarinsdóttir, hjúkrunarfræðingur		
	Edda Ýr Þórsdóttir Hjúkrunarfræðingur		
	Ragnheiður Rafnsdóttir, Skólahjúkrunarfræðingur		
	Valdís Eva Huldudóttir, hjúkrunarnemi		
	Ellen Ósk Jóhannsdóttir Hjúkrunarfræðingur		
	Guðfinna Þorláksdóttir, Hjúkrunarfræðingur		
	Mette Pedersen, Hjúkrunarfræðingur		
	Kolbrún Jónasdóttir hjúkrunarfræðingur		
	Laufey Egilsdóttir, hjúkrunarfræðingur		
	Svanhildur Garðarsdóttir, hjúkrunarfræðingur		
	Louisa Isaksen, hjúkrunarfræðingur		
	Karen Júlía Fossberg, hjúkrunarfræðinemi		

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Ásta Rún Ásgeirsdóttir, hjúkrunarfræðingur
	Unnur Kjartansdóttir, hjúkrunarfræðingur
	Níní Jónasdóttir, hjúkrunarfræðingur
	Halla Jóhanna Magnúsdóttir, hjúkrunarfræðingur
	Inga Kolbrún Hjartardóttir, hjúkrunarfræðingur
	Guðríður Ringsted, hjúkrunarfræðingur
	Margrét Gunnarsdóttir, hjúkrunarfræðingur
	Margrét Ívarsdóttir, hjúkrunarfræðingur
	Ásgerður Kristín Gylfadóttir, hjúkrunarfræðingur
	Auðna Ágústsdóttir, hjúkrunarfræðingur
	Þorbjörg Snorradóttir, hjúkrunarfræðingur
	Eyrún Ösp Guðmundsdóttir hjúkrunarfræðingur
	Valdís Brynjólfsdóttir hjúkrunarfræðingur
	Guðrún Snæbjört Þóroddsdóttir hjúkrunarfræðingur
	Inga Berglind Birgisdóttir, hjúkrunarfræðingur
	Arney Þórarinsdóttir, hjúkrunarfræðingur og ljósmóðir
	Helga Berglind Hreinsdóttir, hjúkrunarfræðingur
	Stefanía Sæmundsdóttir, hjúkrunarfræðingur
	Margrét Baldvinsdóttir, hjúkrunarfræðingur
	Anna Björk Ómarsdóttir, hjúkrunarfræðingur
	Kristín Júlíana Erlendsdóttir, hjúkrunarfræðingur
	Guðríður Kristín Þórðardóttir, sérfræðingur í hjúkrun
	Jóna Ingibjörg Jónsdóttir, hjúkrunarfræðingur og kynfræðingur
	Guðrún Huld Kristinsdóttir, hjúkrunarfræðingur og ljósmóðir
	Sigríður Pálsdóttir, hjúkrunarfræðingur
	Guðríður Þorleifsdóttir, hjúkrunarfræðingur
	Inga Björg Ólafsdóttir, hjúkrunarfræðingur
	Rúna Einarsdóttir, hjúkrunarfræðingur
	Hanna K. Jónsdóttir, hjúkrunarfræðingur
	Regína Stefnisdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Brynja Jónsdóttir, hjúkrunarfræðingur
	Ester Sigurbergsdóttir, hjúkrunarfræðingur
	Gerður Anna Lúðvíksdóttir, hjúkrunarfræðingur
	Björk Guðmundsdóttir, hjúkrunarfræðingur
	Hildur Elísabet Pétursdóttir, hjúkrunarfræðingur
	Sigríður Harpa Hauksdóttir, hjúkrunarfræðingur
	Anna Björg Arnljótsdóttir, hjúkrunarfræðingur
	Mercy Snehalatha Washington, hjúkrunarfræðingur
	Ása Hrund Sigurjónsdóttir, hjúkrunarfræðingur
	Linda Hrönn Eggertsdóttir, hjúkrunarfræðingur
	Jóhanna Rut Hafsteinsdóttir, hjúkrunarfræðingur og ljósmóðir
	Ingibjörg Davíðsdóttir, hjúkrunarfræðingur
	Helena Hyldahl, hjúkrunarfræðingur
	Kristín Linnet Einarsdóttir, hjúkrunarfræðingur
	Gróa Sturludóttir, Hjúkrunarfræðingur og ljósmóðir
	Elma Rún Ingvarsdóttir, sérfræðingur í barnahjúkrun
	Jóhann Kristján Eyfells, skurðhjúkrunarfræðingur
	Guðbjörg Guðmundsdóttir, sérfræðingur í hjúkrun
	Guðbjörg Pétursdóttir, hjúkrunarfræðingur
	Linda Björk Jóhannsdóttir, hjúkrunarfræðingur
	Sólveig Tryggvadóttir, hjúkrunarfræðingur
	Petra Sigfúsdóttir, hjúkrunarfræðingur
	Soffía Scheving Thorsteinsson, hjúkrunarfræðingur
	Ester Þorvaldsdóttir, hjúkrunarfræðingur
	Nína Hrönn Gunnarsdóttir, Hjúkrunarfræðingur og framkvæmdastjóri hjúkrunar HSA
	Silja Björg Róbertsdóttir, hjúkrunarfræðingur
	Helga Bragadóttir, hjúkrunarfræðingur, prófessor
	Þórunn Pálsdóttir, hjúkrunarfræðingur
	Guðbjörg Guðmundsdóttir, hjúkrunarfræðingur
	Elfa Björk Hermannsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Sigurveig Magnúsdóttir, hjúkrunarfræðingur		
	Margrét Helga Skúladóttir, hjúkrunarfræðingur		
	Bylgja Dís Birkirsdóttir, hjúkrunarfræðinemi		
	Esther Thor Halldórsdóttir, Skurðhjúkrunarfræðingur		
	Guðrún Halldórsdóttir, hjúkrunarfræðingur		
	Sigríður Kristinsdóttir, hjúkrunarfræðingur		
	Ólöf Gerður Ragnarsdóttir, Skurðhjúkrunarfræðingur		
	Oddný Silja Herdísardóttir, hjúkrunarfræðingur		
	Jenný Lind Hjaltadóttir Skurðhjúkrunarfræðingur		
	Ólöf Sigrún Sigurðardóttir, hjúkrunarfræðingur		
	Guðbjörg Vallý Ragnarsdóttir, hjúkrunarfræðingur		
	Herdís Guðlaugsdóttir, skurðhjúkrunarfræðingur		
	Hildur Björk Bjarkadóttir, hjúkrunarfræðingur		
	Sigurveig Sigurjónsdóttir Mýrdal, hjúkrunarfræðingur		
	Sóley Ösp Vilhjálmsdóttir, hjúkrunarfræðingur		
	Brynja Björk Gunnarsdóttir, hjúkrunarfræðingur		
	Tinna Lind Hallsdóttir, hjúkrunarfræðingur		
	Hildur Þóra Sigfúsdóttir, hjúkrunarfræðingur		
	Tinna Sigurðardóttir, hjúkrunarfræðingur		
	Svava Aradóttir, hjúkrunarfræðingur		
	Guðjón Hauksson, hjúkrunarfræðingur		
	Birgitta Inga Birgisdóttir, hjúkrunarfræðingur		
	Vera Dögg Snorradóttir, hjúkrunarfræðingur		
	Marta Jónsdóttir, hjúkrunarfræðingur		
	Urður Ómarsdóttir, hjúkrunarfræðingur		
	Berglind Zoëga, hjúkrunarfræðingur		
	Ásdís Lilja Ingimarsdóttir, hjúkrunarfræðingur		
	Kolbrún Jóhannsdóttir, hjúkrunarfræðingur		
	Elín Jónsdóttir, hjúkrunarfræðingur		
	Jóna Bára Jónsdóttir, hjúkrunarfræðingur		

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Ólöf Ýr Ragnarsdóttir, hjúkrunarfræðingur
	Aðalbjörg Ellertsdóttir, hjúkrunarfræðingur
	Anný Mjöll Sigurðardóttir, hjúkrunarfræðingur
	Gyða Pálsdóttir, hjúkrunarfræðingur
	Brynja Dögg Jónsdóttir, hjúkrunarfræðingur
	Ragna Kristmundsdóttir, sérfræðingur í geðhjúkrun barna og unglinga
	Rannveig Eir Helgadóttir, hjúkrunarfræðingur
	Björg Viggósdóttir, skurðhjúkrunarfræðingur
	Elín Friðriksdóttir, hjúkrunarfræðingur
	Ragnheiður Guðmundsdóttir hjúkrunarfræðingur
	Anna Lísa Baldursdóttir skurðhjúkrunarfræðingur
	Lára Kristín Jónsdóttir, hjúkrunarfræðingur
	Guðlaug Ingunn Einarsdóttir, hjúkrunarfræðingur
	Sigríður Stefánsdóttir, hjúkrunarfræðingur
	Nanna Klausen, hjúkrunarfræðingur
	Guðrún Árný Guðmundsdóttir, hjúkrunarfræðingur
	Kolbrún Tryggvadóttir, hjúkrunarfræðingur
	Lilja Björk Bjarnadóttir, hjúkrunarfræðingur
	Hildigunnur Jóhannesdóttir, hjúkrunarfræðingur
	Sigurlaug Ása Pálmadóttir, hjúkrunarfræðingur
	Linda Björk Markúsdóttir, hjúkrunarfræðingur
	Marta Kristjana Pétursdóttir, hjúkrunarfræðingur
	Katla Marín Jónsdóttir, hjúkrunarfræðingur
	Sigríður G. Ferdínandsdóttir, hjúkrunarfræðingur
	Anna Sigríður Þórðardóttir, hjúkrunardeildardstjóri á hjúkrunardeild HSA
	Kamilla Hansen, hjúkrunarfræðingur
	Berglind Víðisdóttir, hjúkrunarfræðingur
	Vilborg Sveinbjörnsdóttir, hjúkrunarfræðingur
	Jóna Birna Óskarsdóttir, hjúkrunarfræðingur
	Guðfinna Sveinbjörnsdóttir, hjúkrunarfræðingur og ljósmóðir

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Anna Jóna Víðisdóttir, hjúkrunarfræðingur
	María Hafsteinsdóttir, skurðhjúkrunarfræðingur
	Kristín Jóhannesdóttir, hjúkrunarfræðingur
	Sandra Leifs Hauksdóttir, hjúkrunarfræðingur
	Jóhanna Helga Þorsteinsdóttir, hjúkrunarfræðingur
	Guðrún I. Hlíðar ,hjúkrunarfræðingur
	Heiðbjört Ófeigsdóttir, hjúkrunarfræðingur
	Jóhanna María Friðriksdóttir, hjúkrunarfræðingur og ljósmóðir
	Anna Lísa Finnbogadóttir, hjúkrunarfræðingur
	Sólveig Bjarney Daníelsdóttir, hjúkrunarfræðingur á Geðsviði LSH
	Anna Margrét Einarsdóttir, hjúkrunarfræðingur og ljósmóðir
	Guðrún Helga Kjartansdóttir, hjúkrunarfræðingur
	Svanhildur Kristínardóttir, hjúkrunarfræðingur
	Málfríður Sandra Guðmundsdóttir, hjúkrunarfræðingur.
	Iris Dögg Guðjónsdóttir, hjukrunarfræðingut
	Katrín Þ. Hreinsdóttir, hjúkrunarfræðingur
	Snekkja Jóhannesdóttir, skurðhjúkrunarfræðingur
	Ólöf Lilja Lárusdóttir Hjúkrunarfræðingur
	Sif Gunnarsdóttir, hjúkrunarfærðingur
	Eva Laufey Stefánsdóttir, hjúkrunarfræðingur og ljósmóðir
	Margrét Vífilsdóttir, hjúkrunarfræðingur
	Hafrún Harðardóttir hjúkrunarfræðingur
	Tinna Ívarsdóttir, hjúkrunarfræðingur og ljósmóðir
	Þórunn H. Ármannsdóttir hjúkrunarfræðingur
	Alma María Rögnvaldsdóttir hjúkrunarfræðingur
	Katrín Ösp Stefánsdóttir hjúkrunarfræðingur
	Apríl Eik Stefánsdóttir Beck Hjúkrunarfræðingur
	María Sif Ingimarsdóttir hjúkrunarfræðingur
	Hafdís Jóna Stefánsdóttir hjúkrunarfræðingur
	Elna Albrechtsen, Hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Anna María Guðjónsdóttir Hjúkrunarfræðingur
	Kristjana Þórisdóttir hjúkrunarfræðingur
	Anna María Ólafsdóttir, hjúkrunarfræðingur
	Linda Rós Pálsdóttir, hjúkrunarfræðingur
	Margrét Kjartansdóttir, hjúkrunarfræðingur
	Sigrún Helgadóttir, hjúkrunarnemi
	Kolbrún Kristjánsdóttir, hjúkrunarfræðingur
	Ingveldur Erlingsdóttir, hjúkrunarfræðingur
	Helga Guðrún Sigurgeirsdóttir, hjúkrunarfræðingur
	Arndís Sverrisdóttir, hjúkrunarfræðingur
	Arna Óskarsdóttir, hjúkrunarfræðingur
	Elín Pálsdóttir, hjúkrunarfræðingur
	Sif Bjarklind Ólafsdóttir, hjúkrunarfræðingur
	Úlla Björnsdóttir, hjúkrunarfræðingur
	Heiða Mjöll Stefánsdóttir, hjúkrunarfræðingur
	Anna Þóra Þorgilsdóttir, hjúkrunarfræðingur
	Anna Margrét Ragnarsdóttir, hjúkrunarfræðingur
	Huldís Mjöll Sveinsdóttir, hjúkrunarfræðingur
	Erna Gunnþórsdóttir, hjúkrunarfræðingur og læknanemi
	Hlín Adolfsdóttir, hjúkrunarfræðingur
	Hrönn Steingrímsdóttir, hjúkrunarfræðingur
	Svanlaug Guðnadóttir, hjúkrunarfræðingur
	Kristrún Snjólfsdóttir hjúkrunarfræðingur
	Elísabet S. Ólafsdóttir hjúkrunarfræðingur
	Lilja Sigurðardóttir, hjúkrunarfræðingur
	Sesselja Jóhannesdóttir, hjúkrunarfræðingur
	Anna Karen Þórisdóttir, hjúkrunarfræðingur
	Bjartey Ingibergsdóttir, hjúkrunarfræðingur
	Eva Karen Ívarsdóttir, hjúkrunarfræðingur
	Jóna Björk Sigurjónsdóttir hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Silja Rún Kjartansdóttir hjúkrunarfræðingur
	Þórunn A. Einarsdóttir skurðhjúkrunarfræðingur
	Kolbrún Eva Sigurðardóttir, hjúkrunarfræðingur og uroterapeut
	Kristín Rún Friðriksdóttir hjúkrunarfræðingur
	Þorri Már Sigurþórsson hjúkrunarfræðingur
	Arna Sif Bjarnadóttir, hjúkrunarfræðingur
	Heiða Gústafsdóttir, hjúkrunarfræðingur
	Ásdís Kristjánsdóttir, hjúkrunarfræðingur
	Hafdís Aradóttir, hjúkrunarfræðingur
	Elísabet G Þorkelsdóttir, hjúkrunarfræðingur
	Ólöf Ásdís Ólafsdóttir hjúkrunarfræðingur
	Ingibjörg Steindórsdóttir hjúkrunarfræðingur
	Svava Guðbjörg Georgsdóttir, Sérhæfður barnahjúkrunarfræðingur
	Hrafnhildur Jónsdóttir, hjúkrunarfræðingur
	Ragna Þyrí Dögg Guðlaugsdóttir, Hjúkrunarfræðingur
	J. Rósa Þorsteinsdóttir, gjörgæsluhjúkrunarfræðingur
	Jón Örvar Gestsson, Skurðhjúkrunarfræðingur
	Guðrún Björk Gunnarsdóttir, hjúkrunarfræðingur
	Kristín Erla Sveinsdóttir, hjúkrunarfræðingur
	Fjóla Ingimundardóttir Hjúkrunarfræðingur
	Guðfinna Ýr Sumarliðadóttir, 3. árs hjúkrunarnemi
	Sigríður Hrönn Halldórsdóttir, hjúkrunarfræðingur
	Jóhanna Guðrún Gunnarsdóttir, hjúkrunarfræðingur
	Halla Tryggvadóttir, hjúkrunarfræðingur
	Heiðrún Sigurjónsdóttir, skurðhjúkrunarfræðingur
	Björk Sigurjónsdóttir, hjúkrunarfræðingur
	Jóhanna Jóhannsdóttir, hjúkrunarfræðingur
	Ásgerður Ólafsdóttir, hjúkrunarfræðingur
	Elín Bergsdóttir, hjúkrunarfræðingur
	Snærún Ösp Guðmundsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Aldís Hauksdóttir, hjúkrunarfræðingur
	Tinna Bjarnadóttir, hjúkrunarfræðingur
	Helga Heiða Helgadóttir, hjúkrunarfræðingur.
	Hólmfríður Rósa Jóhannsdóttir, hjúkrunarfræðingur og ljósmóðir
	Jóna Kolbrún Árnadóttir, hjúkrunarfræðingur
	Emilía Fönn Andradóttir, hjúkrunarfræðingur
	Birna Sif Atladóttir, hjúkrunarfræðingur
	Katrín Ösp Jónsdóttir, hjúkrunarfræðingur
	Gunnhildur H Blöndal hjúkrunarfræðingur
	Laufey Sæunn Birgisdóttir hjúkrunarfræðingur
	Kristín Björg Flygenring, hjúkrunarfræðingur
	Arna Ágústsdóttir, hjúkrunarfræðingur
	Anna María Leifsdóttir Grönqvist, hjúkrunarfræðingur
	Hulda Sædís Bryngeirsdóttir, hjúkrunarfræðingur
	Heiðlóa Ásvaldsdóttir, hjúkrunarfræðingur
	Valdís Arnardóttir, hjúkrunarfræðingur
	Thelma Dröfn Ásmundsdóttir, hjúkrunarfræðingur
	Margrét Gísladóttir, sérfræðingur í geðhjúkrun og fjölskyldufræðingur
	Hlíf Sigurðardóttir, hjúkrunarfræðingur
	Guðrún Sturlaugsdóttir, hjúkrunarfræðingur
	Berglind Eiðsdóttir, hjúkrunarfræðingur
	Birna G. Flygenring, hjúkrunarfræðingur
	Ingibjörg Guðmundsdóttir, hjúkrunarfræðingur og lýðheilsufræðingur
	Arna Rut Ottesen Gunnarsdóttir, svæfingahjúkrunarfræðingur
	Guðrún Hólmfríður Guðmundsdóttir, hjúkrunarfræðingur og ljósmóðir
	Helga Rósa Másdóttir, hjúkrunarfærðingur
	Fríða Björk Skúladóttir, hjúkrunarfræðingur
	Bryndís Aðalsteinsdóttir hjúkrunarfræðingur
	Jóndís Einarsdóttir hjúkrunarfræðingur
	Andrea Kristjánsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Ásdís Elfarsdóttir Jelle, sýkingavarnahjúkrunarfræðingur,
	Margrét Rúna Guðmundsdóttir, gjörgæsluhjúkrunarfræðingur
	Þórunn Guðmundsdóttir, hjúkrunarfræðingur
	Vigdís Árnadóttir, skurðhjúkrunarfræðingur
	Marianne Elisabeth Klinke, hjúkrunarfræðingur
	Ance Laukšteina, hjúkrunarfræðingur
	Thelma Björk Árnadóttir, hjúkrunarfræðingur
	Hildur Hauksdóttir , hjúkrunarfræðingur
	Guðfríður Hermannsdóttir hjúkrunarfræðingur
	Margrét Ýrr Sigurgeirsdóttir hjúkrunarfræðingur
	Katrín Sigurðardóttir Sonnentag, hjúkrunarfræðingur
	Erna Bjargey Jóhannsdóttir, hjúkrunarfræðingur
	Vilborg Gísladóttir, hjúkrunarfræðingur
	Gyða Arnórsdóttir, hjúkrunarfræðingur
	Elínborg G. Sigurjónsdóttir, hjúkrunarfræðingur
	Sólrún Oddný Hansdóttir, Hjúkrunafræðingur
	Sandra Björk Marteinsdóttir, hjúkrunarfræðingur
	Ingibjörg S. Guðmundsdóttir
	Auður Elísabet Jóhannsdóttir, hjúkrunarfræðingur
	Þóra Þórsdóttir, hjúkrunarfræðingur
	Katrín Helga Steinþórsdóttir, hjúkrunarfræðingur
	Kristbjörg Magnúsdóttir, ljósmóðir
	Svandís Birkisdóttir, hjúkrunarfræðingur
	Anna Harðardóttir, hjúkrunarfræðingur
	Aðalbjörg Sigurjónsdóttir, hjúkrunarfræðingur
	Elín Svana Lárusdóttir, hjúkrunarfræðingur
	Friðrika Sigvaldadóttir, hjúkrunarfræðingur
	Marín Björg Guðjónsdóttir, hjúkrunarfræðingur og ljósmóður-nemi
	Hólmfríður H. Morgan, hjúkrunarfræðingur
	Helga Vala Árnadóttir hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Sólrún Ólína Sigurðardóttir, hjúkrunarfræðingur
	Eyrún Ösp Birgisdóttir, hjúkrunarfræðingur
	Ása Björk Ásgeirsdóttir, hjúkrunarfræðingur
	Vilborg Elva Jónsdóttir, hjúkrunarfræðingur
	Ragnhildur Bjarnadóttir, hjúkrunarfræðingur
	Steinunn Skúladóttir, hjúkrunarfræðingur
	Anna Dagný Smith, hjúkrunarfræðingur
	Herdís Magnúsdóttir, hjúkrunarfræðingur
	Jóna Kristjánsdóttir hjúkrunarfræðingur
	Sigurbjörg Marteinsdóttir, hjúkrunarfræðingur
	Hulda María Hermannsdóttir, hjúkrunarfræðingur
	Gerður Guðmundsdóttir, hjúkrunarfræðingur
	Hildur Dögg Ásgeirsdóttir, hjúkrunarfræðingur
	Þórunn Óttarsdóttir, hjúkrunarfræðingur
	Sigríður Sólveig Stefánsdóttir, hjúkrunarfræðingur
	Anna Fríða Magnúsdóttur, hjúkrunarfræðingur
	Björk Bragadóttir, hjúkrunarfræðingur
	Halldóra Egilsdóttir, hjúkrunarfræðingur
	Jóna Ragúels, hjúkrunarfræðingur
	Guðlín Jóna Ómarsdóttir, hjúkrunarfræðingur
	Jónína Lóa Kristjánsdóttir, hjúkrunarfræðingur
	Ardís Henriksdóttir, hjúkrunarfræðingur
	Guðrún Karítas Karlsdóttir, hjúkrunarfræðingur
	Þuríður Jónsdóttir, hjúkrunarfræðingur
	Rut Guðbrandsdóttir, hjúkrunarfræðingur
	Ásta Björk Baldursdóttir, hjúkrunarfræðingur
	Svanhvít Vatnsdal Jóhannsdóttir, hjúkrunarfræðingur
	Elísabet Ellertsdóttir, hjúkrunarfræðingur
	Anna Huld Jóhannsdóttir skurðhjúkrunarfræðingur
	Hrafnhildur Grímsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Friðsemd Thorarensen, hjúkrunarfræðingur		
	Rósa Marinósdóttir hjúkrunarfræðingur		
	Kristin Guðmundsdóttir, hjúkrunarfræðingur		
	Bryndís Snæfríður Gunnarsdóttir, hjúkrunarfræðinemi		
	Halla Þórhallsdóttir, hjúkrunarfræðingur		
	Berglind Gunnarsdóttir, hjúkrunarfræðingur		
	Guðrún Þóra Guðjónsdóttir, hjúkrunarfræðingur og ljósmóðir		
	Inga Ingólfsdóttir, hjúkrunarfræðingur		
	Ingibjörg HR Ragnarsdóttir, skurðhjúkrunarfræðingur		
	Særós Ósk Sævaldsdóttir, hjúkrunarfræðinemi		
	Þórunn Sigurðardóttir, hjúkrunarfræðingur		
	Hrafnhildur Halldórsdóttir, hjúkrunarfræðingur og ljósmóðir		
	Helga Guðmundsdóttir, hjúkrunarfræðingur		
	Auður Þórðardóttir, hjúkrunarfræðingur		
	Helga Sæunn Sveinbjörnsdóttir, hjúkrunarfræðingur		
	Ragnhildur Sigurjónsdóttir Hjúkrunarfræðingur		
	Valgerður H Jensen, hjúkrunarfræðingur		
	Ásdís B. Jóhannsdóttir, hjúkrunarfræðingur		
	Jenný Guðmundsdóttir, hjúkrunarfræðingur		
	Elísabet Heiða Stefánsdóttir, hjúkrunarfræðingur		
	Katrín Björgvinsdóttir, hjúkrunarfræðingur		
	Karítas Gunnarsdóttir, hjúkrunarfræðingur		
	Ósk Guðmundsdóttir, hjúkrunarfræðingur		
	Berglind Þöll Heimisdóttir, hjúkrunarfræðingur		
	Danfríður Kristjánsdóttir, hjúkrunarfræðingur		
	Kristín Erla, hjúkrunarfræðinemi		
	Vilborg Helgadóttir, hjúkrunarfræðingur		
	Vilhelmína Einarsdóttir, hjúkrunarfræðingur		
	Arna Hilmarsdóttir, hjúkrunarfræðingur		
	Árný Björg Halldórsdóttir, hjúkrunarfræðingur		

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Erla Jóhannsdóttir, hjúkrunarfræðingur
	Auðna Margrét Haraldsdóttir, hjúkrunarfræðingur
	Dóra Halldórsdóttir, hjúkrunarfræðingur og ljósmóðir
	Berglind Ósk Birgisdóttir, hjúkrunarfræðingur
	Hildur Sveinbjörnsdóttir, hjúkrunarfræðingur
	Þórlína Sveinbjörnsdóttir, hjúkrunarfræðingur
	Fanný Rósa Bjarnadóttir, hjúkrunarfræðingur
	Kristbjörg Tinna Ásbjörnsdóttir, hjúkrunarfræðingur
	Petrea Aðalheiður Ásbjörnsdóttir, hjúkrunarfræðingur og ljósmóðurnemi
	Kristín Ingólfsdóttir, hjúkrunarfræðingur
	Erna Björk Þorsteinsdóttir, hjúkrunarfræðingur
	Ingibjörg Björnsdóttir, hjúkrunarfræðingur
	Eydís Antonsdóttir, hjúkrunarfræðingur
	Edda Arndal, geðhjúkrunar og fjölskyldufræðingur
	Helga Ólöf Eiríksdóttir hjúkrunarfr. og ljósmóðir
	Árný Gunnarsdóttir, hjúkrunarfræðingur
	Sóley Erla Ingólfsdóttir, hjúkrunarfræðingur
	Sigríður Hulda Árnadóttir, hjúkrunarfræðingur
	Ólína Kristín Jónsdóttir, hjúkrunarfræðingur
	Anna Baldrún Garðarsdóttir, hjúkrunarfræðingur
	Kristín Gunnarsdóttir, hjúkrunarfræðingur
	Júlía Matthildur Brynjólfsdóttir Hjúkrunarfræðingur
	Bryndís Erlingsdóttir Hjúkrunarfræðingur
	Guðmunda Hrönn Óskarsdóttir, hjúkrunarfræðingur
	Alenka Zak, hjúkrunarfræðingur
	Guðrún Einarsdóttir, hjúkrunarfræðingur
	Berglind Hálfdánsdóttir, hjúkrunarfræðingur og ljósmóðir
	Anna María Friðriksdóttir, Hjúkrunarfræðingur
	Ellen Helga Steingrímsdóttir, hjúkrunarfræðingur
	Ásthildur Ólöf Ríkarðsdóttir, hjúkrunarfræðinemi

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Fanney Jóhannsdóttir, hjúkrunarfræðingur
	Kristín Helga Einarsdóttir, hjúkrunarfræðingur og ljósmóðir
	Halla Sigrún Arnardóttir, hjúkrunarfræðingur
	Ingibjörg Hreiðarsdóttir, hjúkrunarfræðingur
	Fanney Grétarsdóttir, hjúkrunarfræðingur
	Auður Indíana Jóhannesdóttir, Hjúkrunarfræðingur
	Þórdís Katrín Þorsteinsdóttir, hjúkrunarfræðingur
	Fríða Ólöf Ólafsdóttir, hjúkrunarfræðingur
	Inga Þ. Steindórsdóttir hjúkrunarfræðingur
	Sigríður Árna Gísladóttir, hjúkrunarfræðingur
	Elín Karitas Bjarnadóttir hjúkrunarfræðingur
	Tinna Torfadóttir, 3.árs hjúkrunarnemi
	Sigríður Jóna Kjartansdóttir, hjúkrunarfræðingur
	Erla Björg Guðlaugsdóttir, hjúkrunarfræðingur
	Ásta S. Sigurðardóttir hjúkrunarfræðingur
	Berglind Tryggvadóttir, hjúkrunarfræðinemi
	Elfa Ólafssdóttir, hjúkrunarfræðingur
	Andrea Hlín Harðardóttir, hjúkrunarfræðingur
	Margrét Ingiþórsdóttir, hjúkrunarfræðingur
	Þórunn Pálsdóttir hjúkrunarfræðingur og ljósmóðir
	Berglind Helgadóttir, hjúkrunarfræðingur
	Sigríður Ólafsdóttir, hjúkrunarfræðingur
	Elsa Hrund Jensdóttir, hjúkrunarfræðingur
	Sigrún Huld Gunnarsdóttir, hjúkrunarfræðingur og ljósmóðir
	Gréta María Birgisdóttir, hjúkrunarfræðingur og ljósmóðir
	Oddný Hólmsteinsdóttir, hjúkrunarfræðingur
	Ragna Dóra Rúnarsdóttir, hjúkrunarfræðingur
	Magdalena Sigurðardóttir hjúkrunarfræðingur
	Katrín Ólafsdóttir, hjúkrunarfræðingur
	Áshildur Arnarsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Jóhanna Garðarsdóttir, hjúkrunarfræðingur		
	Kristrún Benediktsdóttir, hjúkrunarfræðingur		
	Hildur Sif Rafnsdóttir, 3.árs hjúkrunarfræðinemi		
	Torfhildur Hólm Jensdóttir, hjúkrunarfræðingur		
	Ellen Óskarsdóttir Barnahjúkrunarfræðingur		
	Hildur Björk Sigurdardòttir hjùkrunarfræðingur		
	Kristín Guðný Sæmundsdóttir, hjúkrunarfræðingur		
	Íris Björg Sigmarsdóttir hjúkrunarfræðingur		
	Lýdía Rós Hermannsdóttir, hjúkrunarfræðingur		
	Helga Birgisdóttir Hjúkrunarfræðingur		
	Margrét Blöndal, hjúkrunarfræðingur		
	Tonie Gertin Sørensen Barnahjúkrunarfræðingur		
	Snædís Jónsdóttir, hjúkrunarfræðingur		
	Guðrún Hauksdóttir, hjúkrunarfræðingur		
	Anna Kristín Einarsdóttir, hjúkrunarfræðingur		
	Ólöf Sigfríður Sigurðardóttir, hjúkrunarfræðingur		
	Jónína Sigurgeirsdóttir, hjúkrunarfræðingur		
	Regína Böðvarsdóttir, hjúkrunarfræðingur		
	Fjóla Helgadóttir, hjúkrunarfræðingur		
	Mínerva Sveinsdóttir, hjúkrunarfræðingur		
	Sunna Eir Haraldsdóttir, hjúkrunarfræðingur		
	Rannveig Björnsdóttir, hjúkrunarfræðingur		
	Inga Lúthersdóttir, hjúkrunarfræðingur		
	Hildur Vattnes Kristjánsdóttir, hjúkrunarfræðingur		
	Árni Már Haraldsson hjúkrunarfræðingur		
	Sólrún W. Kamban, barnahjúkrunarfræðingur		
	Kristín Edda Ragnarsdóttir, hjúkrunarfræðingur		
	Ágústa Eiríksdóttir, hjúkrunarfræðingur		
	Erla Dögg Ragnarsdóttir, hjúkrunarfræðingur		
	Sólrún Hansdóttir, hjúkrunarfræðingur		

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Sólveig J Haraldsdóttir, hjúkrunarfræðingur
	Rannveig Þorvarðardóttir, skurðhjúkrunarfræðingur
	Arndís Mogensen, Hjúkrunarfræðingur og ljósmóðir
	Harpa Heiðarsdóttir, hjúkrunarfræðingur
	Steinunn Guðmundsdóttir, hjúkrunarfræðingur
	Dagmar Ýr Sigurjónsdóttir, hjúkrunarfræðingur
	Alma Rún Vignirsdóttir, hjúkrunarfræðingur
	Snjólaug Ármannsdóttir, hjúkrunarfræðingur
	Hólmfríður Guðmundsdóttir, hjúkrunarfræðingur
	Hulda Margrét Valgarðsdóttir, hjúkrunarfræðingur
	Hugrún Hjörleifsdóttir, hjúkrunarfræðingur
	Sigríður Jónsdóttir, hjúkrunarfræðingur
	Bryndís María Björnsdóttir, hjúkrunarfræðingur
	Rósa Guðrún Jóhannsdóttir, hjúkrunarfræðingur
	Rut Petersen, hjúkrunarfræðingur
	Anna Valdimarsdóttir, hjúkrunarfræðingur
	Þórdís Jóna Guðmundsdóttir hjúkrunarnemi
	Sigríður Særún Gautsdóttir hjúkrunarfræðingur
	Rakel B. Jónsdóttir, sérfræðingur í hjúkrun nýbura
	Guðrún Jakobína Jónsdóttir, hjúkrunarfræðingur
	Margrét Guðnadóttir, hjúkrunarfræðingur
	Helga Lárusdóttir, Hjúkrunarfræðingur
	Helena Sigurgeirsdóttir Hólm, hjúkrunarfræðingur
	Danía Anfinnsdóttir Heinesen, Hjúkrunarfræðingur
	Þórhalla Ágústsdóttir, hjúkrunarfræðingur
	Valgerður Margrét Magnúsdóttir, hjúkrunarfræðingur
	Hjördís Jóhannesdóttir, hjúkrunarfræðingur
	Lena Margrét, hjúkrunarfræðingur
	Hildur Birna Helgadóttir, hjúkrunarfræðingur
	Guðrún Árnadóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Halla Hrund Arnardóttir, hjúkrunarfræðingur
	Sólrún Rúnarsdóttir, hjúkrunarfræðingur
	Þórdís Rósa Sigurðardóttir, hjúkrunarfræðingur
	Helga Steingerður Sigurðardóttir, hjúkrunarfræðingur
	Lilja Hannesdóttir, hjúkrunarfræðingur
	Linda Björk Ólafsdóttir, hjúkrunarfræðingur
	Guðný Valgeirsdóttir, hjúkrunarfræðingur
	Ingibjörg Rós Kjartansdóttir, hjúkrunarfræðingur
	Eva Hjörtína Ólafsdóttir hjúkrunarfræðingur
	Guðrún Sigurjónsdóttir hjúkrunarfræðingur
	Sólveig Halldórsdóttir, hjúkrunarfræðingur
	Guðný Baldursdóttir, hjúkrunarfræðingur
	Hrönn Stefánsdóttir, bráðahjúkrunarfræðingur
	Sigríður Rúna Þóroddsdóttir, hjúkrunarfræðingur
	Helga Jónsdóttir, hjúkrunarfræðingur
	Ágústa Erna Hilmarsdóttir, hjúkrunarfræðingur
	Þuríður Geirsdóttir, Hjúkrunarfræðingur
	Guðmunda Jakobsdóttir, hjúkrunarfræðingur
	Anna Þóra Óskarsdóttir, hjúkrunarfræðingur
	Sonja D. Hákonardóttir, svæfingahjúkrunarfræðingur
	Hólmfríður Rós Eyjólfsdóttir, hjúkrunarfræðingur
	Sigríður S. Þorleifsdóttir, hjúkrunarfræðingur
	Ásdís Árnadóttir, hjúkrunarfræðingur
	Anna Eðvaldsdóttir, ljósmóðir
	Hrund Magnúsdóttir, hjúkrunarfræðingur
	Helena Hrund Jónsdóttir, hjúkrunarfræðingur
	Gunnþórunn Elíasdóttir, hjúkrunarfræðingur
	Jenný Sigurðardóttir, hjúkrunarfræðingur í Noregi
	Heiða Birna Bragadóttir, hjúkrunarfræðingur
	Heiða Magnúsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Kristín Þorbjörnsdóttir, hjúkrunarfræðingur		
	Halldóra Víðisdóttir, hjúkrunarfræðingur		
	Guðmunda Helgadóttir, hjúkrunarfræðingur		
	Rebekka Rós Hafsteinsdóttir, svæfingahjúkrunarfræðingur		
	Branddís Jóna Garðarsdóttir, hjúkrunarfræðingur		
	Erla Hrönn Matthíasdóttir, hjúkrunarfræðingur		
	Dóra Stephensen, hjúkrunarfræðingur og ljósmóðir		
	Anna Margrét Arthúrsdóttir, hjúkrunarfræðingur		
	Erla Kristofersdottir, hjúkrunarfræðingur		
	Ingigerður Torfadóttir, hjúkrunarfræðingur		
	Guðný Einarsdóttir, hjúkrunarfræðingur		
	Þuríður Stefánsdóttir, hjúkrunarfræðingur		
	Anna Dagbjört Gunnarsdóttir, hjúkrunarfræðingur		
	Ester Elín Bjarnadóttir, hjúkrunarfræðingur		
	Klara Þorsteinsdóttir, hjúkrunar- og félagsfræðingur		
	Berglind Íris Hansdóttir, hjúkrunarfræðingur		
	Jóna Ólafsdóttir, hjúkrunarfræðingur		
	Guðrún Jónsdóttir, hjúkrunarfræðingur		
	Dóra María Garðarsdóttir, hjúkrunarfræðingur		
	Þórhildur Höskuldsdóttir, hjúkrunarfræðingur		
	Fanney Kristjánsdóttir, 3 árs hjúkrunarnemi		
	Sigurbjörg Gyða Guðmundsdóttir, hjúkrunarfræðingur		
	Kristlaug Sigríður Sveinsdóttir, hjúkrunarfræðingur		
	Olga Eir Þórarinsdóttir, hjúkrunarfræðingur		
	Hildur Jónsdóttir, hjúkrunarfræðingur		
	Björg Jónsdóttir hjúkrunarfræðingur		
	Ragnhildur Hjartardóttir, hjúkrunarfræðingur		
	Drífa Eysteinsdóttir, hjúkrunarfræðingur		
	Linda Rós Thorarensen, hjúkrunarfræðingur		
	Theódóra Kolbrún Jónsdóttir, hjúkrunarfræðingur		

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Hafdís Hafþórsdóttir, hjúkrunarfræðingur
	Eva Björg Guðmundsdóttir, hjúkrunarfræðingur
	Gunnhildur Ósk Sæbjörnsdóttir, hjúkrunarfræðingur
	Rósa Eiríksdóttir, hjúkrunarfræðingur
	Ingibjörg Ásta Claessen, hjúkrunarfræðingur
	Fanney Svala Óskarsdóttir, skurðhjúkrunarfræðingur
	Marsa Hrönn Daníelsdóttir, hjúkrunarfræðingur
	Sveinbjörg Ólafsdóttir, hjúkrunarfræðingur
	Thelma Lind Guðmundsdóttir, hjúkrunarfræðingur
	Kristín Rós Sigurðardóttir, hjúkrunarfræðingur
	Helga María Hermannsdóttir, hjúkrunarfræðingur
	Anita Agestad, hjúkrunarfræðingur
	Aðalbjörg Guðmundsdóttir, hjúkrunarfræðingur
	Lilja Petra Ólafsdóttir, hjúkrunarfræðingur
	María Elísabet Kristleifsdóttir, hjúkrunarfræðingur
	Þóra Filippusdóttir, ljósmóðir og hjúkrunarfræðingur
	Linda Margrét Stefánsdóttir, hjúkrunarfæðingur og ljósmóðir
	Nína Björg Magnúsdóttir, hjúkrunarfræðingur og ljósmóðir
	Svandís Bergsdóttir, hjúkrunarfræðingur
	Margrét Þorsteinsdóttir, hjúkrunarfræðingur
	Ingibjörg Þórðardóttir, hjúkrunarfræðingur
	Bryndís Ósk Brynjarsdóttir, hjúkrunarfræðingur
	Guðrún Einarsdóttir, hjúkrunarfræðingur
	Elsa Friðrika Eðvaldsdóttir, hjúkrunarfræðingur
	Helga Hákonardóttir, hjúkrunarfræðingur
	Berta Björk Arnardóttir, hjúkrunarfræðingur
	Kristín Lilja Jónsdóttir, hjúkrunarfræðingur
	Anna Reynisdóttir, hjúkrunarfræðingur
	Gyða Valdís Guðmundsdóttir, hjúkrunarfræðingur
	Rúna Guðmundsdóttir, svæfingahjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Hafdís Björk, hjúkrunarfræðingur
	Kolbrún Jóhannsdóttir, hjúkrunarfræðingur
	Sigríður Sigmarsdóttir, hjúkrunarfræðingur
	Guðrún Stefánsdóttir, hjúkrunarfræðingur
	Guðbjörg Aðalsteinsdóttir, hjúkrunarfræðingur
	Aðalbjörg Guðsteinsdóttir, hjúkrunarfræðingur
	Birgitta Hafsteinsdóttir, hjúkrunarfræðingur
	Elinóra Friðriksdóttir, hjúkrunarfræðingur
	Alda Björk Guðmundsdóttir, hjúkrunarfræðingur
	Hjördís Birgisdóttir, hjúkrunarfræðingur
	Kristín Guðmundsdóttir, hjúkrunarfræðingur
	Herdís Sif Ásmundsdóttir, hjúkrunarfræðingur
	Rikka Mýrdal, hjúkrunarfræðingur
	Jóhanna María Oddsdóttir, hjúkrunarfræðingur
	Sigrún Ingvarsdóttir, hjúkrunarfræðingur og ljósmóðir
	Guðfinna Bettý Hilmarsdóttir, hjúkrunarfræðingur
	Auður Einarsdóttir, hjúkrunarfræðingur
	Jónína Rún Agnarsdóttir, hjúkrunarnemi á 3ja ári
	Magnhildur Ósk Magnúsdóttir, hjúkrunarfræðingur
	Sóley Ívarsdóttir, 4. Árs hjúkrunarnemi
	Hulda Viktorsdóttir, 4.árs hjúkrunarnemi
	Jóna Ellen Valdimarsdóttir, skurðhjúkrunarfræðingur
	Ólafur G. Skúlason, hjúkrunarfræðingur
	Halldóra Hálfdánardóttir, hjúkrunarfræðingur
	Íris Gísladóttir, hjúkrunarfræðingur
	Jóhanna Ólafsdóttir hjúkrunarfræðingur og ljósmóðir
	Björg Eyþórsdóttir, hjúkrunarfræðingur
	Erna Sólveig Júlíusdóttir, hjúkrunarfræðingur
	Agla Ösp Sveinsdóttir, hjúkrunarfræðingur
	Birta Brá Barkarsóttir, skurðhjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Unnur María Pétursdóttir, bráðahjúkrunarfræðingur
	Erna Sólveig Júlíusdóttir, hjúkrunarfræðingur
	Lilja Björg Sigurjónsdóttir, hjúkrunarnemi
	Kristín Rósa Ármannsdóttir, hjúkrunarfræðingur
	Ingibjörg Magnúsdóttir, hjúkrunarfræðingur
	Sólveig Hrönn Gunnarsdóttir, hjúkrunarfræðingur
	Martha Sandholt Haraldsdóttir hjúkrunarfræðingur
	Valgerður Jónsdóttir, hjúkrunarfræðingur
	Þórunn Björk Einarsdóttir, hjúkrunarfræðingur
	Guðrún Brynja Gísladóttir, hjúkrunarfræðingur
	Jórunn Oddssdóttir, hjúkrunarfræðingur
	Hildur Dís Kristjánsdóttir, hjúkrunarfræðingur
	Ásta Jóna Guðmundsdóttir hjúkrunarfræðingur
	Hrafnhildur Eyþórsdóttir, hjúkrunarfræðingur
	Ólína Björg, hjúkrunarfræðingur
	Sif Ólafsdóttir, hjúkrunarfræðingur
	Halldóra Hreinsdóttir, hjúkrunarfræðingur
	Jórunn Þórðardóttir, hjúkrunarfræðingur
	Sigríður Björk Halldórsdóttir, Hjúkrunarfræðingur
	Rakel Valdsdóttir, hjúkrunarfræðingur
	Helena Benjamínsdóttir, hjúkrunarfræðingur
	Telma Glóey Jónsdóttir, hjúkrunarfræðingur
	Guðrún Pétursdóttir, hjúkrunarfræðingur
	Jóna Maren Magnadóttir, hjúkrunarfræðingur
	Elsa Björnsdóttir, hjúkrunarfræðingur
	María Haraldsdóttir, hjúkrunarfræðingur og ljósmóðir
	Rakel Dögg Sigurðardóttir, hjúkrunarfræðingur
	Rakel Óskarsdóttir, hjúkrunarfræðingur og ljósmóðurnemi
	Freyja Sigursveinsdóttir, hjúkrunarfræðingur á gjörgæsludeild
	Gígja Hrund Birgisdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Guðlín K. Jónsdóttir, hjúkrunarfræðingur
	Ragnheiður Tómasdóttir, hjúkrunarfræðingur
	Hulda Dóra Þorgeirsdóttir, hjúkrunarfræðingur
	Sóldís Helga Sigurgeirsdóttir, hjúkrunarfræðingur
	Steinunn Sigurðardóttir, hjúkrunarnemi
	Rakel Gunnlaugsdóttir, hjúkrunarnemi
	Heba Theodórsdóttir, skurðhjúkrunarfræðingur
	Guðlaug Steinsdóttir, hjúkrunarfræðingur
	Kristín Hlín Pétursdóttir, hjúkrunarfræðingur
	Sofia Björg Pétursdóttir, hjúkrunarfræðingur
	Rúna Björk Ólafsdóttir, hjúkrunarfræðingur
	Elín Björnsdóttir, hjúkrunarfræðingur
	Sólveig Pálsdóttir, hjúkrunarfræðingur
	Fanney Maríasdóttir, hjúkrunarfræðingur
	Bryndís Guðmundsdóttir, hjúkrunarfræðingur
	Sigrún Sigurðardóttir, hjúkrunarfræðingur
	Pálína Hugrún Björgvinsdóttir, hjúkrunarfræðingur
	Kristrún Marvinsdóttir, hjúkrunarfræðingur
	Helga Harðardóttir, hjúkrunarfræðingur og ljósmóðir
	Sigurborg Skúladóttir Kaldal, hjúkrunarfræðingur
	Sandra María Filippusdóttir, hjúkrunarfræðingur
	Soffía S. Jónasdóttir, hjúkrunarfræðingur
	Rebekka Laufey Ólafsdóttir, hjúkrunarfræðingur
	Björk Önnudóttir, hjúkrunarfræðingur
	Sigríður Rós Jónatansdóttir, hjúkrunarfræðingur
	Hrönn Harðardóttir, hjúkrunarfræðingur
	Ellen Björnsdóttir, hjúkrunarfræðingur
	Heiða Berglind Magnúsdóttir, hjúkrunarfræðingur
	Sigríður Guðmundsdóttir, hjúkrunarfræðingur
	Bergþóra Guðnadóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Hrefna Magnea Guðmundsdóttir, hjúkrunarfræðingur
	Katrín Ósk Þorgeirsdóttir, hjúkrunarfræðingur
	Maren Ösp Hauksdóttir, hjúkrunarfræðingur
	Bryndís Konráðsdóttir, hjúkrunarfræðingur
	Guðrún Ólafsdóttir, hjúkrunarfræðingur
	Helena Árnadóttir Bjartman, hjúkrunarfræðingur
	Lilja Ester Ágústsdóttir, hjúkrunarfræðingur
	Elín Hilmarsdóttir, hjúkrunarfræðingur
	Halldóra Kristín Halldórsdóttir, hjúkrunarfræðingur
	Gyða Sjöfn Njálsdóttir, hjúkrunarfræðingur
	Fjóla Sveinmarsdóttir, hjúkrunarfræðingur
	Áshildur Kristjánsdóttir, skurðhjúkrunarfræðingur
	Tinna Kr Gunnarsdóttir hjúkrunarfræðingur
	Gígja Skúladóttir, Hjúkrunarfræðingur
	Berglind Anna Karlsdóttir, hjúkrunarfræðingur
	Sunna Lind Svavarsdóttir 4.árs hjúkrunarnemi
	María V. Guðmundsdóttir hjúkruarfræðingur
	Ingibjörg Hjaltadóttir, hjúkrunarfræðingur
	Stefanía Inga Sigurjónsdóttir, hjúkrunarfræðingur
	Sólrún Inga Halldórsdóttir, hjúkrunarfræðingur
	Bergrún S. Benediktsdóttir, hjúkrunarfræðingur
	Sigurður Ýmir Sigurjónsson, hjúkrunarnemi
	Sigrún Óskarsdóttir skurðhjúkrunarfræðingur
	Oddný Sigrún Magnúsdóttir, hjúkrunarfræðingur
	Auður Ketilsdóttir, sérfræðingur í hjúkrun
	Inga Dagný Eydal hjúkrunarfræðingur
	Guðný Birna Guðmundsdóttir, hjúkrunarfræðingur
	Hanna Kristín Guðjónsdóttir, hjúkrunarfræðingur
	Soffía Svava Adolfsdóttir, hjúkrunarfræðingur
	Kristrún Vala Benediktsdóttir, hjúkrunarfræðinemi

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Árný Anna Svavarsdóttir, ljósmóðir og hjúkrunarfræðingur
	Heiður Sif Heiðarsdóttir, ljósmóðir og hjúkrunarfræðingur
	Bára Agnes Ketilsdóttir, hjúkrunarfræðingur
	Björg Sigurðardóttir ljósmóðir og kennari
	Hermína Stefánsdóttir, hjúkrunarfræðingur og ljósmóðir
	Bríet Magnúsdóttir, Hjúkrunarfræðingur
	Halla Dröfn Þorgerirsdóttir, hjúkrunarfræðingur
	María Hrönn Björgvinsdóttir, hjúkrunarfræðingur
	Ásdís Ingvarsdóttir, hjúkrunarfræðingur
	Elsa Thor, hjúkrunarfræðingur og ljósmóðir
	Þóra Sigurðardóttir, hjúkrunarfræðingur
	Ingibjörg Guðmundsdóttir, hjúkrunarfræðingur
	Hilma Ýr Davíðsdóttir, hjúkrunarfræðingur
	Magnea Gunnarsdóttir, hjúkrunarfræðingur
	Sigríður Arna Júlíusdóttir, hjúkrunarfræðingur
	Nanna Bryndís Snorradóttir, hjúkrunarfræðingur
	Hildur Helgadóttir, hjúkrunarfræðingur
	Iðunn Lúðvíksdóttir, hjúkrunarfræðingur
	Margrét Inga Gísladóttir, hjúkrunarfræðingur og ljósmóðurnemi
	Anna Soffía Bragadóttir, hjúkrunarfræðingur
	Melkorka Víðisdóttir, hjúkrunarfræðingur
	Sigurlaug Gunnarsdóttir, hjúkrunarfræðingur
	Brynhildur Jónasdóttir, hjúkrunarfræðingur
	Heiða Björk Birkisdóttir, hjúkrunarfræðingur
	Guðrún Valdís Sigurðardóttir, hjúkrunarfræðingur
	Rakel Rut Reynisdóttir, Hjúkrunarnemi
	Kristín Thorhallsdóttir, hjúkrunarfræðingur
	Vilborg Linda Indriðadóttir, hjúkrunarfræðingur
	Guðrún Þórsdóttir, hjúkrunarfræðingur
	Anna María Malmberg, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Berglind Wright Halldórsdóttir, hjúkrunarfræðingur
	Telma Björk Sörensen, hjúkrunarfræðingur
	Íris Björk Gunnlaugsdóttir, hjúkrunarfræðingur
	Ástrós Sverrisdóttir, hjúkrunarfræðingur
	Dagný Sif Stefánsdóttir, hjúkrunarfræðingur
	Berglind Beck, hjúkrunarfræðingur
	Margrét Manda Jónsdóttir, hjúkrunarfræðingur
	Anna R. Ingvarsdóttir, hjúkrunarfræðingur
	Eva Brynjarsdóttir, hjúkrunarfræðingur
	Magndís Blöndahl Halldórsdóttir, hjúkrunarfræðingur
	Margét Irene Schwab, hjúkrunarfræðingur
	Svanbjörg Pálsdóttir, hjúkrunarfræðingur
	Gunnfríður Ólafsdóttir, hjúkrunarfræðingur
	Ásdís Hinriksdóttir, hjúkrunarfræðingur
	Lóa Björk Smáradóttir, hjúkrunarfræðingur
	Helga Margrét Clarke, hjúkrunarfræðingur
	Erla Birgisdóttir, skurðhjúkrunarfræðingur
	Guðrún Selma Steinarsdóttir, hjúkrunarfræðingur
	Guðrún Freyja Daðadóttir, hjúkrunarfræðingur
	Hrefna Sif Gísladóttir, hjúkrunarfræðingur
	Agnes Reymondsdóttir, hjúkrunarfræðingur
	Jóna Sigríður Gunnarsdóttir, hjúkrunarfræðingur
	Sigrún Sunna Skúladóttir, bráðahjúkrunarfræðingur
	Oddrún Assa Jóhannsdóttir, hjúkrunarnemi á 3ja ári
	Una Sigríður Ásmundsdóttir, hjúkrunarfræðingur
	Helga Jensen, hjúkrunarfræðingur
	Ása Kolbrún Hauksdóttir, hjúkrunarfræðingur
	Álfheiður Snæbjörnsdóttir, hjúkrunarfræðingur
	Elísabet Brynjarsdóttir, hjúkrunarfræðingur
	Lóa Rún Björnsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Edda Dröfn Daníelsdóttir, hjúkrunarfræðingur
	Gunnur Ýr Gunnarsdóttir, hjúkrunarfræðingur
	Hrönn Håkansson, hjúkrunarfræðingur
	Snjólaug María Gunnarsdóttir, hjúkrunarfræðingur
	Ingibjörg Fjölnisdóttir, hjúkrunarfræðingur
	Katrín Inga Geirsdóttir, hjúkrunarfræðingur
	Björk Önnudóttir, hjúkrunarfræðingur
	Árni Már Haraldsson, hjúkrunarfræðingur
	Eydís Rut Gunnarsdóttir, hjúkrunarfræðingur
	Barbara Ösp Ómarsdóttir, hjúkrunarfræðingur
	Harpa Kristín Sæmundsdóttir, hjúkrunarnemi
	Silja Gylfadóttir, hjúkrunarfræðingur
	Ása H. Magnúsdóttir, hjúkrunarfræðingur
	Linda Nabye, hjúkrunarfræðingur
	Jórunn Ósk Frímannsdóttir Jensen, hjúkrunarfræðingur
	Helga Jóna Guðjónsdóttir, hjúkrunarfræðingur
	Dröfn Gunnarsdóttir, hjúkrunarfræðingur
	Heiðrún Sigurðardóttir, hjúkrunarfræðingur
	Tinna Halldórsdóttir, hjúkrunarfræðingur
	Ragnheiður Helga Reynisdóttir, hjúkrunarfræðingur og ljósmóðir
	Dýrleif Sigurjónsdóttir, hjúkrunarnemi
	Berlind Júlíusdóttir, hjúkrunarfræðingur
	Fríða Dóra Steindórsdóttir, hjúkrunarfræðingur
	Kolbrún Sara Guðjónsdóttir, hjúkrunarnemi
	Ragnheiður Kristín Björnsdóttir, hjúkrunarfræðingur
	Guðrún Birna Jónsdóttir, hjúkrunarnemi á 3ja ári
	Sólveig Aðalheiður G. Hjarðar, hjúkrunarfræðingur
	Sigríður Ólafsdóttir, hjúkrunarfræðingur
	Signý Helga Jóhannesdóttir, hjúkrunarfræðingur og ljósmóðir
	Signý Dóra Harðardóttir, ljósmóðir og hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Valgerður Anna Hannesdóttir, hjúkrunarnemi
	Jenný Kamilla Knútsdóttir, hjúkrunarfræðingur
	Guðrún Ingibjörg Guðmundsdóttir, hjúkrunarfræðingur
	Guðný Helgadóttir, hjúkrunarfræðingur
	Ragnheiður Thorkelsdóttir, hjúkrunarfræðingur
	Jórunn Edda Hafsteinsdóttir, hjúkrunarfræðingur
	Herdís Lína Halldórsdóttir, hjúkrunarfræðinemi á 3ja ári
	Guðbjörg Eva Rafnsdóttir, hjúkrunarfræðinemi á 3ja ári
	Stella Sharon Kiernan, hjúkrunarfræðingur
	Guðrún Karólína Guðjónsdóttir, hjúkrunarfræðingur
	Kristín Ólafsdóttir, hjúkrunarfræðingur
	Ásrún Ösp Jónsdóttir, hjúkrunarfræðingur og ljósmóðir
	Gróa Margrét Jónsdóttir, ljósmóðir
	Guðrún Hulda Gunnarsdóttir, hjúkrunarfræðingur og ljósmóðurnemi
	Kristín Hálfdánardóttir, hjúkrunarnemi
	Ásthildur Björnsdóttir, hjúkrunarfræðingur
	Ásdís Hreinsdóttir, hjúkrunarfræðingur
	Kristín Ásgeirsdóttir, hjúkrunarfræðingur
	Hildur Bára Leifsdóttir, hjúkrunarfræðingur
	Guðrún Rebekka Jakobsdóttir, hjúkrunarfræðingur
	Védís Klara Þórðardóttir, hjúkrunarfræðingur
	Guðný Lilja Jóhannsdóttir, Hjúkrunarnemi
	Sigríður Björg Ingólfsdóttir, hjúkrunarfræðingur
	Ellen Ösp Víglundsdóttir, hjúkrunarfræðingur
	Alma Sif Stígsdóttir, hjúkrunarfræðingur
	Hrefna Hugosdóttir, hjúkrunarfræðingur
	Elínborg Angantýsdóttir, hjúkrunarfræðingur
	Hrefna Björk Jónsdóttir, hjúkrunarnemi 3. Árs.
	Anna Ír Pétursdóttir, hjúkrunarfræðingur
	Hugborg Kjartansdóttir, hjúkrunarfræðingur og ljósmóðir

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Alma Emilía Björnsdóttir, hjúkrunarfræðingur
	Arna Þórðardóttir, hjúkrunarfræðingur
	Hildur Gunnarsdóttir, hjúkrunarnemi
	Þorsteinn Jónsson, hjúkrunarfræðingur
	Jóna Margrét Guðmundsdóttir
	Karólína Andrésdóttir, hjúkrunarfræðingur
	Lilja Bjarney Valdimarsdóttir, hjúkrunarfræðanemi.
	Steinunn Margrét Gylfadóttir hjúkrunarfræðingur
	Júlía Linda Ómarsdóttir hjúkrunarfræðingur/ljósmóðir
	Elfrið Ida Björnsdóttir, Hjúkrunarfræðinemi
	Guðlaug Linda Harðardóttir, Hjúkrunarfræðingur
	Karítas Halldórsdóttir ljósmóðir og hjúkrunarfræðingur
	Svanhvít Loftsdóttir, hjúkrunarfræðingur
	Sigrún Jensdóttir, hjúkrunarfræðingur
	Hallveig Skúladóttir, skólahjúkrunarfræðingur
	Hrafnhildur Ævarsdóttir hjúkrunarfr og ljósmóðir
	Jóna Rán Sigurjónsdóttir, hjúkrunarfræðingur
	Helga Kristín Jónsdóttir hjúkrunarfræðingur
	Margrét Björnsdóttir, hjúkrunarfræðingur
	Sólveig Kristbjörg Vagnsdóttir, Hjúkrunarfræðingur
	Jóhanna Tryggvadóttir, hjúkrunarfræðingur
	Þórunn Bjarney Garðarsdóttir, hjúkrunarfræðingur
	Hrafnhildur Ólöf Ólafsdóttir, Hjúkrunarfræðingur
	Kristín M. Hreinsdóttir, hjúkrunarfræðingur
	Anna Svandís Gísladóttir, hjúkrunarfræðingur
	Birna M. Gudmundsdottir, hjúkrunarfræðingur og ljósmóðir.
	Katrín Erna Þorbjörnsdóttir, hjúkrunarfræðingur
	Guðrún Margrét Gunnsteinsdóttir, hjúkrunarfræðingur
	Eygló Alda Sigurðardóttir Hjúkrunarfræðingur
	Eydís Hrönn Vilhjálmsdóttir hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Hildur Þóra Stefánsdóttir hjúkrunarfræðingur
	Jóhanna Rut Óskarsdóttir, 4. Árs hjúkrunarfræðinemi
	Harpa Lind Hilmarsdóttir hjúkrunarfræðingur
	Guðrún Katrín Gunnarsdóttir hjúkrunarfræðingur.
	Una Sóley Pálsdóttir Hjúkrunarfræðingur
	Sunnefa Lindudóttir, hjúkrunarfræðingur
	Elínborg Einarsdóttir Hjúkrunarfræðingur
	Guðrún Berglind Jóhannesdóttir, hjúkrunarfræðingur
	Þórdís Guðjónsdóttir, hjúkrunarfræðingur
	Bryndís Reynisdóttir, Hjúkrunarfræðingur
	Elísabet Íris Þórisdóttir, skurðhjúkrunarfræðingur
	Hafdís Jóhannsdóttir, hjúkrunarfræðingur
	Ósk Stefánsdóttir, hjúkrunarfræðingur
	Úlfhildur Guðjónsdóttir Hjúkrunarfræðingur
	Arna Ingimundardóttir, hjúkrunarfræðingur og ljósmóðir
	Anna Ólafsdottir, hjúkrunarfræðingur
	Hulda Pálsdóttir, hjúkrunarfræðingur
	Sigríður Zoëga, hjúkrunarfræðingur
	Drífa Björnsdóttir, ljósmóðir
	Ásta Dan Ingibergsdóttir, ljósmóðir og hjúkrunarfræðingur
	Rannveig Elíasdóttir, skólahjúkrunarfræðingur
	Heiðdis Dögg Sigurbjörnsdóttir, ljósmóðir og hjúkrunarfræðingur.
	Bryndís Berg, Hjúkrunarfræðingur
	Gróa Linddís Dal Hjúkrunarfærðingur
	Heiða María Elfarsdóttir, hjúkrunarfræðingur
	Ólína Ingibjörg Gunnarsdóttir hjúkrunarfræðingur
	Arna Huld Sigurðardóttir, hjúkrunarfræðingur
	Eygló Anna Tómasdóttir, hjúkrunarfræðingur
	Vigdís Jóhannsdóttir, hjúkrunarfræðingur
	Herdís Herbertsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Guðrún Svana Zophoníasdóttir, ljósmóðir
	Hrönn Sigurðardóttir, skurðhjúkrunarfræðingur
	Rakel Káradóttir, hjúkrunarfræðingur og ljósmóðir
	Íris Friðriksdóttir, hjúkrunarfræðingur
	Sigríður Tryggvadóttir, hjúkrunarfræðingur
	Guðrún Ágústsdóttir, hjúkrunarfræðingur
	Auður Ólafsdóttir, hjúkrunarfræðingur
	Margrét Ó. Thorlacius, hjúkrunarfræðingur og ljósmóðir
	Ásthildur Guðlaugsdóttir. Hjúkrunarfræðngur
	Kolbrún Sigurðardóttir. Hjúkrunarfræðingur
	Edda Rún Ólafsdóttir Hjúkrunarfræðingur
	Kristín Björg Róbertsdóttir, 4.árs hjúkrunarfræðinemi
	Sara Lovísa Halldórsdóttir, Hjúkrunarfræðingur
	Halldóra Kristjánsdóttir Hjúkrunarfræðingur
	Kristín Ásgeirsdóttir hjúkrunarfræðingur
	Sigurbjörg Ólafsdóttir Hjúkrunarfræðingur og Ljósmóðir
	Sigrún Eva Sigurjónsdóttir Hjúkrunarfræðingur
	Birgitta Káradóttir, hjúkrunarfræðingur
	Eygló Tómasdóttir, hjúkrunarfræðingur
	María Bóel Gylfadóttir, hjúkrunarfræðingur
	Kristín Birna Halldórsdóttir, hjúkrunarfræðingur
	Arnbjörg Jóhannsdóttir, hjúkrunarfræðingur
	Hilda Friðfinnsdóttir, hjúkrunarfræðingur og ljósmóðir
	Veronika Carstensdóttir Snædal, ljósmóðir
	Herdís Katrín Bjarnadóttir, hjúkrunarfæðingur
	Erna Niluka Njálsdóttir, hjúkrunarfæðingur
	Guðrún Þorláks Íslandi Hjúkrunarfræðingur og Framhaldsskólakennari
	Oddný Kristinsdóttir, Hjúkrunarfræðingur
	Guðrún Linda Friðriksdóttir Ljósmóðir og Hjúkrunarfræðingur
	Guðný Svava Guðmundudóttir, Hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Eva Rut Guðmundsdóttir, hjúkrunarfræðingur og ljósmóðir
	Elfa Þöll Grétarsdóttir, sérfræðingur í hjúkrun
	Ágústa Árnadóttir, hjúkrunarfræðingur
	Thelma Kristjánsdóttir, Hjúkrunarfræðingur
	Þóra Hrönn Þorgeirsdóttir, hjúkrunarfræðingur
	Stefanía Ösp Guðmundsdóttir, hjúkrunarfræðingur
	Emma Marie Swift, ljósmóðir
	Brynja Örlygsdóttir, hjúkrunarfræðingur
	Guðbjörg Pálsdóttir, sérfræðingur í hjúkrun
	Ingunn Steingrímsdóttir, hjúkrunarfræðingur
	Elísabet Guðmundsdóttir hjúkrunarfræðingur
	Jónína Salný Guðmundsdóttir hjúkrunarfræðingur og ljósmóðir
	Jóna Björg Jónsdóttir hjúkrunarfræðingur
	Ása María Guðjónsdóttir, hjúkrunarfræðingur
	Fanný B. Miiller Jóhannsdóttir, hjúkrunarfræðingur
	Áslaug Kristjánsdóttir, hjúkrunar- og kynfræðingur
	Kristín Sigurðardóttir, hjúkrunarfræðingur
	Guðrún Ásta Sigurðardóttir, hjúkrunarfræðingur
	Aðalsteinn Baldursson, hjúkrunarfræðingur
	Sigríður Einarsdóttir, Hjúkrunarfræðingur
	Björg S. Skarphéðinsdóttir skurðhjúkrunarfræðingur
	Inger Ágústsdóttir hjúkrunarfræðingur
	Hrönn Harðardóttir hjúkrunarfræðingur
	Elfa Lind Einarsdóttir 3.árs hjúkrunarnemi
	Rakel María Magnúsdóttir, hjúkrunarfræðingur
	Þóra Gunnlaugsdóttir, hjúkrunarfræðingur
	Svanhildur Ósk Sigurfinnsdóttir, hjúkrunarfræðingur
	Anna Þórunn Sigurðardóttir, hjúkrunarfræðingur
	Katrín Hilmarsdóttir, hjúkrunarfræðingur
	Bjork Bragadottir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Vilborg Guðlaugsdóttir, hjúkrunarfræðingur
	María Sif Ingimarsdóttir, hjúkrunarfræðingur
	Bryndís Stefanía Halldórsdóttir, hjúkrunarfræðingur
	Helga Hrönn Þórsdóttir, hjúkrunarfræðingur
	Guðbjörg Bergmundsdóttir, hjúkrunarfræðingur
	Anna Birna Jensdóttir, hjúkrunarfræðingur
	Soffía Arna Ómarsdóttir, hjúkrunarfræðingur
	Guðrún Hjartardóttir, hjúkrunarfræðingur
	Ólöf Guðbjörg Eggertsdóttir, hjúkrunarfræðingur
	Hanna María Alfreðsdóttir, hjúkrunarnemi
	Guðríður Ester Geirsdóttir, hjúkrunarnemi
	Bryndís Hulda Ríkharðsdóttir, hjúkrunarfræðingur
	Birna María Einarsdóttir, hjúkrunarfræðingur
	Bylgja Rún Stefánsdóttir, hjúkrunarfræðingur
	Rán Jósepsdóttir, hjúkrunarfræðingur
	Margrét Sigmundsdóttir, hjúkrunarfræðingur
	Kristín Auður Sophusdóttir, hjúkrunarfræðingur
	Tinna Huld Karlsdóttir, hjúkrunarfræðingur
	Sigurdís Ólafsdóttir, hjúkrunarfræðingur
	Guðný Björg Helgadóttir, 4. Árs hjúkrunarnemi
	Sigrún Elva Guðmundsdóttir, hjúkrunarfræðingur
	Steinunn Jónsdóttir, hjúkrunarfræðingur
	Hrönn Birgisdóttir, hjúkrunarfræðingur
	Guðrún Margrét Birgisdóttir, hjúkrunarfræðingur
	Steinunn Hauksdóttir, hjúkrunarfræðingur
	Guðrún Einarsdóttir, hjúkrunarfræðingur
	Þorbjörg Anna Steinarsdóttir, hjúkrunarfræðingur
	Eyrún Harpa Hlynsdóttir, hjúkrunarfræðingur
	Inga Steinlaug Hauksdóttir, hjúkrunarfræðingur
	Gígja Gylfadóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Guðrún Gígja Pétursdóttir, hjúkrunarfræðingur		
	Guðrún Björnsdóttir, hjúkrunarfræðingur		
	Gunnhildur Árnadóttir, hjúkrunarfræðingur		
	Fjóla Bjarnadóttir, hjúkrunarfræðingur		
	Steina Þórey Ragnarsdóttir, hjúkrunarfræðingur og ljósmóðir		
	Anna Eðvaldsdóttir, hjúkrunarfræðingur og ljósmóðir		
	Valdís Ösp Jónsdóttir, hjúkrunarfræðingur		
	Halldóra Margrét Bjarnadóttir, hjúkrunarfræðingur og ljósmóðir		
	Sunna Ipsen, hjúkrunarfræðingur		
	Marta Lilja Sigurbjarnadóttir, hjúkrunarfræðingur		
	Kristín Hrönn Reynisdóttir, hjúkrunarfræðingur og ljósmóðir		
	Harpa Indriðadóttir, hjúkrunarfræðingur		
	Soffía Jakobsdóttir, hjúkrunarfræðingur		
	Anna María Jónsdóttir, hjúkrunarfræðingur		
	Kristín Kristinsdóttir, skurðhjúkrunarfræðingur		
	Katrín Olsen Björnsdóttir, hjúkrunarfræðingur		
	Kristjana Arnardóttir, hjúkrunarfræðingur		
	Anna Vilbergsdóttir, hjúkrunarfræðingur		
	Sigrún Esther Guðmundsdóttir, hjúkrunarfræðingur		
	Guðrún Daníelsdóttir Hjúkrunarfræingur		
	Edda Karen Haraldsdóttir, hjúkrunarfræðingur		
	Sigrun Maria Gudlaugsdottir, hjúkrunarfræðingur		
	Anna Rósa Pálsdóttir, Hjúkrunarfræðingur		
	Hjálmfríður Nikulásdóttir, hjúkrunarfræðingur		
	Hrafnhildur Björk Gunnarsdóttir, hjúkrunarfræðingur.		
	Eygló Valdimarsdóttir, hjúkrunarfræðingur.		
	Sigurbjörg Jónsdóttir, hjúkrunarfræðingur		
	Arnlaug Borgþórsdóttir, hjúkrunarfræðingur		
	María Egilsdóttir, hjúkrunarfræðingur og ljósmóðir		
	Halla Harðardóttir, hjúkrunarfræðingur og ljósmóðir		

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan
	Herdís María Júlíusdóttir, hjúkrunarfræðingur
	Anna Stefánsdóttir, hjúkrunarfræðingur
	Aldey Traustadóttir, hjúkrunarfræðingur
	Karin Sandberg, hjúkrunarfræðingur
	Alma Björk Guttormsdóttir, hjúkrunarfræðingur
	Linda Björk Rúnarsdóttir, hjúkrunarfræðingur
	Steinunn Ósk Geirsdóttir, hjúkrunarfræðingur
	Hanna Jóna Stefánsdóttir, hjúkrunarfræðingur
	Þórunn Hanna Ragnarsdóttir, hjúkrunarfræðingur
	Inga Marta Jónasdóttir, hjúkrunarfræðingur
	Björk Gísladóttir, hjukrunarfræðingur
	Fanney Gunnarsdóttir, hjúkrunarfræðingur
	Karen Sigurjónsdóttir, Hjúkrunarfræðingur
	Jóna Ósk Lárusdóttir hjúkrunarfræðingur
	Eyrún Jónsdóttir, hjúkrunarfræðingur
	Margrét Salóme, hjúkrunafræðingur
	Ásthildur Gestsdóttir, hjúkrunarfræðingur og ljósmóðir
	Unnur Alma Thorarensen, hjúkrunarfræðingur
	Clara Guðjónsdóttir, hjúkrunarfræðingur
	Jóhanna Helgadóttir, hjúkrunarfræðingur
	Sif Sigurðardóttir, hjúkrunarfræðingur
	Eva Björk Aðalgeirsdóttir, hjúkrunarfræðingur
	Aðalheiður Valgeirsdóttir, hjúkrunarfræðingur og ljósmóðir
	Guðrún Ásta Gísladóttir, Hjúkrunarfræðingur og ljósmóðir
	Njóla Elísdóttir, hjúkrunarfræðingur
	Guðrún Anna Valgeirsdóttir, hjúkrunarfræðingur og ljósmóðir
	Ásta Rut Ingimundardóttir, hjúkrunarfræðingur
	Linda Hrönn Eggertsdóttir, hjúkrunarfræðingur
	Inger Sofía Ásgeirsdóttir hjúkrunarfræðingur
	Hafdís Björnsdóttir, hjúkrunarfræðingur

Timestamp	Ef þú ert sammála þessari yfirlýsingu vinsamlega skrifaðu nafn þitt og starfsheiti hér að neðan		
	Hrafnhildur Ása Karlsdóttir, hjúkrunarfræðingur		
	Jóhanna Eiríksdóttir, hjúkrunarfræðingur		
	Helga Ýr Erlingsdóttir, hjúkrunarfræðingur		

-----Original Message-----
From: Jack M [mailto:jmicay@ca.inter.net]
Sent: 28. febrúar 2018 23:09
To: althingi@althingi.is
Subject: ban on male circumcision

Dear Iceland

My wife and I have visited your beautiful country 3 times and hope to go back again. However we cannot in good conscience do so if you follow through on the proposed legislation to ban male circumcision. This is blatantly discriminatory against both Jews, like us, as well as Muslims, to whom this is an essential part of our religion. As a doctor I know that there is no health reason to ban male circumcision. In fact, it has proven health benefits in terms of preventing infections, including HIV, and even cancer of the penis.

So please don?t follow through with this anti-Semitic and anti-Muslim legislation so that we can return once again to your beautiful country

Jack Micay MD
Toronto, Canada

Jacob Sysser, FM (Helsingfors)

Radiogatan 11A23, FI-00240

13.03.2018

Almenn hegningalög (bann við umskurði drengja), frumvarp 183

Frjálslyndir gyðingar hafna umskurði

Svo virðist sem rödd frjálslyndra gyðinga heyrist ekki jafn hátt og rödd rétttrúnaðar gyðinga í umræðunni um umskurð á drengjum. Það er ekki sanngjarnt þar sem frjálslyndir gyðingar eru í meirihluta í gyðingasamfélögum samtímans. Í Norður Evrópu eru frjálslyndir gyðingar í miklum meirihluta. Þessi staðreynd kemur glögglega í ljós þegar bænahús gyðinga í einhverri borg í Norður Evrópu eru heimsótt, og fjöldi gyðinga sem stundar tilbeiðslur í bænahúsum borinn saman við fjölda gyðinga í þeirri borg.

Íhaldsamir gyðingar tala ekki fyrir munn allra

Frjálslynd gyðingasamfélög skortir innra skipulag og þar með koma þau ekki sínum sjónarmiðum kerfisbundið á framfæri við fjölmiðla. Innan samfélaga íhaldsamra gyðinga eru frjálslynd viðhorf til gyðingdómsins almennt ekki viðurkennd. Því geta frjálslyndir gyðingar ekki nýtt sér sömu rásir og hin trúarlegu hefðbundnu gyðingasamfélög, til að hafa áhrif á stjórnsýslu og fjölmiðla. Þar af leiðir að þeir sem hafa áhuga á að kanna viðhorf frjálslyndra gyðinga, til dæmis um umskurð drengja, verða að leita sérstaklega eftir þeim á meðan rétttrúnaðar gyðingar koma sínum skoðunum á framfæri um heim allan og birtast eins og talsmenn allra gyðinga, sem þeir eru ekki.

Breytt viðhorf gagnvart umskurði

Í Ísrael hefur viðhorf gagnvart umskurði umturnast á síðustu árum. Þar sem stærstu fjölmiðlar í Ísrael eru eru ekki í eigu eða undir stjórn rétttrúnaðar gyðinga þá ná þessi sjónarmið til almennings. Flestir fjölmiðlar fjalla um frjálslyndar gyðingafjölskyldur sem hafa kosið að umskera ekki syni sína, þrátt fyrir hefðina innan gyðingdómsins. Margir fjölmiðlar vitna til skoðana frjálslyndra gyðinga sem eru áberandi í umræðunni og eru á móti umskurði á drengjum, svo sem Theodor Herzl stofnanda Zionista hreyfingarinnar, eða Sigmund Freud, sálkönnuðar Sumir hafa vitnað í einn virtasta leiðtoga gyðingdómsins, Moses Maimonides, sem mótmælti umskurði en sjónarmið hans voru þögguð niður, þar til nú.

Aðrar viðurkenndar athafnir hjá gyðingum án inngrips

Mörg samtök, bæði formleg og óformleg, hafa verið stofnuð í Ísrael í þeim tilgangi að koma á framfæri nútímalegri viðhorfum gagnvart umskurði. Sérstaklega hefur verið lögð áhersla á að kynna athafnir sem fela ekki í sér inngrip í líkama barns (Brit Shalom), eins og umskurður (Brit Milah) gerir. Árið 1998 lögðu Samtök í Ísrael um bann við umskurði barna (The Israeli Association against Genital Mutilation of Babies), fram mál í hæstarétti í Ísrael um að banna umskurð. Það mál fékk ekki stuðning þar sem ekki lágu fyrir nægilega margar læknisfræðilegar rannsóknir og upplýsingar um áhrif umskurðar. Á þeim forsendum var málinu hafnað.

Umskurðum hefur fækkað

Síðan þá hefur vaxandi fjöldi gyðingafjölskyldna kosið að láta ekki umskera börnin sín. Talið er að á svæðum þar sem frjálslyndir gyðingar eru í meirihluta, er umskurður ekki stundaður en fólk velur að nota aðrar athafnir sem viðurkenndar eru í gyðingdómi eins og Brit Shalom en þá eru fætur barnsins þvegnar með vatni. Í Bandaríkjunum hefur umskurður fækkað gríðarlega hin síðari ár. Frjálslynd gyðingasamtök eins og Gyðingar gegn umskurði (Jews against Circumcision) hafa öðlast töluverðan sýnileika og hljómgrunn á samfélagsmiðlum.

Nú horfa frjálslyndir gyðingar til Íslands og vona að samstaða um málstaðinn aukist. Við viljum sýna meirihluta gyðinga vináttu í verki, og síðat en ekki síst verja gyðinga, múslima og öll börn frá því sem nú er álitið vera mannleg fórn.

-----Original Message-----
From: JACQUES HADIDA [mailto:jacqueshadida1@yahoo.com]
Sent: 28. febrúar 2018 23:08
To: althingi@althingi.is
Subject: Ban on circumcision

Hello,

I come to add my names to all those who wish the Government of Iceland lifts the ban on circumcision

For us Jews, this has been a practice we followed for over 3000 years.
You can appreciate how hard it is for us not to respect our commandments.

It is not too hard to put yourself in someone else's position to understand our predicament.
History has shown that countries who mistreated Jews did not end up doing well

Maybe it is worth giving it another look.

Jacques Hadida
Carlsbad, California

Sent from my iPad

Tuesday, March 27, 2018

Re: Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Honorable Members of Icelandic Parliament,

I am writing in support of your bill to protect the human rights to bodily integrity and autonomy of all children, including boys.

I have had to live since 1954 with the unwanted results of a cruel, partial genital amputation imposed in infancy.

For 25 years I have been studying this issue and working to educate and eradicate all genital surgery on healthy children.

It is time for reasonable people to stand up for the most basic of human rights.

Thank you Iceland for considering this important issue and voting to protect the human rights of all children.

James Loewen

16 – 1101 Nicola Street
Vancouver, BC
Canada
V6G 2E3

26.2.2018

Name Jeremy S. Rosof

Email jrosof@gmail.com

Subject Icelandic Circumcision Ban: a return to pre-enlightenment discrimination

Message Dear Sir/Madam:

The ban contemplated of male circumcision in Iceland is most peculiar. Circumcision is an ancient rite with health benefits that is endorsed by the physicians of the United States, who are among the most advanced in the world. Most American males are circumcised for health reasons. American laws protect the free exercise of religion, including male circumcision. Iceland proposes to ban male circumcision and criminalize those who exercise their faith sending them to jail for six years, but does nothing about the nearly identical "scourge" of ear piercing of girls, which is commonly practiced by ethnic Icelanders. One must question the selective focus and what it says about Iceland, esp. given the country's inglorious Holocaust era record, which included supplying members of the Nazi S.S. and denying admission to Austrian Jews, a population that f aced certain death and which led the world in science, letters and the arts (Mahler, Schoenberg, and Freud to name a few). Iceland needs to decide whether it truly wants to be a liberal nation or to revert to

European medievalism with bans on Jews and Muslims as in Fifteenth and Sixteenth Century Spain. I was interested in visiting your country en route to continental Europe and the UK but now must reflect on what kind of a society exists in Iceland that could adopt such a narrow-minded, parochial and indeed insular law.

Sincerely,

Jeremy S. Rosof

28.3.2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál

I fully support the bill to ban forced male genital mutilation in Iceland. I am actually from America, a place where this sexist gender based violence of our most vulnerable is till loved by far too many people. I really appreciate the efforts being made. We need to stand up against religious abuse and bullshit. We cannot allow religious people to do whatever they want. In the Torah(what Jews believe) it says that gays should be put to death, but of course we dont allow this. We should allow them to sexually assault and rape their children either.

Jessica T
anotherjessica@outlook.com
707 628 0939

JEWS AGAINST CIRCUMCISION

Alþingi
Kirkjustræti
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál

25 March 2018

Ágæta Alþingi / Dear Members of the Parliament:

We, the undersigned, are members of the group **Jews Against Circumcision**. We are writing in support of your proposed ban on non-therapeutic involuntary circumcision of minors. We are also writing in rebuttal to letters that you have received in opposition to the proposed legislation from several prominent Jewish organizations including the Anti-Defamation League, the Swiss Federation of Jewish Communities and the Belgian Federation of Jewish Organizations. We want it to be known that, on the matter of involuntary circumcision, these organizations do not speak for all Jews and they do not speak for us.

First, a word about who we are and what we believe in. We are men and women who come from different walks of life and different parts of the world but who are united in two important respects: our identification as Jews and our unwavering opposition to male genital mutilation ("circumcision"). Some of us are secular Jews, identifying as Jewish ethnically and culturally, and some of us are religious Jews for whom Judaism is central to our beliefs and values. Some of us have been subjected to involuntary circumcision and others have not. Some of us were subjected to involuntary circumcision within the context of the brit milah. Other members of our group were subjected to it merely because we were born into a particular time and place and so were swept up in the tide of medicalized (but still customary) involuntary circumcision that has inundated and warped the practice of neonatal medical care during the past one hundred seventy-five years or so. Those of us who *have* been subjected to involuntary circumcision declare unambiguously that we object to having been subjected to it without our consent. We were violated, harmed and deprived of our fundamental human rights and dignity.

We emphatically do *not* reject our Jewishness and, for those of us who are religious, we do not reject Judaism: what we reject is involuntary circumcision. We reject it and we oppose it on the following grounds:

First, we reject the proposition that involuntary circumcision is essential to the practice of Judaism for the individual himself. It isn't. Jewish women are not subjected to involuntary circumcision and they are no less spiritual - nor do they regard themselves any less beloved by Him (or Her) who they believe to be the Creator of the universe - than their Jewish fathers, brothers, sons and husbands who were. More to the point, there are countless Jewish boys and men the world over - no less spiritual and no less devout than our Jewish brethren who have written to oppose the involuntary-circumcision ban - who were not, as neonates, subjected to this ancient and barbaric ritual.

Second, we reject the proposition that involuntary circumcision is essential to the survival of Judaism as a cohesive religion. It isn't. Religious Jews around the world, in ever-increasing numbers, are replacing the brit milah with the brit shalom, a non-violent, non-harmful religious ceremony that serves exactly the same spiritual and communal purposes as the brit milah but without the harm, without the blood, without the pain, without the trauma, and without the human rights violation.

Third, we reject the proposition that involuntary circumcision is essential to the continued existence of the Jews as a distinct people. It isn't. The Jewish people existed long before the advent of involuntary neonatal circumcision as a religious mandate, we existed longer still before involuntary circumcision was expanded into the radical prepucectomy (*peri'ah*) that is practiced today, and we will continue to exist long after involuntary circumcision has gone the way of various other strict religious mandates that are no longer followed by the majority of Jews, such as certain dietary restrictions, the proscription against intermarriage, and post-menstrual ritual bathing. And we will continue to exist long after it has gone the way of other long-discarded and long-rejected customs and acts that were once practiced by our forebears contemporaneously with involuntary circumcision including polygyny, death by stoning, and slavery.

Fourth, we reject the proposition that involuntary circumcision is a necessary part of being Jewish. It isn't. A Jewish boy born to a Jewish mother is no less Jewish by

virtue of not having had part of his penis cut off. Jewishness is a product of one's genes, one's heritage, one's family life and upbringing, one's values, one's traditions and culture and, in the case of Judaism, it is a product of one's religious beliefs.

Fifth, we reject involuntary circumcision because we regard *all* genital cutting of children without their consent as a violation of the fundamental human right to have one's body unmolested and unharmed. We believe that every human being has an inherent right to grow up with all of his or her body parts intact. Perforce, that means that every human being has an inherent right to grow up with the genitals that she or he was born with. This belief is inseparable and inextricable from our values as Jews and from the ethical and moral beliefs that we, as Jews, hold dear. Our fervent opposition to involuntary circumcision, then, is not *in spite* of our Jewish beliefs and values but *because* of them.

Sixth, we reject the broad assertion that the movement to ban involuntary circumcision - and the specific assertion that the proposed legislation banning it that is before this committee of the Alþingi - is nothing more than a thinly veiled attack on Jews or Judaism and that it is anti-Semitic. It isn't. We Jewish opponents of involuntary circumcision regard this movement as a progressive human-rights struggle and we regard this legislation as a long-overdue inclusion of boys - including Jewish ones - within the protective ambit of the already-existing legal framework under which female genital mutilation has been banned in Iceland and throughout much of the world. We regard the proposed legislation not as an attack on Jews but as the inevitable logical conclusion of contemporary and increasingly universal standards regarding human rights and children's rights as articulated in the **Universal Declaration of Human Rights** (ratified by the United Nations General Assembly in 1948) and in the **Convention on the Rights of the Child** (adopted by the United Nations General Assembly in 1989 and ratified in 1990), and specifically as articulated in *Article 37*, *part a* of the latter which states that "No child shall be subjected to torture or other cruel, inhuman or degrading treatment or punishment."

Seventh, we reject the assertion that the right to subject an infant or child to involuntary circumcision is a fundamental right that comes under the rubric of "religious freedom." While we recognize that the freedom to *believe* (or not to believe, for that matter) is fundamental and, therefore, absolute and illimitable, we reject the extension of that principle to the assertion that the freedom to *act* is likewise fundamental and, therefore, absolute and illimitable. We believe that one

person's right to practice her or his religion ends where another person's body begins. We believe that one person's fundamental right of religious liberty is delimited by every other person's even more fundamental right not to be physically harmed. We believe that the only person who has a right to cause to have his or her genitals (or any other body part) mutilated, deformed, scarred, or surgically altered in any way is the individual himself or herself. No one else has a right to decide what parts of a boy's penis he gets to keep and what parts get cut off. We do not consider that a radical or even a controversial position, much less an anti-Jewish, anti-Semitic or anti-Muslim one. On the contrary, we consider it to be simply and rather obviously in accordance with contemporary norms regarding fundamental human rights and human dignity. We believe that no one has the right to cut off part of an unconsenting child's penis as a religious rite, for reasons of culture, for reasons of cosmesis, for reasons of convenience, for reasons of conformity, for reasons of tradition or on the basis of dubious and specious justifications related to health or hygiene when perfectly efficacious non-invasive, non-harmful, non-painful and non-permanent alternatives are readily available (such as soap and water).

Having stated all of the foregoing, we also wish it to be known that neither do we oppose circumcision under all circumstances. While we may not approve, we subscribe to the right of a man to choose circumcision for himself for whatever reason he may have once he is an adult and of an age at which he can make informed choices about his own body. Once he is capable of exercising informed consent, we endorse, on the principle of autonomy and self-determination, his right to have his body altered in accordance with his own beliefs and values - whether these beliefs have their origin in religion or anything else. It is *his* body and that is why it should be *his* choice.

We also acknowledge the social context in which opposition to this proposed legislation by the aforementioned Jewish organizations has arisen. We are fully aware of the history of anti-Semitism and the persecution of our ancestors throughout so much of European history. And we acknowledge that that persecution has manifested itself in circumcision prohibitions in generations past. But when these earlier prohibitions were enacted, they were part of explicitly anti-Semitic, anti-Jewish government programs. It is understandable, especially with the memory of the Holocaust still fresh in our minds, that some Jews would hear ominous echoes of Europe's dark anti-Semitic past in the current effort to prohibit involuntary circumcision. Such fears may acquire even greater validation

and urgency given the alarming recrudescence of nationalism, xenophobia and anti-Semitism that has occurred on both sides of the Atlantic during the past few years (and especially during the last year and a half).

But as Jews, ourselves, who oppose involuntary circumcision, we vigorously reject the assertion that the modern genital autonomy movement (which seeks to ban *all* genital cutting: of girls as well as of boys) is nothing more than a resurgent manifestation of anti-Semitism. Indeed, we are offended by that assertion. Circumcision prohibitions from centuries past that were anti-Jewish in design and the contemporary movement to ban involuntary circumcision are as different as night and day. Although they may coincidentally culminate in and intersect at the point of banning involuntary circumcision, they are fundamentally dissimilar both in origin and purpose. Previous prohibitions originated in ethnic and religious hatred while the modern genital autonomy movement originates in respect for the body-rights of the individual and in a philosophical objection to violence and to the needless causing of pain and suffering to infants. Previous prohibitions sought to ban an ancient, involuntary blood-letting ritual not because of what it is but because of who practiced it. The modern genital autonomy movement seeks to ban the same ancient, involuntary blood-letting ritual not because of who practices it but because of what it is.

We also reject the assertion that the effect, if not the stated purpose, of the proposed involuntary-circumcision prohibition would be to make Jews (or Muslims) personae non gratae in Iceland. As Jonathan Greenblatt of the ADL put it, "Such a ban would mean that no Jewish family could be raised in Iceland, and it is inconceivable that a Jewish community could remain in any country that prohibited brit milah." That assertion completely discounts the thousands upon thousands of Jews who abhor the brit milah and who would be only too happy to raise their families - and to raise them as proudly Jewish - in a country where brit milah is prohibited by law. How many new Jewish parents have been pressured - against their natural maternal and paternal instincts, against their inmost beliefs, and against their better judgment - into subjecting their offspring to circumcision? Time and again we learn of the extent to which it is the social pressure on behalf of involuntary circumcision that is brought to bear on new parents by *their* parents, relatives or others in their community that is chiefly and ultimately responsible for the perpetuation of this reprehensible practice. The paradox is that, contrary to Mr. Greenblatt's supposition - that the involuntary-circumcision ban must necessarily result in an exodus of Jews from Iceland - such a prohibition could just as likely

have the opposite effect: an influx of Jews who would gladly raise their families in a country where they are free of the pressure to subject their children to genital mutilation.

There is nothing in the text of the proposed bill that could lead anyone to fairly conclude that it is motivated by anti-Jewish (or even anti-Islamic) sentiment. The bill has sponsors from the Progress Party, the People's Party, the Left-Green Movement and the Pirate Party. And while the Progressive Party and the People's Party have recently been linked with populism and the espousal of anti-immigration sentiments, the bill is also co-sponsored by MPs from parties that are associated mainly with environmentalism, feminism and pacifism (the Left-Green Movement), and direct democracy (the Pirate Party).

We are thus left to weigh the merits and potential significance of the proposed legislation against the historical backdrop of anti-Semitism and against the contemporary backdrop of xenophobia and anti-immigrant nationalism that have swept across much of the northern hemisphere. We are left, further, to weigh, as best we can with the information that is currently available to us, whether the proposed legislation has roots sunk deep within nationalist, anti-immigrant and anti-Semitic soil, as some have claimed of this and of similar proposed legislation elsewhere or, as we would like to believe, that it is the flowering of the same humanist and progressive impulses that inform the genital autonomy movement of which **Jews Against Circumcision** is a part.

Having done so, we wholeheartedly and enthusiastically endorse this legislation. The proposed circumcision prohibition would ban all non-therapeutic involuntary genital cutting of boys, no matter what reasons are entertained by the child's parents for wanting to subject their child to circumcision, no matter what that child's parents' religion or ethnicity happens to be and, for that matter, even irrespective of any ulterior or merely unfairly impugned motives on the part of the bill's sponsors. This opportunity is too important not to seize. The right of every child to be free of genital cutting is an idea whose time has come. The proposed circumcision ban, as we see it, represents the inevitable and irresistible march of human progress toward greater respect for the rights of the child and the rights of the individual. We endorse that progress and are proud, as Jews and consistent with our Jewish ethos, to be a part of it.

Respectfully submitted on behalf of ***Jews Against Circumcision*** by,

David Balashinsky, Binghamton, NY, U.S.A.
Katherine Bennett, Flushing, NY, U.S.A.
Jonathan Lambert, Manchester, UK
Thea Oldan, Oslo, Norway
Jacob Sysser, Helsinki, Finland
Shayna Ginsberg - Ontario Canada
Lisa Paige Glass, Boca Raton, FL.
Colin Ames, Freiburg, Germany
Rosa Chavez Adams, Denver Colorado USA
Mikael Aktor, Copenhagen, Denmark
Eva Posner, Copenhagen, Denmark
Victoria Simon, York, Maine U.S.A.
Carrie Simon, Long Island, NY, U.S.A.
Andrew S. Kohler, Ann Arbor, MI
Julie Morrow, Truckee, CA, U.S.A.
Noel Levin, Ruckersville, VA, USA
Rachel Lavoie, Floral Park, NY, U.S.A.
Daniel Tati, Denver, CO, U.S.A.
Evan Roman, Tallinn, Estonia
Rosa Chavez Adams, Denver, CO, U.S.A
James Pinkley, Ellicott City, MD, U.S.A
Amy Greenebaum
Jenny Bot, Sacramento, CA, U.S.A.
Connor Jackson Licolli, U.S.A.
Eric Clopper, Boston, MA, U.S.A.
Alon Sivroni, Tel-Aviv, Israel
Jérôme Segal, Vienna, Austria

2.4.2018

Regarding the proposed legislation banning non-therapeutic circumcision.

Ágæta Alþingi / Dear Members of the Parliament:

Last week, I sent a PDF document to you on behalf of the organization ***Jews Against Circumcision*** in support of the proposed ban on involuntary circumcision of minors. Attached to this current email is a document containing the names of several additional co-signers who requested that their names be added to the original letter after it had been sent. I am requesting, therefore, that the document enclosed herein be accepted as an addendum to the letter from ***Jews Against Circumcision*** that you received last week.

Thank you for your consideration,

David Balashinsky,
Binghamton, NY, U.S.A.
Jews Against Circumcision

Alþingi
Kirkjustræti
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál

Nicola Teranella, Hyampom, CA, U.S.A.
Yana Lausten-Thomsen, Fourquex, France
Devorah Michal, Jerusalem, Israel
Kelly Schenkman, CT, U.S.A.
Benjamin Schenkman, CT, U.S.A.
Ofer Neiman, Jerusalem, Israel
Jerrold Greenberg, New York, NY, U.S.A

From: Joel Rubinovich [mailto:jlr@catoronto.ca]
Sent: 1. mars 2018 13:58
To: althingi@althingi.is
Subject: Proposed circumcision ban

Gentlemen/Ladies:

I have read about your proposal to ban non-medical circumcisions in your country. While it is the right of your country to maintain its own laws, I would suggest that the proposal interferes with a widely accepted religious practice which most observant Jews take as divinely proclaimed. Surely the proposal is an attempt, directly or indirectly, to interfere with the religious beliefs of some of your citizens and, as such, is deserving of condemnation and defeat.

Yours truly,

Joel L Rubinovich CPA CA

709-44 Jackes Ave

Toronto ON M4T 1E5

T - 416.944.3281

F - 416.981.8798

E - jlr@catoronto.ca

From: John Tyrrell [mailto:frjohntyrrell@hotmail.com]
Sent: 28. febrúar 2018 22:52
To: althingi@althingi.is
Subject: Male circumcision

It is my understanding that there is a move within your parliament to ban this long-standing and benign practice of male circumcision. I urge you to stop or defeat such a move. In fact the American Academy of Pediatrics has determined the health benefits far outweigh any negative concerns.

Any such ban is a direct anti-Semitic attack as well in my opinion.

With best wishes and blessings,

Dean John Tyrrell+

Chaplain Barrhead and Westlock RCMP Detachments

Secretary-Treasurer CPCA

The Very Rev. John Tyrrell, CD

Dean Emeritus, Cathedral of St. Paul,

Nicosia, Cyprus

DOCTORS OPPOSING CIRCUMCISION URGES ICELAND TO RESTRICT MALE CIRCUMCISION TO MEDICAL NEED ONLY

Doctors Opposing Circumcision
Doctorsopposingcircumcision.org
Office of the General Counsel
2040 Westlake Avenue North, #420
Seattle, Washington, USA 98107-4137
docdirector.geisheker@gmail.com
+1 206. 465. 6636

15 March 2018

Alþingi
Kirkjustræti
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágæta Alþingi / Dear Members of the Parliament:

Our registered international physicians' charity, Doctors Opposing Circumcision, respectfully asks you to **please support the proposed restrictions on male circumcision in Iceland –unless there is proven medical need.**

We believe that Iceland has this obligation under the United Nations Convention on the Rights of the Child which Iceland has ratified. That UN Convention, at Art 24, sec. 3, declares:

"States Parties shall take all effective and appropriate measures with a view to ***abolishing traditional practices prejudicial to the health of children.****"*
http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx -

As you will know, 'medicalised' circumcision was a puritanical invention of English-language doctors before the discovery of germs. It has NO place in modern medical care except for consenting adults or proven medical need. A full discussion, with references to modern science, of our many objections to unnecessary and painful male genital cutting, including the recent HIV claims, may be found at:

https://www.doctorsopposingcircumcision.org

Circumcision amputates healthy, functional, sensitive, sexual tissue that no normal adult male would easily give up. Please see our website for further medical information too extensive to detail in this brief message.

The recent complaints of the religious community are easily answered:

ISLAM does not require circumcision. It is merely cultural, not divine, and the Qu'ran does not demand it. See https://www.facebook.com/muslimsagainstcirc/ or

http://www.quranicpath.com/misconceptions/circumcision.html -

JUDAISM has an alternative ceremony, *Brit Shalom*, a welcome ceremony without any cutting, which is increasingly popular among Jews around the world. The site below was founded and is maintained by our Jewish Executive Vice-President, Mark D. Reiss, M.D.
See: http://www.britshalom.info
and
http://www.beyondthebris.com/2012/04/choosing-brit-shalom-over-brit-milah.html

Claims that such a restriction will drive religious minorities from Iceland are an exaggeration, pure scare-tactics, as the practice is not a '*sine qua non*' in either religion.

Moreover, we need to protect the religious freedom of the BOY himself. Not everyone stays with his family's religious heritage, and the child's future choices need to be preserved. Parents do not own their children, and cannot do as they please to their child's body.

Your example may start an important worldwide conversation about the worthiness of ancient practices injurious to children, which the United Nations Convention on the Rights of the Child recognizes as a universal concern.

Once again, we urge you, respectfully, to **please support the ban in Iceland on non-medical, merely cultural, unnecessary, male circumcision.**

Respectfully submitted,

———

John V. Geisheker, JD, LL.M,

Executive Director; General Counsel,

on behalf of the Board Members and Advisors of Doctors Opposing Circumcision:

George C. Denniston, MD, MPH, President

Mark D. Reiss, MD, Executive Vice-President

George Hill, Vice-President for Bioethics

Morris L. Sorrells, MD, Pediatric consultant

Andrew R. Biles, Jr, MD, Pediatric consultant

John W. Travis, MD, MPH, Infant Wellness

Mat Masem, MD, Professor of Medicine,

Michelle Storms, MD, Family Medicine

Gabriel Symonds, MB, GP consultant

Sarah E. Strandjord, MD, Pediatric consultant

James Snyder, MD, Urology consultant

Adrienne Carmack, MD, Urology consultant

Zenas Baer, JD, Legal consultant

Michaelle M. Wetteland, RN, MMA, Nursing

Amanda M. Morse, MPH, Maternal & child health

Gillian Longley, RN, BSN, MSS, Neonatal ICU

Janet Heimlich, *The Child-Friendly Faith Project*

John V. Geisheker, JD, LL.M
Executive Director,
General Counsel,
Doctors Opposing Circumcision
DoctorsOpposingCircumcision.org
2040 Westlake Ave. N., Suite #420
Seattle, WA 98109
tel +1. 206. 465. 6636

Advocating Genital Integrity for All Children Everywhere

1.4.2018

Umsögn um umskurðarmál.

UMSÖGN FRÁ GUÐSPEKIFÉLAGI SKAGAFJARÐAR:

Höfundur þessarar umsagnar er skírður og fermdur inn í íslensku Þjóðkirkjuna og er þess vegna 100% KRISTINNAR TRÚAR.

Nýja-Testamentið; málgagn KRISTINNA MANNA er með skýra afstöðu í þessum málum:

I. Korintubréfi 7.kap 18-19. versi.

"Sá sem er óumskorinn, láti ekki umskera sig.
Umskurnin er ekkert og yfirhúðin ekkert, heldur það að halda boðorð Guðs".

T.d. eins og BOÐORÐIN 10.

https://thjodarskutan.blog.is/blog/thjodarskutan/entry/2212214/

--
Jón Þórhallsson
Heimspekingur.

30.3.2018

Criminalizing 'circumcision' (I.e., the non-therapeutic skinning of male children alive in their copulatory organs)

Dear Members of Parliament,

As a victim of this sexual torture I am begging you to grant to boys the same protection you already grant to girls. The non-therapeutic excision of erogenous and functionally important tissue from the body of a child is an obvious violation of his natural right to bodily integrity. How can any society claim to care about human rights and allow this practice to continue? It is basically non-reversible and inherently harmful: always resulting in iatrogenic ischemic necrosis on part of the penis and making neurologically and mechanically normal coitus impossible. As if one's parents or custodians and the genital-cutter to whom they subjected him had a right to determine how their son would copulate and what he would feel when he did so for the rest of his life by tearing, crushing, cutting and ultimately removing the healthy, protective and someday naturally lubricating tissue of his little penis.

Yours faithfully,

Justin Joseph Gleesing.

From: Juston Freeman [mailto:justonfreeman277@gmail.com]
Sent: 1. mars 2018 00:16
To: althingi@althingi.is; Ísl. Kanada - Ottawa <icemb.ottawa@utn.stjr.is>
Subject: stop male genital mutilation

Somehow B'nai Brith began sending me their email propaganda. The most recent pertained to Iceland's proposed circumcision ban. B'nai Brith is even pandering to Canadians to lobby Iceland on their affairs in this matter.

For the record, as a circumcised male, non-Jew, I applaud Iceland's decision to stop this mutilating practice and let males make a decision to get circumcised when they are able to lawfully make decisions for themselves, especially if the decision pertains to an issue that cannot be undone... and for what purpose? A cultish belief?

I was circumcised as an infant because of societal norms at the time and because my father was circumcised. He also is a non-Jew. His immigrant parents were told it was a good idea to do it. Yet, I wonder if the medical profession was at all influenced by Jewish bias on this issue, especially in the Atlantic northeast region of the USA. There is no sound reason to do this as simple washing will mitigate any potential for infection.

The glans is SUPPOSED to be a very sensitive part of the male organ, very much like the tissue which makes up a women's clitoris. Having the foreskin removed makes the glans become desensitized and, for lack of a better description, "weathered." Yes, there remains sensitivity but so does sensitivity exist in one's fingertips. It is not anywhere close to the same.

As a male ages, the duration of erections usually diminishes. The condition is exacerbated when a very sensitive area, like the glans, is catastrophically desensitized which results in less surface area being available for maximum stimulation.

It seems that western civilization expresses abhorrence at genital mutilation that is forced on young females by their Muslim parents and relatives, and I would argue, "rightly so." Yet, very little if nothing is made of male genital mutilation. I was not even aware that male Muslims were circumcised, as B'nai Brith claims. Has male genital mutilation gone largely undiscussed because the Jewish faith and culture has monopolized their claim to historical

victimhood above all other cultures who have been decimated by wars, pogroms, invasion, neglect and deceit?

Is it because governments throughout the western world have been heavily lobbied to put in place statutes that override public discussion and personal opinions in favor of "hate-speech" laws? Is it because some of the most financially powerful lobbies and organizations, like AIPAC and the ADL stand vigilantly on guard to get the State to step on the throat of an individual who voices doubt or concern over Jewish claims of fact? If a non-Jew expresses disgust about Zionist policies that banished and killed 750,000 Palestinians he/she is labeled an anti-semite. If a Jew, such as Miko Peled has the courage to denounce these policies, he is labeled a self-loathing Jew.

The rabbis could not kill Christ because he was a fellow Jew, so they lobbied the Romans hard to do their bidding and most of us know how that story ended. Has anything really changed in 2018 years?

Well here is my voice in the wilderness. Please set an example to the rest of the world to end forcible genital mutilation of males and females.

-----Original Message-----
From: Karen Goldenberg [mailto:kgoldenberg@debtcare.ca]
Sent: 1. mars 2018 01:10
To: althingi@althingi.is
Subject: Male circumcision

It is with great respect for your country that I hope you will not ban this religious practice. It is a ritual important to people of the Jewish and Muslim faith.
It is also recognized as a healthy practice and has gained favour for many families with little boys.
I do hope you do the tight thing with respect to this important issue

Karen Goldenberg, C.M.
Kgoldenberg@debtcare.ca
416 788 3216

Umsögn biskups kaþólskra á Íslandi um 114. mál: Frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja).

Fyrst vil ég segja að ég skil hugtakið umskurn vel, og þessi hefð var og er lifandi hjá þjóð Guðs í Gamla testamentinu, og er enn lifandi meðal trúaðra Múslíma.
Jesús sjálfur var umskorinn, sem og postular hans, en ekki er nauðsynlegt að kristnir menn séu umskornir á líkamanum, heldur, eins og segir í Postulasögunni (sbr. Post 7:51), eiga þeir að vera umskornir á hjarta og eyrum. Guðs þjóð tilheyrir ekki sá sem er umskorinn hið ytra, heldur sá sem er umskorinn hið innra, í hjarta sínu (Róm 2:29).
Í okkar augum er svo að sjá að þeir sem hafa svo mikinn áhuga á þessu efni kunni að geta misnotað umskurn í þeim tilgangi að ofsækja einhvern fyrir trú þeirra. Hvað þetta snertir styðjum við Múslíma og Gyðinga í baráttu þeirra fyrir því að játa trú sína í frelsi.

Með kveðju,

Davíð B. Tencer OFMCap.
Reykjavíkurbiskup

Reykjavík, 7. mars 2018

-----Original Message-----
From: Ken Kivenko [mailto:kenkiv@gmail.com]
Sent: 28. febrúar 2018 23:14
To: althingi@althingi.is
Subject: Ban on circumcision

The ban is being viewed as an anti Semitic Act.
It should not be allowed to pass.

Ken K

Sent from my iPad

Embætti landlæknis
Directorate of Health

Alþingi
Kirkjustræti
150 Reykjavík

Reykjavík, 13. mars 2018
1803038/0.4.1/eb

Efni: Umsögn Embættis landlæknis um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál.

Embætti landlæknis fagnar því að Alþingi ræði breytingar á lögum varðandi umskurð á drengjum. Hins vegar er embættið eindregið á móti því að umskurður á drengjum falli undir hegningarlög. Embættið er ósammála flutningsmönnum þegar þeir leggja að jöfnu „umskurð" á stúlkubörnum og konum og umskurð á drengjum. Í nágrannalöndum okkar er ekki talað um „umskurð" á kynfærum stúlkna. Svíar kalla slíkt á sinni tungu „könsstympning" meðan þeir tala um „omskärelse" hvað varðar drengi. Á íslensku þýðir orðið „könsstympning" nánast aflimun eða limlesting á kynfærum. Þetta er bannað samkvæmt hegningarlögum í nágrannalöndum okkar og sem betur fer einnig á Íslandi. Þessi hugtök er að mati embættisins ekki rétt að nota yfir umskurð á drengjum.

Eins og flutningsmenn taka fram er umskurður drengja gerður af trúarlegum ástæðum í samfélagi gyðinga og múslíma. Í stórum hluta Afríku er umskurður drengja gerður án trúarlegra ástæðna og fremur sem merki þess að drengur sé kominn í tölu fullorðinna. Í Bandaríkjunum Norður-Ameríku og í vissum öðrum löndum er umskurður á drengjum enn gerður meira eða minna sem hrein rútína af hreinlætisástæðum og vegna þess að aðgerðin er talin fyrirbyggja sjúkdóma. Þessi skoðun er umdeild og flestir telja að fyrir henni liggi engin vísindaleg rök.

Það er álit Embættis landlæknis að trúarlegar og menningarlegar hliðar á þessu máli séu svo ríkar, að umskurður á forhúð drengja muni verða framkvæmdur um ófyrirsjánalega framtíð óháð því hvaða afstöðu heilbrigðiskerfið og samfélagið að öðru leyti mun hafa til þess að leyfa þessa aðgerð. Það er því nauðsynlegt að löggjöf á þessu sviði sé gerð þannig úr garði að umskurður á drengjum valdi ekki barninu skaða.

Embætti landlæknis óttast að umrædd þingsályktunartillaga muni leiða til þess að þessar aðgerðir muni verða gerðar við aðstæður sem ekki tryggja öryggi þeirra barna sem hér um ræðir. Embættið mælir með því að horft sé til reynslu Svía, þar sem bæði löggjafinn og Socialstyrelsen hafa sett fram skýrt regluverk um það hvenær, við hvaða aðstæður og af hverjum þessar aðgerðir eru gerðar. Brot á þeim reglum varðar við hegningarlög.

Virðingarfyllst,

Birgir Jakobsson,
landlæknir

Alþingi
Kirkjustræti 150
Reykjavík

Umsögn um frumvarp til laga um breytingu à almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. màl.

28 Mars 2018

Ágætu þingmenn Alþingis.

Ég þakka innilega Silju Gunnarsdóttir þingmanni, fyrir frumvarpið til verndar öllum börnum jafnræði à Íslandi varðandi bann við umskurð drengja og tryggja að ekkert barn mun brotið verða à kynfærum þess àn kasta við vernd og laga à Íslandi.

Ég er móðir 6 barna af bàðum kynjum. Kynfæri beggja kynja à að vera vernduð í lögum gegn umskurði enda er annað kynið ekki lægra metið en hitt à Íslandi.
Jafnræði kynja à að vera.

Ég à 2 syni sem eiga föður fjölskyldu frà erlendu landi þ.s tíðkast umskurður drengja óhàð trú því það er hefð í því samfélagi að umskera.

Faðir drengjanna er Islam trúar en virðir lögin í landinu og er því ekki að ýta undir umskurð, en við fjölskyldu hans sögðum við, að þetta væri bannað à Íslandi og þau sögðust virða það.

Í trúarriti múslima, Kóran, stendur ekkert um umskurð drengja en þar stendur að múslimi sem flytur í annað land, ber að fara eftir lögum í því landi sem hann flytur í.
Og þetta fer faðirinn eftir.

En lögin um "bann við umskurð drengja" er svo mikilvæg að nà í gegn, því hún mun líka vernda börnin sem eiga ættir að rekja til lands sem aðhyllist umskurð vegna hefða eða trúar, og samfélagsþrýstingin þaðan.
Foreldrar gætu því farið erlendis í heimsóknir með börn sín til ættmenna, stuðst við hegningarlögin til fræðslu og verndun barna sinna og þrýsting og notið samverunnar àn hræðslu.

Umskurður à heilbrigðum börnum er alvarleg àràs à líkama barna. Hún er hættuleg börnum. Börn hafa dàið vegna umskurð à kynfærum þess. Að halda barni niðri og skera part af kynfærum þess er ómannúðlegt og à hvergi að viðgangast og þarf að útrýma.

Hvaða fullorðinn manneskja mun vilja sjàlfviljug ganga í gegnum þessar hræðilegar pyntingar à kynfærum sínum!

Frumvarpið verður að nà í gegn, annað er ómennska.

Ísland er sjàlfstætt land, vil minna ykkur à kæru þingmenn, skildu ykkar til að vernda landsmenn, þjóðina, menningu og lögin.

Ef frumvarpið verður ekki samþykkt er þà umskurður ekki bannaður í lagalegum skilningi ef màl færi til dómstóla?

Gæti dómari þurft að taka tillit til þess að þingið sem setur lög landsins hafi ekki samþykkt að það væri bannað?

Mig langar að biðja þingmenn sem hafa þá ábyrgð að vera löggjafi Íslands að huga að þeim atriðum sem ég og líklega margir foreldrar velta fyrir sér í dag á Íslandi. Ef frumvarpið verður ekki samþykkt og löggjafar landsins þannig ekki tilbúnir til að segja að umskurður sé bannaður á börnum á Íslandi, eru þá börnin mín sem og önnur börn á Íslandi með óvarin mannréttindi á Íslandi og erlendri grundu í lagalegum skilningi? Ef löggjafinn á Íslandi er ekki tilbúinn að segja að umskurður á börnum er bannaður, getur þá barn eða annað foreldri ekki kært þann sem sker í kynfæri barns? Einnig, hversu lengi telja þingmenn þá að foreldrar hafi rétt á að skera í kynfæri barna sinna, eingöngu á meðan þau eru ómálga, eða þegar þau geta sagt „nei“, 10 ára eða 18 ára eða hvenær telja þeir að ekki megi skera lengur í kynfæri barna án þeirra samþykkis?

Àbyrgðin er í ykkar höndum, verndun allra barna í landinu er á ykkar ábyrgð.

Aðeins læknar á Íslandi skmt lögum má gera aðgerðir á líkama barna.
Læknar á Íslandi gera ekki aðgerðir á heilbrigðum börnum.

Verndið börn og rétt þeirra yfir eigin líkama.

Kveðja
Linda Magnúsdóttir

LÆKNAFÉLAG ÍSLANDS
STOFNAÐ 1918
Icelandic Medical Association

Nefndasvið Alþingis
nefndasvid@althingi.is

Kópavogi 8. mars 2018.

Efni: Frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál, þingmannafrumvarp.

Vísað er til tölvubréfs Alþingis frá 7. mars 2018 þar sem óskað er álits Læknafélags Íslands (LÍ) á frumvarpi til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál á 148. löggjafarþingi.

Um er að ræða þingmannafrumvarp sem gerir ráð fyrir því að bann við umskurði stúlkna, sem sett var með breytingu á almennum hegningarlögum með lögum nr. 83/2005 verði rýmkað þannig að það nái einnig til umskurðar á drengjum.

Það er almenn afstaða LÍ að ónauðsynlegar aðgerðir eigi ekki að framkvæma á börnum og vísar félagið í því sambandi ekki síst til Barnasáttmála Sameinuðu þjóðanna. Umskurður á drengjum, sem hefur engan heilsufarslegan tilgang en kann að leiða til alvarlegra fylgikvilla, fellur undir slíkar aðgerðir.

Á fimmta hundrað læknar hafa þegar undirritað yfirlýsingu þar sem lýst er stuðningi við frumvarpið. Í yfirlýsingu læknanna kemur fram að þó málið hafi ýmsar hliðar þá sé það ekki flókið. Allar aðgerðir, hversu tæknilega einfaldar sem þær séu, hafi mögulega fylgikvilla. Umskurður á börnum gangi gegn Genfar-yfirlýsingu lækna og samræmis því síður grundvallarviðmiðum Helsinki-yfirlýsingar lækna um réttinn til sjálfsákvörðunar og upplýsts samþykkis. Þá telja læknarnir í yfirlýsingu sinni að umskurður drengja brjóti gegn Barnasáttmála Sameinuðu þjóðanna og gangi gegn Hippókratesareiðnum: „Primum non nocere" – Umfram allt ekki skaða. LÍ tekur undir þessa yfirlýsingu læknanna.

Þó LÍ styðji framlagt frumvarp að þessu leyti, telur félagið að ekki verði framhjá því litið að mikil umræða hefur skapast um frumvarpið og skiptar skoðanir eru um það. Því er m.a. haldið fram í umræðunni, að verði frumvarpið samþykkt, felist í því árás á trúarbrögð og trúfrelsi þar sem umskurður drengja sé hluti af helgisiðum tiltekinna trúfélaga. Þess vegna megi ekki gera umskurð drengja refsiverðan. Öll umræða um þetta mál er mikilvæg og nauðsynleg. Því ber að fagna að framlagning frumvarpsins hefur hrint af stað þessari umræðu.

LÍ er þó þeirra skoðunar að réttur barns til friðhelgi og ákvæði Barnasáttmála Sameinuðu þjóðanna vegi þyngra en helgisiðir trúarbragða foreldranna og samfélagsins sem barnið fæðist inn í. Hafna beri öllum aðgerðum hjá ósjálfráða einstaklingum sem ekki hafa skýr heilsufarsleg markmið og læknisfræðilegar ábendingar vegna undirliggjandi sjúkdóma. LÍ er kunnugt um það að í núverandi stöðu mála hafa flestir ef ekki allir læknar hér á landi beðist undan því að framkvæma umskurð á drengjum sem ekki hafa skírskotun til læknisfræðilegra ábendinga.

Hlíðasmára 8 · 200 Kópavogur · Ísland · Sími: (+354) 564 4100 · Fax: (+354) 564 4106 · Kt. 450269-2639 · www.lis.is · lis@lis.is

LÍ leggur til að heilbrigðisráðherra verði falið að gangast fyrir því að útbúið verði fræðsluefni fyrir verðandi foreldra um réttindi barna skv. íslenskum lögum og alþjóðasamþykktum sem íslensk stjórnvöld hafa undirgengist að framfylgja, svo og um mögulegar afleiðingar og fylgkvilla aðgerða á ytri kynfærum barna. Slíku fræðsluefni skuli komið á framfæri við foreldra sem íhuga slíkar aðgerðir án læknisfræðilegra ábendinga eða undirliggjandi sjúkdómsástands ásamt viðeigandi ráðgjöf.

Fulltrúar LÍ eru að sjálfsögðu reiðubúnir til að koma til fundar við velferðarnefnd Alþingis vegna þessa lagafrumvarps, verði eftir því óskað.

Virðingarfyllst,
f.h. stjórnar LÍ,

Reynir Arngrímsson

Reynir Arngrímsson, formaður

Hlíðasmára 8 · 200 Kópavogur · Ísland · Sími: (+354) 564 4100 · Fax: (+354) 564 4106 · Kt. 450269-2639 · www.lis.is · lis@lis.is

Kópavogi þ. 7. mars 2018

Alþingi

Kirkjustræti v/Austurvöll

101 Reykjavík

Allsherjar- og menntamálanefnd Alþingis.

Efni: Bann við um umskurði drengja.

Virðulega nefnd. Nú liggur fyrir frumvarp Silju Daggar Gunnarsdóttur, alþingismanns, um breytingu á almennum hegningarlögum, nr. 19/1940, 218. gr., þar sem segir: „Hver sem með líkamsárás veldur tjóni á líkama eða heilsu stúlkubarns eða konu með því að fjarlægja kynfæri hennar að hluta eða öllu leyti skal sæta fangelsi allt að 6 árum." Breytingin sem lögð er til, er að orðinu „stúlkubarn" verði breytt í „barn" og nái því til drengja og stúlkna.

Undirritaður styður frumvarpið eins og það er lagt fram.

Undirritaður eignaðist son þ. 11. nóvember 2011 á Landspítala við Hringbraut. Móðir drengsins, frá Filippseyjum, hefur verið búsett á Íslandi frá árinu 2004. Foreldrar hennar eru búsettir í Bandaríkjunum og eru móðirin og foreldrar hennar kaþólskrar trúar. Undirritaður er utan trúfélaga.

Frá því að drengurinn fæddist hafa bæði móðirin og foreldrar hennar viljað umskera drenginn. Móðirin myndi sjálf sjá um umskurðinn og framkvæma hann á okkar heimili. Þau töldu mikilvægt að umskurðurinn færi fram sem allra fyrst til þess að drengurinn myndi ekki muna eftir sársaukanum. Rök þeirra voru að þetta væri „nice" og stúlkur vildu umskorna menn. *Engin önnur rök hafa þau fært fyrir umskurði.*

Undirritaður hefur alla tíð verið harðlega á móti umskurði á drengnum og sem betur fer tekist að koma í veg fyrir að hann hafi verið beittur þessu hrottalega ofbeldi.

Þar sem lítið sem ekkert var að finna í íslenskum lögum um umskurð drengja, var fátt sem undirritaður gat gert í þeirri stöðu sem upp var komin en þó hefur hann frá árinu 2011 vakið máls á þessu við: Barnaheill, barnaverndarnefnd á Suðurnesjum, Heilbrigðisstofnun Suðurnesja (ungbarnavernd), lögregluna á höfuðborgarsvæðinu, Umboðsmann barna, lækna,

hjúkrunarfræðinga og aðra sem að hugsanlega kæmu að svona máli. Allir þessir aðilar brugðust faglega við málinu með þeim takmörkunum sem lög heimiluðu.

Verði frumvarpið ekki samþykkt, hefur undirritaður eftirfarandi spurningar og óskast skriflegt svar við þeim.

1) Hvað telst læknisverk og hvaða skurðaðgerðir er öðrum en læknum heimilt að framkvæma?
2) Á hvaða tímabili frá fæðingu drengs er æskilegt að umskera dreng?
3) Hver mun sjá um kennslu við umskurð drengja?
4) Hvaða verkfæri ber að nota við umskurð?
5) Nú fer umskurður úrskeiðis og kalla þarf til sjúkrabíl og barnalækni. Hvað má gera margar tilraunir til umskurðar eftir að sjúkrahúsdvöl barnsins lýkur?
6) Hvað ber að gera við forhúðina sem fjarlægð verður eftir umskurð?
7) Hvaða veitingar ber að færa viðstöddum eftir framkvæmd umskurðar?

Verði frumvarpið samþykkt, en þá með þeim takmörkunum, að umskurður skuli framkvæmdur af lækni á viðurkenndri heilbrigðisstofnun, hefur undirritaður eftirfarandi spurningar og óskast skriflegt svar við þeim.

1) Nú er umskurður óafturkræf aðgerð. Hver er réttur barnsins til þess að mótmæla umskurði?
2) Nú eru foreldrar ekki sammála um það hvort framkvæma eigi umskurð eða ekki. Hvort munu hagsmunir barnsins (að framkvæma ekki umskurð) eða hagsmunir þess foreldris sem vill framkvæma umskurð á dreng sínum ráða för?
3) Nú hefur umskurður verið framkvæmdur og drengur er orðinn lögráða, hann er ósáttur við að hafa undirgengist slíka aðgerð, mun ríkissjóður greiða honum bætur, eða mun hann þurfa að höfða skaðabótamál gegn þeim sem framkvæmdi aðgerðina?

Virðingarfyllst.

Magnús Einarsson Smith

kennitala: 061286 – 2769

MANNRÉTTINDASKRIFSTOFA ÍSLANDS
ICELANDIC HUMAN RIGHTS CENTRE

Reykjavík, 21. mars 2018.

Alþingi
Nefndasvið
Austurstræti 8-10
150 REYKJAVÍK

Umsögn Mannréttindaskrifstofu Íslands um breytingu á almennum hegningarlögum (umskurður drengja), þskj. 183, 114. mál.

Mannréttindaskrifstofu Íslands (MRSÍ) hefur borist framangreint frumvarp til umsagnar. MRSÍ telur þörf frekari og víðtækra umræðna um efnið, út frá öllum sjónarmiðum, þ. á m. réttindum barna, trúfrelsi (þ. á m. hvort ónauðsynlegar aðgerðir á kynfærum barna falli undir trúfrelsi), refsinæmi o.s.frv. Skrifstofan vill samt sem áður koma eftirfarandi upplýsingum og sjónarmiðum á framfæri:

A. Í lögum nr. nr. 19/2013, um samning Sameinuðu þjóðanna um réttindi barnsins segir að ávallt skuli taka mið af því sem barni er fyrir bestu þegar teknar eru ákvarðanir um málefni er þau varða. Samkvæmt 12. gr. laganna eiga börn rétt á að láta í ljós skoðanir sínar og óskir, í samræmi við aldur þeirra og þroska, og að tekið sé tillit til þeirra. Í áliti umboðsmanna barna og sérfræðinga í barnalækningum á Norðurlöndunum varðandi umskurð drengja segir m.a.:

> „Umskurður sem framkvæmdur er, án læknisfræðilegra ástæðna, á einstaklingi sem ekki getur veitt samþykki sitt, er brot gegn siðferðilegum grunngildum læknisfræðinnar, þar sem inngripið er óafturkræft, sársaukafullt og getur leitt til alvarlegra fylgikvilla.
> Það eru engar læknisfræðilegar ástæður fyrir því að heimila umskurði á ungum drengjum á Norðurlöndunum. Þær læknisfræðilegu ástæður sem geta átt við um umskurð fullorðinna karlmanna eiga ekki við um börn á Norðurlöndunum. Drengir geta sjálfir tekið ákvörðun um mögulegan umskurð þegar þeir komast á þann aldur að geta veitt samþykki sitt.
> Það er álit okkar sem umboðsmenn barna og sérfræðingar í barnalækningum að umskurður drengja án læknisfræðilegra ástæðna brjóti gegn ákvæðum 12. gr. Barnasáttmála Sameinuðu þjóðanna, sem kveður á um rétt barna til að láta í ljós skoðanir sínar í öllum málum er varða þau, og 3. tölul. 24. gr. sem kveður á um vernd barna gegn hefðum sem eru skaðlegar heilbrigði þeirra. Mannréttindaráð Sameinuðu þjóðanna hvatti árið 2013 öll aðildarríki Sameinuðu þjóðanna til að stöðva inngrip sem eru skaðleg friðhelgi og heilbrigði barna og eru skaðleg drengjum og stúlkum. Að mati okkar er það grundvallaratriði að réttindi foreldra séu ekki ríkari en réttur barna til líkamlegrar friðhelgi. Það sem er barni fyrir bestu skal ávallt hafa forgang, jafnvel þó það takmarki rétt fullorðinna til að iðka trú sína eða halda í heiðri siði.
> Umboðsmenn barna á Norðurlöndunum og sérfræðingar í barnalækningum vilja beita sér fyrir því að eingöngu verði heimilt að umskera drengi í þeim tilvikum þar sem drengur hefur náð þeim aldri og þroska að geta skilið nauðsynlegar læknisfræðilegar upplýsingar og hefur veitt samþykki sitt fyrir aðgerðinni. Við óskum eftir umræðu sem einkennist af gagnkvæmri virðingu, milli allra þeirra sem hlut eiga að máli, um hvernig unnt er að veita drengjum ákvörðunarrétt um framkvæmd umskurða. Við hvetjum ríkisstjórnir Norðurlandanna til að

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gera nauðsynlegar ráðstafanir til að tryggja að drengir fái sjálfir að ákveða hvort þeir vilji láta umskera sig.“

MRSÍ tekur undir þessi sjónarmið og bendir jafnframt á 1. gr. Barnaverndarlaga nr. 80/2002 en þar segir að börn eigi rétt á vernd og umönnun, að þau skuli njóta réttinda í samræmi við aldur sinn og þroska og að allir þeir sem hafi uppeldi og umönnun barna með höndum skuli sýna þeim virðingu og umhyggju og að óheimilt sé með öllu að beita börn ofbeldi eða annarri vanvirðandi háttsemi. Þar segir jafnframt að foreldrar skuli gæta velferðar barna í hvívetna.

B. Hvað varðar refsinæmi verknaðarins er þegar að finna bann við umskurði/limlestingu á kynfærum stúlkna í 218. gr. a í hegningarlögum nr. 19/1940. Ætlunin er að fella umskurð drengja undir ákvæðið og má færa rök að því að vernd veitt stúlkum vegna limlestingar á kynfærum þeirra ætti einnig að ná til drengja vegna limlestingar á kynfærum þeirra, að öðrum kosti sé um að ræða brot gegn 24. gr. jafnréttislaga nr. 10/2008, þ.e. mismunun á grundvelli kyns. Hins vegar má einnig færa rök að því að ólíku sé saman að jafna, að umskurður stúlkna sé mun alvarlega og viðurhlutameira inngrip í líkama þeirra. Bent skal á að á Möltu hafa verið sett mjög framsækin lög er varða réttindi trans- og intersex fólks. Samkvæmt þeim lögum er umskurður drengja bannaður án þess að refsing liggi við og að mati MRSÍ er þörf á að ræða og skoða refsinæmið nánar, hvort umskurður drengja skuli gerður refsiverður og hvort sama refsing eigi þá að liggja við og um umskurð stúlkna. Slík umræða er einkum mikilvæg í ljósi þess að umskurður drengja er hluti af hluti af trúarbrögðum og trúarvitund gyðinga og ýmissa trúarsamfélaga múslima víða um heim. Rétt er að geta þess að trúfrelsi er varið af 63. gr. Stjórnarskrárinnar. Mikilvægt er að sýna aðgát og skoða mál frá öllum hliðum þegar mannréttindi eru annars vegar, umheimurinn fylgist mjög náið með framgangi mála hér á landi og ekki er ólíklegt, verði frumvarpið að lögum í óbreyttri mynd, að öfgahópar í nágrannalöndum okkar beiti sér fyrir sambærilegri löggjöf þar í landi sem gæti leitt til ofsókna á hendur gyðingum og múslimum og þess að þeir hópar upplifi sig einangraða frá samfélaginu og jafnvel útskúfaða.

D. Loks má geta þess að nú bíður afgreiðslu barnaréttarnefndar Sameinuðu þjóðanna mál er varðar umskurð á dreng, en nefndin er alþjóðlegur eftirlitsaðili framkvæmdar samnings Sameinuðu þjóðanna um réttindi barnsins. Málið sem um ræðir er einstaklingsmál gegn Finnlandi þar sem drengur var umskorinn án samþykkis móður hans. Í málinu er því meðal annars haldið fram að Finnland hafi ekki staðið við skuldbindingar sínar samkvæmt 1., 2., 3., 16. og 19. gr. Barnasáttmálans.

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Virðingarfyllst,
f.h. Mannréttindaskrifstofu Íslands

Margrét Steinarsdóttir
framkvæmdastjóri

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26.3.2018

Dear Sir/Ma'am,

I hope this message reaches you in the best of health.

My name is Mansoor Ahmad Malik and I am currently serving, most humbly, as the Imam and National President of the Ahmadiyya Muslim Community in Iceland.

Over the last few months, since the discussion of the proposed bill to ban the circumcision of young boys in Iceland has been introduced, I have had the opportunity to express my thoughts and feelings on this very misleading and uneducated bill and approach on this subject.

I have nothing but respect for the leaders of our country and authority in general. However, I most respectfully disagree with the stance that has been taken on this issue by the members of parliament, not based on my opinion, and as some may like to say based on my religious beliefs, but based on the medical evidence in support of male circumcision, which is overwhelming to say the least.

Doctors pledge to uphold the Hippocratic Oath under any circumstances, which states, among other things, "I will prevent disease whenever I can, for prevention is preferable to cure". Keeping in mind that infections such UTI (urinary tract infection) are most common and severe in infancy, this debate seems to be rather hypocritical, especially with the support it has received from various doctors, who perhaps should be reminded of this oath they pledge to uphold; **to prevent disease, not to wait until it needs to be treated.**

Without prolonging the email, I have attached the articles I have written in relation to this and which were published onlne by Fréttablaðið. I most humbly request you to take a few moments out of your schedule and thoroughly read through these artilces. The second article in particular is filled with medical references in relation to this subject.

I have also given the relevant links to the articles published online.

https://www.frettabladid.is/skodun/umskurur-i-islam-eingoengu-fyrirmaeli-um-hreinlaeti

https://www.frettabladid.is/skodun/umskurur-ungra-drengja

Thank you

Most respectfully

Mansoor Ahmad Malik
Imam & National President
Ahmadiyya Muslim Community Iceland

Umskurður í íslam – Eingöngu fyrirmæli um hreinlæti

Mikið hefur verið rætt að undanförnu á Íslandi um að vilja banna umskurð ungra drengja. Eftir að hafa lesið umrætt frumvarp þykir mér það dálítið villandi. Einnig grunar mig samkvæmt því sem stendur í frumvarpinu að ástæðan fyrir þessari trúarlegu hefð sé ekki kunnug. Auðvitað er ég sammála sumum atriðum frumvarpsins eins og að leyfa ekki umskurð kvenna.

Jafnvel þótt þessi hefð sé frá því árþúsundum fyrir tíma íslams, get ég aðeins talað sem Músliimi fyrir íslam og hið íslamska sjónarmið og ástæðu þessarar hefðar – ***„Eingöngu fyrirmæli um hreinlæti“.***

Þeim íslömsku fyrirmælum sem nefna umskurð fylgja fjölmargir aðrir hreinlætisþættir eins og það að snyrta skegg, klippa neglur, hreinsa tennur (nota tannþráð) og raka skapahár. Allt eru þetta hreinlætisaðgerðir að meðtöldum umskurði. Alvarlegur misskilningur er að ganga út frá því – jafnvel í eitt augnablik - að nokkur annar (illur) ásetningur liggi að baki þessari hefð.

Sem foreldrar tökum við fjölmargar ákvarðanir fyrir börn okkar dag hvern án þess nokkru sinni að spyrja börn okkar um sína skoðun, sitt val eða hvort þeim líki. Þessar ákvarðanir varða til að mynda hina einföldu ákvörðun um að klæða þau eða fara með þau í gönguferð sem getur meðal annars reynst skaðlegt heilsu barnsins þar sem það getur valdið hita og flensu þegar höfð eru í huga veðurskilyrði hér á Íslandi (ég býst því við að næsta frumvarp ætti að fjalla um að leggja bann við að fara með barn út í gönguferð) og fleiri flóknar ákvarðanir eins og það að senda þau í skóla; skóla sem VIÐ kynnum að telja betri en annan, stað sem fullur er af bakteríum og sýklum sem ógna heilsu barna okkar, gætu margir sagt! Við erum nú einu sinni að tala um heilsu barna okkar sem, samkvæmt frumvarpinu, sýnist vera eitthvað sem virðumst ekki sjálf hafa gengið í gegnum.

Rétt er það að sú læknisfræðilega aðgerð sem umskurður er getur valdið sýkingu ef hún er ekki framkvæmd á réttan hátt. Eftir stendur hins vegar spurningin um hvaða læknisfræðilega aðgerð sé undanþegin því. Er ekki venjan á Íslandi að foreldrar ákveði að senda barnið sitt til læknis til þess að fjarlægja háls- og nefkirtla án samþykkis barnsins? Förum við ekki með ung börn okkar til læknisins í skoðanir og bólusetningar í frumbernsku sinni með lækni öðru megin og hjúkrunarfræðing hinu megin sem stinga nálum í hvorn fótlegg, græta barnið, valda því óþægindum og jafnvel „áfalli“ að sögn sumra og segja einnig foreldrum að barnið kunni að þjást af hita gegnum nóttina? Erum við búin að ræða þetta fyrst við ungbarnið eða höfum við farið út í þetta sem varúðarráðstöfun gagnvart einhverju sem barnið *gæti* þjáðst af?

Meirihluti frumvarpsins virðist einblína á það sem snertir heilsu barnsins og ég sjálfur sem faðir fellst á að það er mikilvægasti þátturinn. Á hinn bóginn virðist þetta fremur hræsnisfullt þar sem ávinningurinn af umskurði gagnvart heilsunni, sem sannaður hefur verið af sérfræðingum á heilbrigðissviði, vegur mun þyngra. Umskornir karlmenn eru ólíklegri til að þjást af þvagfærasýkingum, kynsjúkdómum (sem ekki er einskorðað við drenginn heldur geta smitast til stúlkunnar), reðurvandamál og reðurkrabbamein. Fyrir utan þetta veitist hreinlæti einfaldara og auðveldara. Þrátt fyrir allt þá er jú *forvörn betri en lækning*!

Faðir minn var nýlega greindur með þarmakrabbamein og fékk alvarlega bakteríusýkingu sem varð að fjarlægja með skurðaðgerð. Raunar var ég einmitt að tala við föður minn í síma meðan verið var að innrita hann á sjúkrahús og þegar læknirinn kom til að tala við hann um ástandið. Eftir að hafa útskýrt aðgerðina nefndi hann í lokin áhættuna sem fylgdi aðgerðinni; dauða. Samt sem áður, vitandi að ávinningurinn vóg þyngra en áhættan, þá krafðist það ekki umhugsunar að fara í aðgerðina.

Hvað varðar fullyrðinguna um að „valda áfalli“ þá er ég, með allri virðingu, ósammála þessari hugmynd. Sem múslimi og einstaklingur sem hefur verið sjálfur umskorinn get ég borið því vitni - og ég er þess fullviss að milljónir á milljónir ofan um allan heim geta borið það sama - að það hefur ekki valdið þeim nokkrum sálrænum erfiðleikum. Í fullri hreinskilni man ég ekki eftir að hafa verið umskorinn, hvernig ég var umskorinn eða hversu sársaukafullt það var, ekkert!

Ég er því sammála og myndi hvetja til að slíkar aðgerðir séu framkvæmdar í viðeigandi umhverfi af fagfólki og svo fljótt sem auðið er eftir fæðingu drengs í stað þess að seinka því til hærri aldurs eins og „tíu ára aldurs“, sem aftur á móti er alls ekki að finna í íslömskum fyrirmælum. Að leggja hins vegar bann við slíku trúarlegu boði mun reynast mörgum múslimum og fylgjendum annarra trúarbragða sem iðka umskurn mikilli áþján. Og þetta getur leitt til þess að fólk framkvæmi slíkar aðgerðir sjálft í óviðeigandi umhverfi, hugsanlega til skaða fyrir barnið. Þess vegna hvet ég til að ekki verði lagt bann við slíku trúarlegu boði en að fremur verði fundnar leiðir til að gera aðgerðina öruggari og þægilegri: eitthvað sem finna má í mörgum öðrum löndum.

Að lokum, sem múslimi almennt og sérstaklega sem fulltrúi Ahmadiyya Múslimasamfélagsins á Íslandi, þá kennir íslam okkur að hlýða lögum landsins og þess vegna munum við verða bundin til að hlýða hverjum þeim lögum sem sett eru. Hins vegar, þar sem ég er ósammála þessu frumvarpi á grundvelli heilsu og öryggi barnsins þar sem umskurður er alfarið hreinlætisaðgerð, mun ég með fullri virðingu beita rödd minni til að mótmæla þessu.

Eftir

Mansoor Ahmad Malik
Imam & Landsformaður
Ahmadiyya Múslimasamfélags Íslands

Umskurður ungra drengja – samkvæmt Hippókratesareiðnum

Hippókratesareiðurinn sem tekinn er af læknum og þeir heita að virða undir öllum kringumstæðum segir meðal annars: „ég *mun ekki gera neinum mein"*. Undanfarna daga hefur sannarlega borið á þessum hluta eiðsins í tengslum við lagafrumvarp um bann við umskurði drengja. Fram hefur komið að margir læknar hér á landi styðji þetta frumvarp. Ég vil samt sem áður vekja athygli lesenda - og jafnvel lækna - á öðrum hluta sama eiðs, hluta sem er fólki kannski ekki eins kunnugur: „*ég mun hindra sjúkdóm hvenær sem mér er unnt, því forvörn er betri en lækning*".

Nýverið hef ég orðið þess heiðurs aðnjótandi að eiga einhvers konar viðræður um málið við marga Alþingismenn, einkum þá sem styðja þetta frumvarp að meðtöldum þeim sem mæla fyrir því. Með allri virðingu var ég dálítið vonsvikinn með rök þeirra og þau gögn sem þeir framvísuðu. „Wiki"-slóð og greinar sem byggðar eru á persónulegri skoðun geta varla talist sönnunargögn, sama hversu oft einhver endurtekur: „*það er einfaldlega enginn hagur í umskurði*". Þvert á móti hafa læknisfræðileg gögn, tölfræði og yfirlitsgreinar um slembiraðaðar samanburðarrannsóknir, sem segja má að séu sterkasta framsetning læknisfræðilegra gagna, sannað hið gagnstæða.

Það er mikil blessun að eiga vini og kunningja á sviði læknisfræðinnar. Þeir hafa deilt með mér hafsjó af þekkingu um þetta málefni og vil ég nota þetta tækifæri til að tjá þeim öllum þakklæti mitt. Lítum nú á nokkrar tölfræðilegar upplýsingar.

Í vísindagrein sem mikið hefur verið vitnað í og birtist í einu virtasta læknatímariti heims kemur fram að umskurður karla er vörn gegn fjölda heilsufarsvandamála að meðtöldu krabbameini í kynfærum. Í greininni kemur einnig fram að áhættu-/ávinningsgreining leiðir til þeirrar niðurstöðu að kostir umskurðar karlmanna séu 100 á móti 1 ókosti.
Greiningin leiddi ennfremur í ljós að helmingur allra umskorinna karla mun upplifa skaðleg áhrif á heilsufar sitt vegna forhúðar.

https://www.ncbi.nlm.nih.gov/pubmed/24702735/

Umskurður karla ver þá gegn margs konar kynsjúkdómum, þ.á.m. sárasótt, kynfæraherpes (HSV-2), linsæri og HPV-sýkingu (human papilloma virus). Umskurður karla veitir yfir 60% vörn gegn HIV. Þrjár stórar slembirannsóknir sem framkvæmdar voru í Afríku, sunnan Sahara, sýndu ítrekað að umskurður karla veitir örugga vernd gegn HIV-sýkingu.

https://www.sciencedirect.com/science/article/pii/S0025619614000366?via%3Dihub

https://www.ncbi.nlm.nih.gov/pubmed/11089625

Umskurður karla er einnig vörn gegn krabbameini í getnaðarlim og, í minna mæli, krabbameini í blöðruhálskirtli.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3734995/

Þar að auki virðist umskurður karlmanna minnka hættu á krabbameini maka eða bólfélaga. Allsherjargreining sem samanstendur af 14 rannsóknum staðfesti að umskurður karla tengdist áhrifamikilli vörn gegn leghálskrabbameini.

https://www.ncbi.nlm.nih.gov/pubmed/19126309

http://srh.bmj.com/content/familyplanning/35/1/5.full.pdf

Einhverjir gætu bent á að nokkrar þessara rannsókna voru framkvæmdar á svæðum í Afríku eða í vanþróuðum löndum. Raunveruleikinn er hins vegar sá að við horfumst í augu við svipð vandamál hér á Vesturlöndum einnig. MBL sagði frá því í maí 2017, skv. Embætti Landlæknis að HIV og aðrir kynsjúkdómar væru í sókn. Ég myndi segja að HIV sé æði alvarlegur sjúkdómur þegar barist er gegn honum í litlu landi eins og Íslandi. HPV er önnur veira sem fundist hefur meðal kvenna hér á landi. Umskurður getur verið mikilvægur þáttur í að stjórna, ef ekki draga umtalsvert úr sumum sjúkdómum.

https://icelandmonitor.mbl.is/news/politics_and_society/2017/05/19/cases_of_hiv_double_in_iceland/

Samkvæmt gögnum sem birt voru af ICO (upplýsingamiðstöð um HPV og krabbamein) í júlí 2017 greinast 14 konur með leghálskrabbamein á Íslandi á hverju ári og tvær látast árlega af þeim sökum. Vel er kunnugt að HPV er beinn valdur leghálskrabbameins (og orsakar 77% af ífarandi leghálskrabbameini) og einnig endaþarms-, getnaðarlims-, munnhols-, legganga- og kvenskapakrabbameins.

Andstætt þeim yfirlýsingum að umskurður sé limlesting er sannað með mörgum áreiðanlegum, vísindalegum rannsóknum að hann dregur úr útbreiðslu krabbameinsvaldandi HPV-veira. Umskurður er því ómissandi viðbót við fræðslu, notkun smokka og bólusetningar til að draga úr sýkingar- og dánartíðni sökum sjúkdóma eins og HPV og HIV, bæði á lands- og alþjóðavísu.

http://www.hpvcentre.net/statistics/reports/ISL_FS.pdf

Auk framangreindra sýkinga eru engin aldurstakmörk á sýkingum í þvagfærum meðal óumskorinna karlmanna. Þvagfærasýkingar eru algengastar og alvarlegastar á fyrstu sex mánuðunum í lífi barns. Umskurður nýbura veitir umfangsmikla vörn gegn hættu á þvagfærasýkingum á fyrstu mánuðunum í lífi þeirra.

https://www.ncbi.nlm.nih.gov/pubmed/16140703

http://pediatrics.aappublications.org/content/116/3/644?sso=1&sso_redirect_count=1&nfstatus=401&nftoken=00000000-0000-0000-0000-000000000000&nfstatusdescription=ERROR%3a+No+local+token

Brian Morris prófessor og fleiri sérfræðingar á þessu sviði framkvæmdu gagnrýna greiningu á umfangsmiklum gögnum í því skyni að komast að niðurstöðu um hvaða aldur væri bestur til að framkvæma umskurð. Þetta varð til þess að þeir mæla með umskurði

snemma á barnsaldri, með leyfi foreldra, í stað þess að fresta umskurði þar til drengurinn er orðinn nógu gamall til að ákveða það sjálfur. Þeir halda því fram að umskurður í frumbernsku sé auðveldari, ódýrari, hentugri, feli í sér staðdeyfingu (fremur en með fullri svæfingu sem hefur í för með sér ákveðna áhættuþætti) og leiði til skjótari bata og betri árangurs m.t.t. útlits.

https://www.ncbi.nlm.nih.gov/pubmed/22373281

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3359221/

Alvarlegir fylgikvillar umskurðar eru afar sjaldgæfir, bæði hjá ungabörnum og fullorðnum. Flestir fylgikvillar eru tæknilegir, minniháttar og auðveldlega meðhöndlaðir. Rannsókn á 1.400.920 umskornum drengjum sýnir að hlutfall skaðlegra fylgikvilla umskurðar var um 0,5% meðal ungbarna.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4578797/

Ábyrgðarfullt uppeldi krefst þess að foreldrar ákveði hvað er best fyrir börnin þeirra. Það á einnig við um að verja þau fyrir sýkingum og krabbameini. Að bíða fram á unglings- eða fullorðinsár til að leyfa karlmanni að ákveða sjálfur rænir hann ekki einungis öllum þeim kostum sem aðgerðin veitir í barnæsku hans og á unglingsárum, heldur gerir hann á sama tíma varnarlausan gagnvart aukinni hættu á fylgikvillum og óþægindum.

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978617/

Umskurður nýfæddra drengja er bæði siðferðilegur og löglegur og nýtur stuðnings í Sáttmála Sameinuðu þjóðanna um réttindi barnsins. Því hefur verið haldið fram að túlka megi grein 24(3) í Sáttmála Sameinuðu þjóðanna um réttindi barnsins sem fyrirskipun um umskurð, þar sem það að umskera ekki drengi hefur verið talið skaðlegt heilsu þeirra. Þegar áhrif umskurðar nýfæddra drengja á samfélagið og einstaklinginn eru könnuð, einkum varðandi líkur á neikvæðum fylgikvillum, verður ljóst að þessi framkvæmd er ekki brot á mannréttindum.

https://www.stonybrook.edu/commcms/bioethics/_pdf/TheEthicsofCircumcisionofMaleInfants.pdf

Að lokum, eins og fram kemur í fyrri grein minni, er algengt að foreldrar á Íslandi taki þá ákvörðun að láta fjarlægja hálskirtla úr ungum börnum sínum til að losna við mein; mein sem einfaldlega má meðhöndla með sýklalyfjum. Enginn vafi leikur á því að hlutverk hálskirtla er mun mikilvægara gagnvart lífi og heilsu fólks heldur en forhúðin. Áhættur umskurðar eru ítarlega kynntar þótt framangreindar rannsóknir staðfesti að þessar hættur séu býsna sjaldgæfar. Kirtlataka getur hins vegar haft í för með sér hættulegar aukaverkanir, mun fleiri og alvarlegri vandamál en þau sem tengjast umskurði.

http://onlinelibrary.wiley.com/doi/10.1111/jpc.13745/full

Spurning mín er einföld: af hverju erum við svona vandlát? Umskurður drengja er ekki einu sinni algeng framkvæmd hér. Ég hef ekki séð eina einustu tilvísun eða skýrslu sem

inniheldur áreiðanlega, læknisfræðilega tölfræði í tengslum við þetta mál hér á Íslandi. Samkvæmt rökum þessa frumvarps, ætti þá ekki fyrst að ræða um kirtlatöku á börnum „án þeirra samþykkis“, sem auðveldlega má meðhöndla með sýklalyfjum og sem gegna mun mikilvægara hlutverki í lífi þeirra og heilsu? Ætti þá ekki að refsa slíkum foreldrum sem láta framkvæma og samþykkja þess háttar aðgerð? Ég er alls ekki að leggja það til þar sem ég lít svo á að sem foreldrar hafi þau rétt til að taka upplýstar ákvarðanir varðandi velferð barna sinna. Mér þykja hins vegar rökin fyrir þessu frumvarpi fela í sér að þetta mál skuli rætt fyrst þar sem kirtlataka er mun almennari hér.

Ef umræðan væri einhliða og ef einungis væri hægt að finna gögn um áhættur umskurðar gæti ég sætt mig við stöðuna og myndi reyndar styðja frumvarpið. Sú er hins vegar alls ekki raunin. Læknisfræðileg gögn sem styðja umskurð, ekki einungis sem almenna reglu heldur fyrir ungabörn sérstaklega, segir allt sem segja þarf og að sniðganga slík rök er ekki hægt að dæma sem annað en algjöra fáfræði. Gleymum ekki Hippókratesareiðnum sem læknar heita að virða og lifa eftir: “*Ég mun hindra sjúkdóm hvenær sem ég mér er unnt, því forvörn er betri en lækning*”.

Eftir
Mansoor Ahmad Malik
Imam og Landsformaður
Ahmadiyya Múslimasamfélags Íslands

Alþingi
Kirkjustræti
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágæta Alþingi / Dear Members of the Parliament,

Dear Honorable Members of Parliament,

I want to express my gratitude for and encourage passage of the proposed bill to protect male children in Iceland from non-therapeutic circumcision. *Every child – male, female, and intersex – needs protection from non-therapeutic genital cutting!*

I am the mother of three circumcised sons (1958, 1961, and 1969), the grandmother of five intact grandsons (born between 1982 and 2015), a midwife, a Registered Nurse, and the Executive Director of Genital Autonomy - America (formerly, NOCIRC, the National Organization of Circumcision Information Resource Centers, the first clearing house for information about circumcision in the USA, which I co-founded in 1985). I first witnessed circumcision as a nursing student in May 1979. As I watched the torture and mutilation of a baby, I burst into tears. The doctor looked at me and said, "There is no medical reason for doing this!" That moment literally changed the course of my life. And, for the past 39 years, I have listened to the complaints of untold numbers of circumcised men (and their sexual partners, too). Anyone who says circumcised men do *not* complain about the harm of circumcision either doesn't listen or doesn't know men who feel comfortable sharing personal information about having a diminished or damaged penis.

Human rights documents, including the UN Declaration on Human Rights (Article 5) and the UN Convention on the Rights of the Child (Article 24.3), protect bodily integrity rights of infants and children, and national laws are in place, too, protecting children from unnecessary physical pain and/or trauma.

Circumcision:

- is a primal wound that is excruciatingly painful;
- interferes with the maternal/infant bond;
- disrupts breastfeeding;
- disturbs normal sleep patterns;
- undermines the baby's first developmental task of establishing trust;
- leaves physical scars, and
- leaves psychological scars, as evidenced by the dramatic response to vaccination pain in 4 - 6-month-old circumcised babies (PTSD), and by the response of men, as evidenced in the "Long-term adverse outcomes from neonatal circumcision reported in a survey of 1,008 men: an overview of health and human rights implications," by Tim Hammond and Adrienne Carmack (*The International Journal of Human Rights, 2017).*

Consciousness is changing about the right of *all* children to bodily integrity and genital autonomy (personal choice). The proposed bill does *not* outlaw circumcision, it simply allows a child to grow up without the pain, trauma, and harmful physical and psychological consequences of non-therapeutic genital cutting and affords that child the right to personal choice when old to make an informed decision.

If a person agrees to a covenant, that person must be old enough to understand the agreement. Otherwise, it is a forced agreement that violates individual rights and is objected to by many men who did not have a choice! Brit shalom, a naming ceremony of peace (no cutting), is being adopted by Jews who recognize the harm of pain and trauma inflicted on the developing brain of an infant and leave the choice of cutting to the owner of the penis when he's old enough to decide for himself.

At the beginning of life a child learns fear and alienation *or* love and trust. Karl Menninger said, "What is done to children, they will do to society," and Gandhi said, "If we are to have real peace, we shall have to begin with the children." Our organization supports those legislators who vote to protect boys from pain, trauma, and harm and applauds Iceland for leading the way toward creating a safer world into which babies are born.

With appreciation and hope,

Marilyn Fayre Milos, RN, Executive Director
Genital Autonomy - America
PO Box 2512
San Anselmo, California USA 94979
+1-415-488-9883 www.gaamerica.org

20 March 2018

To nefndasviðs Alþingis
Umsögn um breytingu á almennum hegningarlögum nr. 19/1940, þingskjal 183- 114. mál (umskurn drengja)

Dear members of Alþingi,

As medical doctors in Denmark, we support the Icelandic bill proposing an 18 years minimum age for non-therapeutic circumcision.

Circumcision, as any surgical procedure, inflicts pain, discomfort and a risk of acute or permanent complications on the patient. Non-therapeutic circumcision has no benefits; and irreversibly removing healthy and highly sensitive tissue from anyone, especially children not capable of giving informed consent, is highly unethical.

Non-therapeutic circumcision is in conflict with the "primum non nocere" ethical tenet of modern medicine - *first, do no harm* – a principle which we have all attested to adhere to in the Hippocratic oath.

We therefore find that circumcision should only be performed in medical conditions that justify the procedure based on evidence-based medicine.

Children deserve the right to bodily integrity and protection from unnecessary surgery, pain, discomfort and potential harm. Fortunately, girls have been secured this right. The time has come for gender equality; the Icelandic bill will ensure this.

Kind regards,

Kasper Linde Ankjærgaard

Morten Staberg

Morten Frisch

Adam Bertelsen

Adam Jama

Afrouz Ahmadzadeh

Agnethe Vale Nielsen

Aina Støttrup Hansen

Aissata Diop Christiansen

Alex Christensen

Alexander Kyhnel

Alexander MacKenzie Omel

Alexander Nolsøe

Alexander Nygård

Alice Rasmussen

Allan Bach

Allan Bayat

Allan Klitgaard Sørensen

Allan Villadsen

Amalie Haagerup

Amira Catharina

AnAs Al-Kahwa

Anastasia Maria Loupis

Anders Hebert

Anders Johansen

Anders Mikkelsen

Anders Peter Gerholt Skovsen

Anders Pitzner-Fabricius

Anders Rune Lander

Anders Skjelsager

Anders Thomsen

Anders Toxværd

Andrea Kjellström

Andreas Andersen

Andreas Carus

Andreas Hoff

Andreas Lundh

Andreea Alexandra Bach-Nielsen

Andri Snær Ólafson Lukeš

Ane Korsholm Ane Korsholm

Ane Mathilde Pedersen

Ane Vase

Anette Gormsen Therkildsen

Anette Kvindebjerg Christophersen

Anette Skadborg

Anika Ajdacka

Anirban Nandy

Anja Birk Kuhlman

Anja Duelund

Anja Falk Riecke

Anja Kastrup Schødt

Anja Mølgaard Riis

Ann Abkjær

Ann Merete Møller

Anna Borgen

Anna Danielsdottir

Anna Herskind

Anna Iben Nørgaard Hollensberg

Anna Maria Strømmen

Anna Quaade

Anna Sophie Hjerrild

Anna Warburg Petersen

Anne Botha

Anne Gedebjerg

Anne Grosen

Anne Hammer Lauridsen

Anne Helene Jacobsen

Anne Katrine

Anne Katrine Leonhard

Anne Kragh Gotfredsen

Anne Kruse

Anne Lise Jensen

Anne Louise Born Sylvest

Anne Lund Knudsen

Anne Marie Sørensen

Anne Mette Larsen

Anne Mette Skjødt-Jensen

Anne Nelander

Anne Obel Dorff

Anne Peen Rodt

Anne Pelle-Klitgaard

Anne Sofie Nyrup Christensen

Anne Thorsen

Anne Wichmand Thorsen

Anne Willerslev

Anne-Marie Støvring

Anne-Sofie Houlberg Jensen

AnneChristine Huth Ruwald

Annemette Jørgensen

Annette Obel

Annette Raskov Kodahl

Annette Strömgren

Annette Thorsen-Meyer

Annette Ulrich

Arnar Bjarnason

Asgeir Snær Vilhjalmsson

Asger Lund

Ashok Ainkaran Ganeshalingam

Aska Drljevic-Nielsen

Aske Mathias Bohm

Asta Hubeck-Graudal

Ásta Milthers Theódórsdóttir

Astha Sijapati

Astrid Julie Bønnelykke

Astrid Plamboeck

Astrid Vinsand Naver

Astrid-Marie Eeg Petersen

Ayhan Al Kole

Bahram Has

Barbara Bonnesen Bertelsen

Benedicte Ersted Ansbæk

Benedikte Kolbæk Jacobsen

Benjamin Finn Denta

Bent Castensøe

Bente Bergqvist Casparij

Bieke FF Schrijvers

Birgit Falk Riecke

Birgitte Baldur-Felskov

Birgitte Carstensen Jørgensen

Birgitte Forsom Sandal

Birgitte Groth Berthelsen

Birte Obel

Bjarke B. Laursen

Bjarke Borregaard Medici

Bjørn Hoe

Bo Baslund

Bo Laksafoss Holbek

Bo Westergaard

Bodil Thorsager

Bolette Gerd Friderichsen

Bolette Silkjær Jakobsen

Bonnie Bruun Bechsgaard

Borgný Skúladóttir

Brian Bjørn

Britt Klæsøe-Lund

Camilla Boslev Bårnes

Camilla Holten Møller

Camilla Kjær Lønkvist

Camilla Lundegaard Asferg

Camilla Melchior

Camilla Nyboe

Camilla Ryge

Camilla Sambleben

Camilla Skovvang Borg

Camilla Winkel

Carita Thomine Nørgaard Skaugen

Carl Martin Söderström

Carolina Malta Hansen

Caroline Haals

Caroline Plaschke

Caroline Raun Hansen

Casper Falster

Casper Hagen

Casper Kloster Pingel Sæbye

Catharina Thornqvist-Kynde

Cathrine Lundgaard Riis

Cecilia Bech Horsted

Cecilie Brandt Lassen

Cecilie Jetsmark Geiker

Cecilie Refsager

Cecilie Utke Rank

Cecilie Vedsted

Charlotte Fergo

Charlotte Hauge

Charlotte Jensen

Charlotte Krabbe Søe

Charlotte Lysén Føhns

Charlotte Lützhøft Rath

Charlotte Schultz Perfitt

Christel Falk Lillevang

Christian Arndt

Christian Bjerre Høyer

Christian Bjørn Poulsen

Christian Eschen

Christian Frøkjær Thomsen

Christian Graugaard

Christian Grønhøj

Christian Meyhoff

Christian Pinkowsky

Christian Schousgaard

Christian Vestergaard

Christian Vinberg Thorup

Christiane Toudal Bak

Christina Bach

Christina E. Høi-Hansen

Christina Gade Jespersen

Christina Louise Rasmussen

Christina Mørup Jørgensen

Christina Neergaard Pedersen

Christina Sivebæk

Christine Bomholt

Christine Puck Holler

Christine Sølling

Christoffer Johansen

Christoffer Skovkjær Jensen

Claire Præst Holm

Claus Behrend Christiansen

Claus Bo Svenningsen

Connie Dydensborg

Connie Henriksen

Cæcilie Bachdal Johansen

Cæcilie Krogsgaard Tolstrup

Cæcilie Larsen Bang

Dan Høffner

Dan Isbye

Danny Svane

Danny Yu

Daria Podlekareva

Didde Trærup Schnack

Ditte Nymark Hansen

Ditte Sigaard Christensen

Ditte Vendelbo Jørgensen

Dominique Czort

Dorte Felbo

Dorte Gad

Dorthe Grosen

Dorthe Licht

Dröfn Hilmarsdóttir

Ea Papsø Løwenstein

Elisabeth Busk

Elisabeth Juul Gade

Elisabeth Lauritzen

Elisabeth Præstekjær Cramer

Ellen Fischer

Else Bønsing

Else Søholm Haaf

Elva Dögg Jóhannesdóttir

Emelie Andersson

Emil Toft

Emilie Knudsen-Nielsen

Emilie Schou

Emilie Stokholm Bækgaard

Erica Gould Christiansen

Erik Døssing

Erik Lilja Secher

Erik Sandsten

Eva Bang Moltke

Eva Bohnstedt Christensen

Eva Boné Stockbridge

Eva Laier Cervin

Eva Nyholm

Eva Schiöth

Eva Wiberg Torstensen

Eva-Marie Gram-Kampmann

Ewa Hordynska

Fanny Susanne Wierød

Fie Astrup

Fie Gregersen Møller

Fie Juhl Vojdeman

Fífa Björnsson

Fjóla Jónsdóttir

Flemming Egeris Vejlgård

Frederik Dalgaard

Frederik Schaltz-Buchholzer

Frederikke Uldall Urne

Frederikke Aabo-Rosendal

Fredrikke Dam Larsen

Freja Ville Zahle

Geerthana Ratnasingam

Gertrud Baunbæk Egelund

Gísli Gunnar Gunnlaugsson

Gitte Bro Schmidt

Gitte Gaudyn

Gitte Grunnet Raabe

Gitte Stokvad Brix

Gordon Thomas Jehu

Gregers BD Rasmussen

Gry Assam Taarnhøj

Guðbjörg Andrésdóttir

Guðný B. Akralíð

Gudny Jona Kristjansdottir Horst

Gudrun Agusta Sigurdardottir

Gunnhild Helmsdal

Gunnhild Vitalis Christiansen

Gunvor Tranberg Iuel

Gustaf Isaksson

Gyða Liv Skúladóttir Flinker

Gylli Mola

Habib Mir Ghasemi

Hadi Riazi

Hanna Kruse Reiband

Hanne Mumm

Hanne Skou Jørgensen

Hanne Trap Wolf

Hans Gottlieb

Hans Henrik Lawaetz Schultz

Hans Kristian Lauritsen

Harpa Maria Ingolfsdottir

Heidi Beate Christensen

Heidi Juul Dahlgaard

Heiðrún María Sigurðardóttir

Helene Bjerno

Helene Korvenius Nedergaard

Helene Ladefoged Grønborg

Helene Moustgaard

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Mette Bagger

Mette Bodekær Larsen

Mette Borch Nørmark

Mette Breum

Mette Christoffersen

Mette Dam Olesen

Mette Dam Vestergaard

Mette Enggård Falkensteen

Mette Falkenberg Krantz

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Mette Hjerrild

Mette Hvitved Andersen

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Mette Lykke Norgaard Bertelsen

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Mette Opstrup Abildgaard

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Nadja Lindberg Bonne

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Nina Åslund

Nini Møller

Nora Vladimirova

Nynne Lasthein-Madsen

Ole Kruse

Otto Ejsing

Pavel Mariager

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Pegah Booyash

Per Cramon

Per Kofoed

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Sidsel Mondorf

Sif Kielgast

Sigge Weisdorf

Signe Agersnap

Signe Bruun Munksgaard

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Aage Christiansen

Åse Klemmensen

المركز الثقافي الإسلامي الآيسلندي
Menningarsetur múslima á Íslandi
Islamic Cultural Center of Iceland

Alþingi
Reykjavik
26 March 2018

Efni: Umsögn um frumvarp til laga um breytingar á almennum hegningarlögum nr. 19/1940, mál 183-114 (bann við umskurði drengja)
Menningarsetur múslima á Íslandi would like to submit the medical statement below which is written to the parliament by a Consultant Paediatrician living in England in support to our position of the bill.

The Medical Statement by Dr Murtaza Khan

Dear Sir/ Madam,

There has been proposed ban on religious male circumcision in Iceland. I am a Consultant Paediatrician practising in the United Kingdom and would like to make you aware of the health benefits of male circumcision and request that this is taken into account in making your judgment as to whether it is banned or not.

There have been numerous studies on the health benefits of male circumcision (MC) and I will only detail the pertinent ones that are directly relevant.

1. HIV infection reduction. There is irrefutable evidence that MC decreases HIV/AIDS infection acquisition by a staggering 60%. This protective efficacy increases with time. This has been confirmed in large studies in both Africa and the United States and applies especially to heterosexual relationships.(1)
2. Sexually transmitted infections (STIs). MC also significantly reduces the risk of other STIs, including genital herpes, genital ulceration and High-Risk Human Papillomavirus (HPV). The latter is oncogenic and increases risk of cervical cancer in women, penile cancer in men and genital warts. MC reduces HPV transmission by 35% in men and 28% in women. (1,2) MC reduces risk of bacterial vaginosis and trichomoniasis by 40 and 48% respectively. (2)
3. Newborn MC provides benefits against urinary tract infection and sepsis, meatitis, balanitis and phimosis (these are infections of the penis) as well as protection from viral STIs. (3) High school students report having sex before 18 years of age, so delaying MC to this age would deny children and adolescents these potential benefits.

There are cost considerations. In the United States a cost-effectiveness analysis by the Center for Disease Control and Prevention, newborn MC was projected to increase quality-adjusted Life-years and estimated to be cost-saving due to reduced HIV infections and

subsequent treatment costs. (4) Pertaining to the benefits of MC the WHO and the UN (UNAIDS) through cost analysis also advocated MC in countries with high HIV epidemics. (6)

Newborn MC is a simple procedure and is safe. The complication rate is only about 0.3 % and the vast majority of these are minor and easily controlled. (5)

In summary, newborn MC, from the medical perspective, is safe, cost-effective and highly beneficial in preventing numerous infections and cancer. In comparison, immunizations are performed throughout the western world from birth to adolescence for preventing TB, diphtheria, meningitis, tetanus and many others. Putting the whole immunization protocol for a given child together they could have between 16 to 20 separate jabs by the age of 2 years. These also cost money, are painful and have complication rates, e.g. encephalitis after whooping cough, local infections, post-immunization fever. But we accept these as necessary and also accept that, although our children will be temporarily in pain, there are long term benefits. Newborn MC is the same, overall it is short procedure, is temporarily painful, safe, and has major long-term health benefits.

The debate around newborn MC should really be focussed on how through education the benefits on health prevention can be more widely available for the general community and not on how it may be beneficial for a particular section of the Icelandic people.

The American Academy of Paediatrics concluded in 2012 that "the health benefits of newborn male circumcision outweigh the risks"(7)

Dr Murtuza Khan

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Sexual mutilation and the moral order
(problematics and basic concepts of the struggle against sexual mutilation)

"It is not worth while saying
That children resemble us,
That they have the same scars
And that they're born with violence.
It really suits us to say that,
It helps us to educate them
In our image..."

"This postulate: parents, learning, power,
And that cunning dictatorship
Which removes them from their initial beauty..."

"When you were a child, remember those marks,
They already told you that enjoyment was hell."

"If you love yourself a little,
"Then, you love others."
Morice Benin

Perpetrated upon whole generations of children,
sexual mutilation of both sexes is the greatest crime against humanity.
Committed within collective madness and without the intention of harming,
it is not reprehensible.
But it is first, aggravated rape (through the use of a sharp instrument),
then, discriminatory mutilation, and, finally, barbarous torture.

I - Who and why?
(the agent of sexual mutilation: the moral order; affiliation-submission through trauma)

"Its first, totemic, phase already brings with it the prohibition against an incestuous choice of object, and this is perhaps the most drastic mutilation which man's erotic life has in all time experienced." Sigmund Freud[1]

"Sexual violence is, with torture, what causes the most psychotraumatic disorders." Muriel Salmona

"The sex of the (child) well appears as a stake of possession, a symbol of submission." after Simone Veil

"Circumcision standardizes the bodies in order to communitarize the minds later and till the grave." Mohamed Louizi (blog mediapart)

"…not only does the child's body not belong to us but... their sex still less." Françoise Dolto

[1] Freud S. Civilization and its discontents. Ch IV.

> "And the circumcision, you think it is consistent with the respect of bodily integrity? And excision of little girls? We should submit since it is cultural?" Bernard This
>
> "That commandment has not been prescribed in order to correct a physical deficiency but **a moral one**." Maimonides

Seeming to want to lecture the whole humanity by a morality against nature, the distinguished Rabi and Jewish philosopher Maimonides appears to be advocating eugenics through circumcision in the name of a moral order that, under the guise of religion or tradition, aspires to make supermen. That statement of moral superiority is distressingly sexist, and racist since founded upon a physical difference. But one may not control impulses by suppressing their source through obnoxious mutilations that painfully castrate the human person, at an age where they are helpless, from the specific organ of autosexuality, decreed immoral. We are in a total puritan aberration since assuming autosexuality blameworthy, only the use of the organ, not the organ itself, would be immoral. Perceived by the child as parental, and very particularly maternal, betrayal, the barbarous torture of that first step to castration (the Hottentots went further through cutting the left testicle at the age of ten) makes a lifelong *threat of castration* present, aggravated by a beginning of realization. It is the tool of a tyrannical order that tends to dominate the child (and the adult)[2], to submit them to the established order, under the pretext of the black pedagogy of the: "It's for your own sake!" Similarly, at the end of the 19th century, excision and circumcision were introduced into the Anglo-Saxon world in order to prevent autosexuality. But in 1950, following Gairdner's alarming article, English medicine abandoned circumcision overnight. In 2010, the Royal Dutch medical association took adamant stand against nontherapeutic circumcision for the motive that, without necessity and at the price of sometimes-serious physical and psychological complications, it violates the right of the child to physical integrity. It was followed by the South-african medical association (2011), the Swedish pediatric society (2012), the German pediatric associations (2012), the ombudswomen and ombudsmen for children of the five Northern countries (2013), the Nordic association of clinical sexology (2013), and the Danish medical society (2014). But they did not know yet that the rate of autism is much higher with circumcised children, and very particularly at birth. The criminal Finnish (2006), then German (2012) justices judged circumcision unlawful. June 14, 2013, in La Sorbonne, opening the founding meeting of "Excision, parlons-en", Mrs Christine Lazerges, the president of the French national consultative commission of human rights, declared that she would mention that feminine and masculine sexual mutilation is discriminatory in her next report to the President of the republic. Indeed, it is an auto-exclusion of the ethnic group that discriminates both the child, the community, and the rest of humanity. But through pronouncing with a strong majority for the respect of the right of the child to physical integrity, the 1st October 2013 decision of the Parliamentary assembly of the

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[2] Immerman R., Mackey W. A biocultural analysis of circumcision: a kinder gentler tumescence. *Soc Biol* 1997; 44(3-4), 265-75. http://www.cirp.org/library/psych/immerman2/

Council of Europe provoked an outcry from the Muslim and Jewish religious, and from the chief of the Israeli state. So that the 2 December 2013 report of the French NCCHR did not hold Madame Lazerges' promise. Nevertheless, for the first time in history, a political assembly: the Council of Europe, condemned circumcision as a mutilation, in the same way as excision. But as soon as 1989, the first symposium of NOCIRC[3], followed by Alice Miller[4] in 1990, had qualified both sex sexual mutilation "the greatest crime against humanity".

Verbal repression complements those atrocious tortures. Likening pleasure to vice, it forbids lightly said infantile sexuality and before-wedding sexuality. Sole present in the rest of the world, that mental sexual mutilation similarly subjects the individual to hypocritical puritanism. Maybe less irreversible than physical excisions, mutilation of minds through speech also is fearsome; it has the same aim of making the individual meek through traumatizing them by unconscious terror and by setting up the aberrant law of the ban of pleasure. Under threat of loss of love, and thus exclusion, a stupid decree makes autosexuality the original sin. That both parental and societal lie is fierce and dangerous. Operating through imbuing from the youngest age, it is a genuine taboo. It is all the more difficult to eradicate from minds that it is set up by violence that erects the reason of might as a rule.

II - How? (sexual mutilation: the height of repression of infantile sexuality)

> "At night, before going to bed, they all had to m.....te, in order well to know what they were going to lose…" Gérard Zwang (preface of "The drama of excision" by Dore-Miloch L.)

> "Do not throw your seed amongst thorn-bushes. Try to circumcise yourselves..."
> Jeremiah, 4: 3-4

Albeit his own circumcision trauma that made him commit grave clinical and theoretical mistakes[5], Freud rose up against that universal taboo. The discovery of the autosexuality of the foetus through ultrasounds brings him strong backing but autosexuality is still repressed. Imagine a being that has freely practised it in its mother's womb: yourself. Once out of this Eden, while having your bath, you are suddenly glowered at and harshly told: "Why is it so? You touched it?", as if it had previously been forbidden. Isn't assuming known and normal a never uttered yet ban the summit of an as savage as blind repression? To crown it all, everybody around you condemns nudity and disparages your act of self-love by referring to it through reproachful terms. The root of the most common one: *stupratio,* denotes disturbance (cf. per-turbation) and refers to "turpitude". "Autosexuality" must replace that abhorrently making-guilty term. Wanting to fight sexual crime is

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[3] Prescott J. http://montagunocircpetition.org/

[4] Miller A. Introduction to reflections about sexual mutilation, in Banished knowledge - facing childhood injuries. New York: Doubleday; 1990. p. 131.

[5] Bertaux-Navoiseau M. Psychoanalysis of sexual mutilation, sexual mutilation of psychoanalysis (Freud between Abraham and Alice Miller).

illusory without acknowledging that autosexuality is not debauchery but natural and healthy behaviour.

The discoveries of psychoanalysis: on the one hand, infantile sexuality and the unconscious, on the other hand, infantile traumas and their ravages (cf. Freud and Alice Miller), stand against those abuses. Violence in education, rather than tender care, has catastrophic results; breeding psychosomatic diseases, neurosis, psychosis and perversion, violence, depression and addiction. Notably, the child perceives the repression of infantile sexuality as a death threat through loss of love (forsaking). Outlawing pleasure in an aberrant way, that threat opposes the resolution of the Oedipus complex: adherence to the law. So, it is likely to block their growth. Numerous mental diseases are the direct consequence of the hypocritical public reprobation of what everybody merrily does in private. Only seducers, rapists, paedophiles, and homophiles "masturbate" in their victims, granting them the same treatment they endured in their own childhood autosexuality. That compulsive need will not exist any longer when autosexuality will be socially accepted. Transcultural studies of American anthropology have, with absolute statistical correlation[6], checked the observations of psychoanalysts upon whole ethnic groups. They report that pain is inhibited by pleasure, and reciprocally, and that violence stems from a lack of tenderness in infancy and of the prohibition of premarital sexuality.

Hurting human independence and dignity in a way that is typical of the moral order: a violation of intimacy, obsessive rituals perpetrated upon the child: sexual mutilation, ear piercing, etc., are a height of this repression. Denuding someone in order to mutilate her or his sex is a revolting humiliation.

In olden days, branding used to be a mark of stigmatization of criminals. But nowadays, a whole fringe of the youth unconsciously stands up against the repression of autosexuality through the absurd realization upon themselves of a caricature of those markings: tattoos, piercings, etc. The adornment symbolizing the sexual organ, those provocative, perverse (fetishism), and discriminatory auto-mutilations are the unconscious expression of both guilt and rebellion against the taboo of autosexuality. That new popular snobbism sometimes qualifies itself "ethnic" but those young people do not realize that they are resorting to reductio ad absurdum against the stigmatization of autosexuality and that tattooing is excluding.

III - What? (a definition)

The preservation of the clitoris and the foreskin is founded on six facts that illustrate their essential-to-life character.

First fact: minors. Sexual mutilation the most often aims at minors. But through fighting feminine mutilation alone in a sexist way[7, 8], Western feminists, at the vanguard

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[6] Prescott J. Body pleasure and the origins of violence. The bulletin of the atomic scientists, 1975, 10-20.

[7] Earp B. Female genital mutilation (FGM) and male circumcision: Should there be a separate ethical discourse?

of the struggle, make it a gendered affair and a contest between sexes. They reproach men for imposing excision on women who realize it upon minor females (!), and accuse non-sexists of confusing excision and circumcision. So doing, they forget that dads have been circumcised with the complicity of their own mums. And we shall see that excision is only the most scandalously visible tip of the iceberg of sexual mutilation. Instead of approaching the latter in a dynamic, historical, and transgenerational, rather than static perspective, feminists conflate violence against adults with violence against minors. But the war of the sexes is a war of "adults ignoring the child within themselves" (according to Maud Mannoni), and that of generations begins with war on children. The fact is that, in order to avoid all resistance, excision is now practised at birth, and in the hospital albeit the forbidding of the OMS. Following Mrs Albagly (Director of the DDASS of the Rhône - 02.26.07 FSM colloquium in Lyon), we affirm: "The right to the respect of the physical integrity of all children is not negotiable."

Second fact: sexual. The specific organs for autosexuality (the clitoris and the foreskin) are not genital organs but organs of pure pleasure, without any other function for the clitoris. Unlike the ablation of the glans, excision only impedes sexual pleasure in order to guarantee fidelity but does not impede reproduction.

Third fact: physical mutilation. For eighty per cent of the world population who enjoy those organs, the particular, incidentally extreme pleasure they provide is indisputable. Excision suppresses, lessens, or turns pleasure into pain; the destruction of clitoral pleasure often entailing that of vaginal pleasure, two-thirds of the excised are frigid. With man, the loss is the most often limited to preputial pleasure, notably that of little orgasms[9], by no means insignificant. Recent anatomical discoveries bring scientific basis to this empirical affirmation. In 1996, John Taylor highlighted the part of exquisite erogenous mechanism of the terminal ring of the foreskin. That discovery contributes to ending the tale according to which the lip protecting the erogeneity of the glans, man's minivagina in autosexuality, would not be an organ. Not having been awarded the Nobel Prize it deserves, it remains ignored though experimentally confirmed by Sorrells' sensitivity inquiry. At last, the third sexual function of the foreskin – that of a gliding cushion reducing friction in coitus – has also been emphasized. It explains why the African women with circumcised partners are much more hit by the HIV than men, which strengthens the contest of the WHO's circumcision campaign in Africa. Several inquiries have shown that the circumcision status does not influence transmission of STIs, except AIDS but in the medium term only. However, bioethics forbids preventive mutilation and circumcision may not be practised without very serious medical motive, upon minors as adults.

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https://www.academia.edu/8817976/Female_genital_mutilation_FGM_and_male_circumcision_Should_there_be_a_separate_ethical_discourse

[8] Carmack A. Female genital mutilation," "circumcision," "gender-conforming surgery": why the double standard?
http://adriennecarmack.com/female-genital-mutilation-circumcision-gender-conforming-surgery-why-the-double-standard/

[9] Bertaux-Navoiseau M. A preliminary poll: 82% of circumcised men ignore the serial anejaculatory mini-orgasms (the male minis), 91% of the intact enjoy them.

Fourth fact: the trauma. Highlighted by Freud, traumas bearing on infantile sexuality provoke the formation of the unconscious and are the deep cause of mental disease. Assaulting the image of the body, the castration of the organs for autosexuality has strong emotional repercussions and, through stunning and dissociation, creates a grave trauma, the most often unconscious. Autosexuality, the very first, natural, innocent and harmless sexuality is heavily made guilty, all the more since circumcision threatens boys of total castration. However, and even in non-excising cultures, girls too, unconsciously suffer from the threat associated with circumcision. If the sheath of the glans is destroyed, what then is going to happen to the very little clitoris? Besides, a symbolic threat is enough and the passing of a knife over the child's body is sometimes substituted for excision. That criminal performance illustrates the presence of the death threat in all sexual mutilation.

Fifth fact: the taking of possession of the individual by the group through means of a terrorist violence. The human sacrifice of a part of the body implements a powerful psychological mechanism of enslavement. Indeed, for the unconscious as for the fetishist, primitive or infantile soul, the part is equivalent to the whole (cf. the abuses of Voodoo that, after the prohibition of sexual mutilation by the slave drivers, "possesses" its victims to the point of forcing them to prostitution through merely cutting a lock of hair off). Founded upon a perverse impulse of control, those abuses of power imply an unacceptable possessiveness: "I know, therefore I have the right to determine what is done to your body."

Sixth fact: discrimination and exclusion. Performed in order to warrant an alleged moral superiority, sexual mutilation isolates the ethnic group through an artificial racism, in the aim of favouring endogamy and possession of women. It is also a means of enslavement through exclusion of opponents.

The worst of ordinary educational violence, sexual mutilation rites set up the law of might and the ban of pleasure through terrorizing the human person at the age when they are the most vulnerable. Barbarian methods of banning infantile sexuality and of making pleasure guilty, possessory markings exert a perverse sway of the group over the still minor individual in order to force them to work, reproduction and war. Vexatious, it humiliates through condemning personal pleasure by the castration of its specific organs. It frequently makes sexuality painful for women and severely impoverishes autosexuality for men. The atrocious pain, the terror of the operation and the permanent reminder of the related threats of castration, exclusion and death deeply traumatize, the most often unconsciously. So, it is one of the most obnoxious techniques of enslaving the individual, responsible for virulent fanaticism and warlike violence. Socializing through warranting a alleged moral value sometimes endorsed by God in person but destroying human identity in its most intimate part, its illusory superiority discriminates foreigners and opponents by an artificial racism that discriminates in order to better exclude.

IV - The consequences: segregation, exclusion, discrimination, racism and violence

> "If hate creates the object, it is also what the most violently threatens its existence. Because it makes of the identity of oneself to oneself an exclusive, and even fetishized concept, hate carries in itself the rejection of all otherness. When it makes itself the ally of a narcissism enemy of "little differences", it becomes the carrier of a purity that no longer tolerates any variegation, any mixing. Purity of the race, purge, ethnic cleansing, the pure and hatred dwell in the same countries." Jacques André and Isée Bernateau

> "An uncircumcised is not a man." (African saying)

1) The exclusion of opponents

Circumcision is a behaviour that is deviant, perverse, dangerous because likely contagious, like all perversions. Like them, it tends to be credible, to carry authority, and therefore, to be reproducible, and even to back itself upon statistics. Moreover, the African saying implies casting out the opponents, considered as minors, debauched and cowardly, and the systematic sanction of the absence of mutilation is exclusion from the community. That punishment reveals the deep characters of the practice: elitism and feeling of superiority (enabling the sexually handicapped to fight depression), exclusion, barrier to marrying outside the group (a great concern of the racist), and finally, forbidding the burial of intacts in community cemeteries, or even in the national ground (Saudi Arabia), but for posthumous circumcision (Jews).

2) The auto-exclusion and exclusion of other ethnic groups

A collective particular sign creates a social link indicating a belonging (an alteration of identity is not an identity), and a collective mutilation is a collective alienation through auto-exclusion. Allegedly providing a moral, physical and even sexual superiority, sectarian mutilations separate the group from humanity. Antisexual, anti-democratic and xenophobic, they discriminate the ethnic group from the neighbouring ones. Maimonides has emphasized that auto-discrimination:

> "It is my opinion that circumcision has another important motive: it makes that those who profess that idea of the unity of God distinguish themselves by the same body sign which is imprinted on them all, so that the one who is not part of them cannot, being a stranger, pretend to belong to them."[10]

But exclusion calls for hatred. Spinoza and Freud exposed circumcision as a source of hatred from neighbouring peoples. That hatred is reciprocal. The contempt of the "un"-circumcised goes along with a veritable racism source of continuous tribal wars: Hutus against Tutsis, Zulus against Xhosas, Kikuyus against Luos. An extremely serious collective pathology (transgenerational and collective syndrome of Münchhausen by proxy, aggravated Stockholm syndrome), circumcision generates particularly high violence. Genocide practically never exists between intacts but of the twenty-five genocides of modern times: Circassian Muslims (1860), Congolese (1870), Hereros (1904-07),

[10] Maimonides M. The guide of the perplexed. 1160. Chicago: Chicago University press; 1963. p. 609.

Greeks (1921-23), Assyrians (1914-20), Armenians (1915), Serbs (41-45), Jews (1942-45), Gypsies (1942-45), Chechens (1944-48), Hindus (India-Pakistan, 1947-49), Muslims (India-Pakistan, 1947-49), Indonesian communists (1965), Biafrans (1966-68), Guineans (1968-79), Bengalis (1971), Hutus (1972), Kurds (1988-89), Tutsis (1994), Bengalis (1990-2000), Bosnians (1991-95), inhabitants of Darfur (2003), Iraqi Kurds (2005), Rohingyas (2012), Yazidis (2015), twenty-four (96%) involved circumcised peoples on at least one side and six on both sides. And the Gipsy exception is moot since some of them are circumcised. The circumcised perpetrated fourteen of them, of which eight against intacts. That strong correlation is logical; a voluntary collective violation of the human body creates a feeling of boastful superiority with those who practise it and the inverse feeling with the others so that the holocaust of the foreskins is responsible for all others. Between 1996 and 2002, all wars without exception involved at least one circumcising country and they were more than three times more numerous in circumcising countries. The death penalty is twice as frequent in them and they are the only ones to practise excision. In Norway, between 2006 and 2010, 2% of the population who are circumcised committed all the rapes upon ninety per cent of native Norwegians. Circumcised Congo holds the world record for rape: 400,000 over a period of one year. Sexual mutilation separates the child from the mother at the age of bonding. That is monstrous, the result is catastrophic; circumcision is the breeding ground of paranoia, sexism, fanaticism and group or state terrorism. It makes the equilibrium of terror and the fortune of gun merchants. The cause of a worldwide systemic racism, sexual mutilation, circumcision very particularly, is a cancer that gnaws at the planet.

More fascist than fascism since it aims at children, sexual mutilation is unbearable to fascists. But democrats may not tolerate those ordeals. Taking the festivities of folklore for an alibi, it is imposed by military and religious elites with adolescent behaviour. Societies that advocate them are affected by a strong propensity to communitarianism, fundamentalism, patriarchal tyranny and domination over women. It has a sexist character. It considers women and children as objects of a right of property. It does not welcome the child into a society regulated by the difference of sexes and ages but socializes or affiliates through the trauma of a barbarous military initiation that enlists for war. So, it is encouraged by tyrannical regimes which use it as an induction to violence and a sign of rallying. The community sign is always a call for nationalism, a sign of war, of possession of the individual and exclusion of foreigners. Sexual mutilation makes the people carry the can (the hat in the French expression!) of a non-existent guilt: scarf, veil, burka, kippa, tattoos, forced obesity, breast ironing, stretched oral or vulvar labia, scarification, filed or knocked off teeth, bound-feet, cut off clitorises, foreskins, uvulas and tongue fraenums, the death penalty, to arms et cetera..., the escalation of the techniques of manipulation of the minds through marking and mutilating the bodies – the worst tools of the war of generations – channels human needs at the service of the interests of the ruling classes and generations. Sexual mutilation is the most monstrous technique of domination of peoples ever imagined.

3) The exclusion from the human species and the discrimination of other ethnic groups

> "But a private person may not perform such an ablation (of a member), even with the patient's consent; **it would be committing an injustice to society**, to which man belongs with all his limbs." Saint Thomas Aquinas

The motivation of the father of the Church is similar to that of the tenth principle of the International declaration of the rights of the child of the United Nations:

> "The child shall be protected from **practices that... may foster racial, religious or any other form of discrimination..."**

Racism is more arrogant when it stands on mutilations that aim at ensuring the possession of women. So, the three great myths of circumcision: moral superiority (virtue, chastity, fidelity, purity, spirituality), hygiene superiority, and sexual superiority, above all aim at convincing young women in order to favour endogamy. That is still more obvious for excision.

Sexual mutilation is not properly racist but founding a collective identity upon an assault against that of the species is not only degrading in itself, it is also discriminatory. It aims at making supermen through alleged community superiority by surgically imposed differentiation. It is an artificial racism, more racist than racism, a power-of-ten racism, some neo-Gobineau enacted by Mengele. The peoples who carve out an identity through knife for themselves upon the body of their children offend the rest of humanity. A height is reached in chapter 17 of Genesis where that racism takes the dimension of a divine obligation that promises hegemony to Abraham and his people:

> "… you will be the father of a multitude of nations…" (Genesis, 17: 4)

That hegemony will later be confirmed by the absolute ethnic superiority of the myth of divine election:

> "... if you keep my covenant, you will be my treasure between all peoples..." Exodus, 19: 5

Since sexual mutilation rests upon antique customs and is committed for the sake of the child, within love and without the intention of harming, the only means of criminalizing it is exposing the will of discrimination and segregation, under threat of exclusion of opponents, of that crime against humanity.

Conclusion

Man is the sole species of which males and females teach their kids the reason of the strongest through humiliating, slapping, smacking, hitting, banging, and even, a height of refinement of sadistic domination, through castrating them of a part of their sexual organs. If there is no biological sign of passage to adulthood, setting up the destruction of the specific organs for autosexuality as a testimony of it is insane. The entire con-

trary, autosexuality is an initiation (auto-initiation). Sexual mutilation gives the right to marriage through certifying a passage to adulthood accomplished within submission to the established order. It is a false certificate. On the contrary, it may be feared that numerous maimed persons do not reach genuine maturity, characterized by deep acknowledgment of the difference of sexes and a true desire of the other sex, an acquisition that alone enables peoples' access to real democracy through the equality of the sexes. As long as the puritan repression of autosexuality and the sexism that sets one gender up against the other instead of gathering them in the defence of toddlers will prevail, it will be impossible to eradicate it.

If the fight against circumcision is in good way in the United States where the rate of circumcision has fallen down from 90 to 55%, that against deadly excision (5 to 15% immediate deaths, 20% at delivery) progresses only in dribs and drabs and, in a scandalous paradox, its medicalization south of the Mediterranean is followed by its restoration north of it. That is because symptoms are attacked without getting to the root: the treatment of the child like an object, the denial of the right to pleasure, and making autosexuality guilty, so that circumcision is not fought, which would bring real efficiency to the fight. The use of the term "abstinence" in official recommendations for the prevention of AIDS shows that autosexuality is still considered a shameful, infantile or profligate behaviour. It seems to be ignored that every human being is an ageing child and that those unable to regress cannot progress either. Sexual mutilation strikes the fundamental right of 850 million persons. Attacking excision only neglects 76% of the victims.

Characterized by discrimination and exclusion, sexual mutilation is the expression of the worst of all racisms. One of the causes of fanaticism, suicidal terrorism and redoubtable tyrannies, it is incompatible with democracy and cultures or political systems that tolerate it do not deserve the name of civilization or democracy. Due to the age of the victims, it is the sole crime against humanity which nobody complains about. Irreversible, it harms the whole population: children, adolescents, temporarily separated, divorced or with-different-sexual-need couples, bachelors, and widowers. Perpetrated under various pretexts: religion, tradition, hygiene, folklore, it imposes the adults' way of living on the child through an odious torture. Founded upon a perversion of ethics distorted into moralizing morality, creating neurosis inside the people in order to give a social basis to that of the rulers, it pretends to give lessons to the people. It is for the profit of those who exploit them. Sexual mutilation is the worst expression of a patriarchy that ensures its domination through a threat of death engraved in the very flesh of the individual. It is the paradigm of the persecution of the individual by society. Its abolition is a stage in the fight against the repression of sexuality and for the human person's right to the free access to their own body and the respect of their physical, emotional and mental integrity, autonomy and dignity. Medicine may not be used as a pretext for barbarity; in the absence of "very serious medical motive" (article 41 of the French Code of medical ethics), mutilating is contrary to bioethics. In a civilized society, not a single hair of a child must be touched and the abolition of corporal punishment must be extended to children. The right to the body must be mentioned in article 1 of the Universal declaration of human rights:

"All human beings are born free and equal in rights, **in first place the right to the body and pleasure, in its three dimensions of integrity, dignity and autonomy."**

"The steel that maims from the satin,
Our useless wounds far away,
We'll change our gates into lanes
And make our cities gardens."
Jean-Jacques Goldman (Il suffira d'un signe)

Given as a lecture) 4 September 2008 at the 10th Symposium of NOCIRC in the University of Keele (UK, this text has been published by AgoraVox and CaféBabel. It has been saluted by Mrs. Najaud-Belkacem, spokeswoman of the French government, and quoted by Jean-Pierre Rosenczveig, ex-President of the children court of Bobigny and member of the International bureau of the rights of the child, in his 7 July 2012 article against excision and circumcision.

RELATED ARTICLES:

Between barbarity and exclusion, ritual circumcision, an artificial racism masked behind religion, tradition, culture and folklore, catalyst of fanaticism, terrorism, war, genocide, and feminicide

- Genocide and circumcision, causality and near absolute correlation

- Terrorism and circumcision; circumcised first, then fanaticized (psychoanalysis of terrorism - circumcision turns men into weapons of war)

Violence and circumcision: genocides, wars, terrorism, the death penalty, excision, and rape

I - Countries practising circumcision in a majority

	THE DEATH PENALTY (in principle)	WARS 1996-2002	TORTURE	EXCISION (Frequency) (in %)
AFGHANISTAN	X	X	X	
ALBANIA	X			
ALGERIA	X	X	X	
ANGOLA		X	X	X
AZERBAIJAN			X	
BAHRAIN	X			
BANGLADESH	X		X	
BENIN	X			13
BISSAU GUINEA		X		45
BOSNIA HERZEGOVINA	X	X		
BRUNEI	X		X	
BURKINA FASO	X		X	4
CAMEROON	X			1
CENTRAL AFRICAN REP.	X	X	X	15
CHAD	X	X	X	44
COMOROS	X			
DEM. REP. OF CONGO (ZAIRE)	X	X	X	5
DJIBOUTI				93
EGYPT	X	X	X	92
EQUATORIAL GUINEA	X		X	
ERITREA	X	X		89
ETHIOPIA	X	X	X	74
FIJI	X		X	
GABON	X			
GAMBIA	X			76
GHANA	X			4
GUINEA	X	X	X	97
GUINEA-BISSAU		X		50
INDONESIA	X			90
IRAN	X		X	X
IRAQ	X	X	X	8
ISRAEL	X	X	X	
IVORY COAST		X	X	36
JORDAN	X		X	X
KAZAKHSTAN	X		X	
KENYA	X		X	27
KIRGHIZSTAN	X			
KUWAIT	X	X	X	
LEBANON	X	X	X	
LESOTHO	X		X	X

LIBERIA	X	X	X	45
LIBYA	X		X	
MADAGASCAR	X			
MALAYSIA	X		X	X
MALDIVES	X			X
MALI		X		85
MAURITANIA	X			69
MOROCCO	X			
NIGER	X			2
NIGERIA	X		X	27
OCCIDENTAL SAHARA	X			X
OMAN	X			X
ORIENTAL TIMOR				X
PAKISTAN	X		X	X
PALESTINIAN AUTHORITY	X	X	X	
PAPUA NEW GUINEA	X			X
PHILIPPINES	X	X	X	X
QATAR	X		X	
RWANDA	X	X	X	
SAMOA	X			
SAUDI ARABIA	X	X	X	
SENEGAL	X	X		26
SIERRA LEONE	X	X	X	88
SOLOMON		X	X	
SOMALIA	X	X	X	98
SOUTH AFRICA			X	
SOUTH KOREA	X			
SUDAN	X	X	X	88
SWAZILAND	X		X	
SYRIA	X	X	X	X
TADZHIKISTAN	X	X	X	
TANZANIA	X		X	15
TOGO	X		X	4
TONGA				
TUNISIA	X		X	
TURKEY	X		X	
TURKMENISTAN			X	
UNITED ARAB EMIRATES	X		X	X
UNITED STATES	X	X	X	
UZBEKISTAN	X		X	
VANUATU				
WESTERN SAHARA				X
YEMEN	X		X	23
81 countries	70 countries (86%)	30 countries (37%)	52 countries (64%)	44 countries (54%)

TOTAL POPULATION: 2,027 billions

II - Countries where circumcision is rare

	THE DEATH PENALTY (in principle)	WARS (1996-2002) implying circumcising countries	TORTURE	EXCISION
ARGENTINA			X	
ARMENIA	X		X	
ASSAM				
AUSTRALIA		(X)		X
AUSTRIA				
BAHAMAS	X			
BELGIUM				
BELIZE	X		X	
BHUTAN				
BYELORUSSIA	X		X	
BOLIVIA	X		X	
BOTSWANA	X			X
BRAZIL	X		X	
BULGARIA			X	
BURUNDI	X	(X)	X	
CAMBODIA				
CANADA				
CHILE	X			
CHINA	X		X	
COLOMBIA			X	X
COSTA RICA				
CROATIA				
CUBA	X			
CZECH REPUBLIC				
DENMARK				
DOMINICA	X			
EIRE				
EQUATOR			X	
ESTONIA				
FINLAND				
FRANCE		(X)		
GEORGIA	X	(X)	X	
GERMANY				
GREECE	X			
GUATEMALA	X		X	
GUYANA	X		X	
HAITI				
HONDURAS			X	
HUNGARY				
ICELAND				
INDIA	X		X	X
ITALIA			X	
JAMAICA	X		X	
JAPAN	X			
LAOS	X		X	

LATVIA	X		X	
LITHUANIA			X	
LUXEMBURG				
MACEDONIA		(X)	X	
MALAWI	X			X
MALTA				
MAURICE			X	
MEXICO	X		X	X
MOLDAVIA			X	
MOZAMBIQUE			X	X
MYANMAR	X			
NAMIBIA			X	
NEDERLAND				
NEPAL			X	
NEW ZEALAND				
NICARAGUA				
NORTH KOREA	X			
NORWAY				
PANAMA	X			
PARAGUAY			X	
PERU	X		X	X
POLAND				
PORTO RICO				
PORTUGAL			X	
RUMANIA			X	
RUSSIA	X	(X)	X	X
SALVADOR	X		X	
SINGAPORE	X		X	X
SLOVAKIA			X	
SLOVENIA				
SPAIN			X	
SRI LANKA	X	X	X	X
SURINAM	X			
SWEDEN				
SWITZERLAND				
TAIWAN	X		X	
THAILAND	X		X	X
TRINIDAD AND TOBAGO	X		X	
UGANDA	X	X	X	1
UKRAINE			X	
UNITED KINGDOM		(X)		
URUGUAY				
VENEZUELA			X	
VIETNAM	X			
YUGOSLAVIA	X	(X)		
ZAMBIA	X		X	
ZIMBABWE	X		X	
92 countries	40 countries (43%)	10 countries (11%)	46 countries (50%)	12 (13%)

TOTAL POPULATION: 4,116 billions

CONCLUSIONS

	NUMBER OF COUNTRIES	THE DEATH PENALTY (in principle)	WARS	TORTURE	EXCISION
Circumcising countries	81 (2,027 B)	70 (86%)	30 (37%)	52 (64%)	44 (54%)
Non-circumcising countries	92 (4,116 B)	40 (43%)	10 (11%)	46 (50%)	12 (13%)

It must not be inferred from these figures that circumcision would concern 1/3rd of the humans. It only hits 1/5th of them. Circumcising countries are less populated (26 million on average) than countries which leave their children intact (45 millions on average).

Genocide practically never occurs between intacts but of the twenty-five genocides of modern times: Circassian Muslims (1860), Congolese (1870), Hereros (1904-07), Greeks (1921-23), Assyrians (1914-20), Armenians (1915), Serbs (41-45), Jews (1942-45), Gypsies (1942-45), Chechens (1944-48), Hindus (India-Pakistan, 1947-49), Muslims (India-Pakistan, 1947-49), Indonesian communists (1965), Biafrans (1966-68), Guineans (1968-79), Bengalis (1971), Hutus (1972), Kurds (1988-89), Tutsis (1994), Bengalis (1990-2000), Bosnians (1991-95), inhabitants of Darfur (2003), Iraqi Kurds (2005), Rohingyas (2012), Yazidis (2015), twenty-four (96%) involved circumcised peoples on at least one side and six on both sides. The circumcised perpetrated fourteen of them, of which eight against intacts. The Gipsy exception being arguable since some of them are circumcised, the correlation between genocide and circumcision is near absolute. That strong correlation is logical; a voluntary collective violation of the human body creates a feeling of superiority with those who practise it and the inverse feeling with the others.

All wars between 1996 and 2002 involved at least one circumcising country and they were more than three times more numerous in circumcising countries. Circumcision makes the fortune of gun merchants.

Since the 1972 slaughter in Munich, the quasi-totality of terrorist attacks in the world, as well as those in American universities, have been committed by circumcised.

The death penalty is more than twice more frequent in them.

Torture is more widespread in them.

Most dictators are circumcised.

Making 15% direct deaths and 20% deaths at delivery, excision is a feminicide, 100% correlated with circumcision since it only exists in circumciser countries (a little more than half of them).
The feminicide in Eastern Congo is the work of circumcised Hutu looters who afterwards destroy those whom they used as a foreskin.
97% circumcised Congo (DRC) (http://globalhealthsciences.ucsf.edu/sites/default/files/content/pphg/triangulation/DRC.pdf) holds the world record for rape: 400,000 over a period of one year.
In Norway, between 2006 and 2010, 2% of the population who are circumcised committed 100% of the rapes upon ninety per cent of native Norwegians.

Sources:
– Amnesty international. 2002 report. (N.B.: Assam, Botswana, Comoros, Costa Rica, Denmark, Djibouti, Estonia, Gabon, Island, Luxemburg, Madagascar, Mali, Malta, Norway, Nederland, Panama, Samoa and Slovenia, do not figure in the 2002 report of Amnesty international).
– Amnesty international. “Abolir la peine de mort” 2002; (41).
– for excising countries: DHS : http://www.measuredhs.com/ and WHO:
http://www.who.int/reproductive-health/publications/fgm/fgm_programmes_review.pdf
and UNICEF: 2013 report
UNICEF: http://www.unicef.org/french/pon96/womfgm.htm
for Indonesia: http://cirp.org/news/smh01-13-04/
– http://sicsociety.org – World maps of excision and circumcision.
– Encarta encyclopaedia (msn-hotmail.com) for population statistics.
- for the Norwegian statistic: Hofvander I. 9th symposium of NOCIRC in Seattle; 2007.

27.3.2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál

Hello,
I am writing to you to ask the members of the Parliament of vote in favor of the proposed circumcision ban. Childhood circumcision is truly barbaric and children should be protected from forced genital cutting. You have support in banning this act in the United States.

Thank you
Michelle Crimaldi

Umsögn frá *Miðstöð foreldra og barna* um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja).

Miðstöð foreldra og barna starfar með hag barna að leiðarljósi.

Út frá hagsmunum barna eru starfsmenn miðstöðvarinnar **sammála** rökstuðningi sem fram kemur í greinargerð með frumvarpinu um að:

- Með umskurði sé brotið á réttindum barna.
- Um sé að ræða varanlegt inngrip í líkama barns sem getur haft í för með sér mikinn sársauka.
- Drengir eigi að taka ákvörðun um slíkt þegar þeir hafa sjálfir náð aldri og þroska til að vera færir um það.

Við gerum á hinn bóginn alvarlegar athugasemdir við 1. grein frumvarpsins en þar segir: "Hver sem með **líkamsárás** veldur tjóni á líkama eða heilsu barns eða konu með því að fjarlægja kynfæri að hluta eða öllu leyti **skal sæta fangelsi allt að 6 árum**."

Hér er notað gildishlaðið og ónákvæmt orðalag. Með "líkamsárás" er væntanlega átt við skurðaðgerð en ekki er ljóst hvort hegningarviðurlögin beinist að þeim sem framkvæma aðgerðina, sem gætu verið læknar, eða þeim sem bera á henni ábyrgð, sem oftast eru foreldrar viðkomandi drengs. Af almennri umræðu má ætla að átt sé við foreldra en þetta þarf að vera mun skýrara. **Við vörum eindregið við refsingu sem felur í sér fangelsisvist foreldra. Það er mótsögn að frumvarp sem ætlað er að vernda börn geti leitt til þess að þau verði svipt foreldrum sínum.**

Umræða um umskurð drengja er ný af nálinni í íslensku samfélagi. Við teljum mikilvægt að henni sé gefið mun meira rými áður en kemur til setningar hegningarlaga.

F.h Miðstöðvar foreldra og barna,
Sæunn Kjartansdóttir

March 26, 2018

Steingrímur J. Sigfússon,
Speaker of Althingi
Reykjavik, Iceland

Dear Speaker Sigfússon and Members of The Althingi:

We are writing to you on behalf of a coalition of Jewish organizations in the United States to express our concern with regard to legislation pending before your legislature that would ban male circumcision for non-medical reasons.

Should this legislation be enacted, Iceland would become the first European country to outlaw the practice of male circumcision—a practice fundamental to the faith of Jews as well as Muslims. The legislation thus would effectively prevent the existence of a Jewish community in your country and deny Jews their freedom of religion.

Male circumcision, or "brit milah," is a foundational rite in Judaism. According to our tradition, as presented in the Hebrew Bible, its origin lies in God's commandment to our forefather Abraham to circumcise himself and his sons Ishmael and Isaac. Jews have continued to practice this rite over thousands of years to this very day; and through this rite Jewish male babies are initiated into our covenantal community by their fathers in a powerful and spiritual manner. Indeed, brit milah is deemed to be so fundamental to our faith that, under Jewish law, males who have not been circumcised are ineligible to participate in some other Jewish rituals such as the Passover night ceremony.

Aside from male circumcision's religious significance, credible medical organizations, including the American Academy of Pediatrics and the World Health Organization, have documented the health benefits of male circumcision. These benefits include, according to the WHO, a 60% reduction in the risk of HIV infection, lower rates of urinary tract infections and a likely lower risk of cervical cancer for women who are the partners of circumcised men. We are attaching their statements to this letter.

The legislation pending before you is an extreme measure to take against a practice that is deemed legitimate by medical entities and foundational to a faith community. It proposes to criminalize male circumcision and impose commensurately severe penalties. A stronger statement against the practice of faith community could not be made. While Iceland's Jewish community is one of the smallest in the world, we are deeply concerned that this legislation, if passed, would have a wide-reaching impact on Jewish communities, both in neighboring European countries and around the world.

The legislation would set a terrible precedent in denying religious minorities the ability to practice their faith. This would be a dramatic step, to say the least, for Iceland to take when nearly 700 million men across the globe are circumcised.

We hope this expression of our views is both informative to you and persuades you to ensure the proposed legislation is not considered by your parliament.

Please contact us if we can provide further information on this issue, and thank you for your consideration of our position.

Sincerely,

Allen Fagin – Executive Vice President, Union of Orthodox Jewish Congregations of America
William Daroff – Vice President, Jewish Federations of North America
Betty Ehrenberg – Executive Director, World Jewish Congress – North America
Mark B. Levin – Chief Executive Officer, NCSEJ
Rabbi Abba Cohen – Vice President for Federal Affairs and
Washington Director, Agudath Israel of America

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

FROM THE AMERICAN ACADEMY OF PEDIATRICS

Organizational Principles to Guide and Define the Child Health Care System and/or Improve the Health of all Children

POLICY STATEMENT

Circumcision Policy Statement

TASK FORCE ON CIRCUMCISION

KEY WORDS

male circumcision, penis, prepuce, phimosis, sexually transmitted infections, HIV, urinary tract infection, analgesia, parental decision-making, ethics

ABBREVIATION

AAP—American Academy of Pediatrics

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abstract

FREE

Male circumcision is a common procedure, generally performed during the newborn period in the United States. In 2007, the American Academy of Pediatrics (AAP) formed a multidisciplinary task force of AAP members and other stakeholders to evaluate the recent evidence on male circumcision and update the Academy's 1999 recommendations in this area. Evaluation of current evidence indicates that the health benefits of newborn male circumcision outweigh the risks and that the procedure's benefits justify access to this procedure for families who choose it. Specific benefits identified included prevention of urinary tract infections, penile cancer, and transmission of some sexually transmitted infections, including HIV. The American College of Obstetricians and Gynecologists has endorsed this statement. *Pediatrics* 2012;130:585–586

POLICY STATEMENT

Systematic evaluation of English-language peer-reviewed literature from 1995 through 2010 indicates that preventive health benefits of elective circumcision of male newborns outweigh the risks of the procedure. Benefits include significant reductions in the risk of urinary tract infection in the first year of life and, subsequently, in the risk of heterosexual acquisition of HIV and the transmission of other sexually transmitted infections.

The procedure is well tolerated when performed by trained professionals under sterile conditions with appropriate pain management. Complications are infrequent; most are minor, and severe complications are rare. Male circumcision performed during the newborn period has considerably lower complication rates than when performed later in life.

Although health benefits are not great enough to recommend routine circumcision for all male newborns, the benefits of circumcision are sufficient to justify access to this procedure for families choosing it and to warrant third-party payment for circumcision of male newborns. It is important that clinicians routinely inform parents of the health benefits and risks of male newborn circumcision in an unbiased and accurate manner.

Parents ultimately should decide whether circumcision is in the best interests of their male child. They will need to weigh medical information in the context of their own religious, ethical, and

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cultural beliefs and practices. The medical benefits alone may not outweigh these other considerations for individual families.

Findings from the systematic evaluation are available in the accompanying technical report. The American College of Obstetricians and Gynecologists has endorsed this statement.

TASK FORCE ON CIRCUMCISION

Susan Blank, MD, MPH, Chairperson
Michael Brady, MD, Representing the AAP Committee on Pediatrics AIDS
Ellen Buerk, MD, Representing the AAP Board of Directors
Waldemar Carlo, MD, Representing the AAP Committee on Fetus and Newborn
Douglas Diekema, MD, MPH, Representing the AAP Committee on Bioethics
Andrew Freedman, MD, Representing the AAP Section on Urology
Lynne Maxwell, MD, Representing the AAP Section on Anesthesiology
Steven Wegner, MD, JD, Representing the AAP Committee on Child Health Financing

LIAISONS

Charles LeBaron, MD – *Centers for Disease Control and Prevention*
Lesley Atwood, MD – *American Academy of Family Physicians*
Sabrina Craigo, MD – *American College of Obstetricians and Gynecologists*

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HIV/AIDS

Male circumcision for HIV prevention

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There is compelling evidence that male circumcision reduces the risk of heterosexually acquired HIV infection in men by approximately 60%. Three randomized controlled trials have shown that male circumcision provided by well trained health professionals in properly equipped settings is safe. WHO/UNAIDS recommendations emphasize that male circumcision should be considered an efficacious intervention for HIV prevention in countries and regions with heterosexual epidemics, high HIV and low male circumcision prevalence.

Male circumcision provides only partial protection, and therefore should be only one element of a comprehensive HIV prevention package which includes: the provision of HIV testing and counseling services; treatment for sexually transmitted infections; the promotion of safer sex practices; the provision of male and female condoms and promotion of their correct and consistent use.

Latest updates

Models to inform fast tracking voluntary medical male circumcision in HIV combination prevention
Meeting report - December 2017

TAG consultation to review changes to male circumcision devices
April 2017

Beyond the 90-90-90: refocusing HIV prevention as part of the global HIV response
January 2017

Tetanus and voluntary medical male circumcision: risk according to circumcision method and risk mitigation
Report of the WHO Technical Advisory Group | 12 August 2016

General information

Voluntary medical male circumcision for HIV prevention in 14 priority countries in eastern and southern Africa
Progress brief - August 2017

Fact sheet on HIV/AIDS
July 2016

Celebrating HIV prevention success: 10 million men access voluntary medical male circumcision in Africa
Infographic - December 2015

Policy and advocacy

A framework for voluntary medical

Technical documents

Information on ShangRing™ (Generation II, self-locking model) device for voluntary medical male circumcision for HIV prevention
pdf, 102kb
June 2015

WHO prequalification of male circumcision devices
pdf, 1.38Mb
Public report, June 2015

WHO list of prequalified male circumcision devices
pdf, 47kb
June 2015

| Geneva, Switzerland - September 2016

Review by the Technical Advisory Group on Innovations in Male Circumcision (TAG) of additional documentation relating to the safety of male circumcision methods
August 2016

Review by the Technical Advisory Group on Innovations in Male Circumcision (TAG) of additional documentation relating to the safety of male circumcision methods
July 2016

male circumcision
Effective HIV prevention and a gateway to improved adolescent boys' & men's health in eastern and southern Africa by 2021 - policy brief

Related topics and links

Useful links

Clearinghouse Male Circumcision

Events and meetings

WHO Informal consultation on tetanus and voluntary medical male circumcision
Technical consultation update to the WHO March 2015 meeting report - June 2016

WHO informal consultation on tetanus and voluntary medical male circumcision
Meeting report, August 2015

WHO technical advisory group on innovations in male circumcision
Meeting report, May 2015

View all publications on male circumcision for HIV prevention

Alþingi
Kirkjustræti
150 Reykjavík

March 22, 2018

Regarding the proposed legislation banning non-therapeutic circumcision.

Dear Members of the Parliament,

My name today is Moe Love, but I was born Mounir Elharim in 1985 in Rabat, the capital of Morocco. Being born to a Muslim family it was a foregone conclusion that I would be circumcised, so when I was 4 days old I was stripped of an important part of my body. The gravity of that action would not become apparent to me until many years later in 2015 when I began researching thanks to a Facebook post I had seen, and as with many other people the more I found out the more horrified and angry I became.

Now it has been 3 years for me in that constant state of disbelief and fury that we are still cutting healthy parts off the genitals of baby boys for reasons that are spurious at best. I have felt like I don't have a choice but to spend countless amounts of time and energy to try to protect other people from what happened to me, and it has been a terrible time filled with unbearable disappointments and setbacks. In these 3 years I have also seen and learned about many attempts to protect baby boys which failed in the face of the types of pressure you are now being subjected to.

For a brief rebuttal of some of the ludicrous arguments and claims being made to support the practice of circumcision; cutting a religion into a baby's genitals is the exact opposite of religious freedom, the "medical" arguments are fraudulent and nonsensical, it's absolutely absurd to perform cosmetic surgery on an infant, and it's beyond outrageous that people would try to threaten Iceland's economy in order to protect circumcision because the right of baby boys to keep all their genitals isn't negotiable or for sale.

I and many other people are really hoping you won't end up being intimidated the way Germany and Norway and other countries have been. Please do the right thing and make your law on genital mutilation gender neutral so that boys can also have their right to genital integrity be acknowledged and protected.

Thanks,

Moe Love

From: eileen [mailto:eileenshapero@hotmail.com]
Sent: 1. mars 2018 20:14
To: althingi@althingi.is
Subject: *PLEASE REPLY: POTENTIAL CIRCUMCISION BAN IN ICELAND..

To whom it may concern,

I am deeply troubled about this potential legislation which flies in the face of G-d's Commandment to the Jewish People to circumcise their newborn boys at 8 days of age. (if medically healthy)

Who has the right to ban this from our sacred religion?

The mere discussion of it completely disregards/disrespects the Jewish Faith and one of its prime Mitzvahs (Commandments) bequeathed to us by G-d Almighty Himself.

On another purely medical note, it has been PROVEN that this procedure is of benefit to its recipients.

A reply from you would be appreciated. Thank you, Mrs. Shapero (Toronto, Canada)

From: Naama Atzitz [mailto:naama651@gmail.com]
Sent: 21. febrúar 2018 20:44
To: Ritstjóri vefsins <ritstjori@althingi.is>
Subject: Against Circumcision of Children - Jews support bill 183

Dear parliament members,

I am a Jewish citizen of Israel, 32 years old. I am against circumcision in children.

My husband had a forced circumcision when he was an eight-day-old baby. We could never have sex as nature intended because he has no foreskin.

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls.

As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israeli's to leave our children intact (not-circumcised).

Circumcision of a child unable to consent is genital mutilation. It is an irreversible surgery that robs the child of an important body part.

The child's right to his body is above any religious practice.

Thank you for having the courage to protect children and fight for this important bill.

Sincerely,

Naama Atzitz

-----Upphaflegt skeyti-----
Frá: n75tal [mailto:n75tal@zoho.com]
Sent: 3. febrúar 2018 19:41
Til: Silja Dögg Gunnarsdóttir ; Ólafur Þór Gunnarsson ; Inga Sæland ; Bjarkey Olsen Gunnarsdóttir ; Ólafur Ísleifsson ; Jón Þór Ólafsson ; Guðmundur Ingi Kristinsson ; Líneik Anna Sævarsdóttir ; Björn Leví Gunnarsson ; Ritstjóri vefsins
Efni: Subject: Against Circumcision of Children - Jews support bill 183

Subject: Against Circumcision of Children, Jews also support moral bill 183

Dear Parliament Member,

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls. As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement to prefer morality over cruel heartless traditions, also among Jews and among Israeli's to leave our children intact (not-circumcised).

Circumcision of a child unable to consent is genital mutilation. It is an irreversible surgery that robs the child of an important body part and is morally unjustifiable. There must be severe penalty for people [even surgeons considering the baby is healthy and certainly undocumented cutters called mohel etc. or any other title] daring to cut a healthy baby and additional jail time for those who do not use pain anesthetic. even the parents must be punished for criminal negligence for arranging the circumcision of any healthy minor... i know what my cruel parents took away from me and this criminal act must stop.

Thank you for having the courage to protect children and fight for this important bill.

Sincerely, mr naphtali smilowitz

From: Oren Safdie [mailto:osafdie@gmail.com]
Sent: 28. febrúar 2018 23:49
To: althingi@althingi.is
Subject:

Please do not pass the circumcision ban. I am so looking forward to visiting your country, but would cancel my trip if something of such this law ere to pass. Believe me, I'm circumcised and have no ill effects.

Oren Safdie

114. mál
Láta barnið njóta vafans, og þess vegna taki það upplýsta ákvörðun, þegar aldur og ábyrgð eru skilgreind.
kv. Pétur

Alþingi
Kirkjustræti
150 Reykjavík

April 15, 2018.

Dear Ministers

Circumcision of Male Minors

I find myself in the sombre position of preparing a statement that I wish had been presented to my parents before I was born in 1957, regarding an issue that has greatly affected me and the life that I have lived.

It is to my mind indefensible that parents can dictate to their infant son that a normal, healthy, functional, erogenous body part be amputated before he even knows he is born. As we know, this is not the case in respect of females. My younger sister who was born in 1959, as far as I am aware, still has the intact genitals she was born with.

It was flagrant sex discrimination in 1957, and still is in the 21st century that girls are now legally protected from any violation of their bodily integrity in many countries (including my place of birth, the UK), and yet boys are not.

This is a question of human dignity. Is it dignified for a civilised society to condone the routine body modification of its most vulnerable and defenceless citizens before they even know they are born, such as animals are routinely subjected to genital surgery? These are people who are most in need of the respect, care and protection that society can afford, and are being ignored by a society that has bought into the notion that parents know what's best for their children, regardless of their religious or cultural beliefs which often motivate them to cut their children's genitals. Although apparently those parents who would propose to cut the genitals of their daughters do not seem to know what's best for their children?

The fact that my genitals were interfered with whilst I was an infant and part of my penis was cut off my body is tantamount to state sponsored rape in my opinion, and that of many other men who were subjected to the indignity of neonatal circumcision. The consequence of living life with part of my penis missing is that a profoundly insidious and detrimental effect on my sexuality and sexual relations has prevailed, and will continue to for the rest of my days.

I do not dispute that an estimated one third of the male population of the world is circumcised and the vast majority of them are apparently content with their circumcised status. However, it greatly troubles me that the vast majority of those men had no option as to whether or not their foreskin was amputated without their consent. I wonder how many circumcised men there would be in the world if every one was able to choose as an adult? Despite all the rhetoric from the pro-circumsion lobby and the religious zealots, there are undoubtedly many circumcised men, in addition to myself, who would rather have been given the opportunity to live their lives with the intact genitals they had at birth. My parents were catholics, but I know of men whose parents are Jews and Muslims that also resent the fact that they were circumcised as infants or minors, before they had attained sufficient maturity to give legitimate consent to the irreversible surgical modification of their bodies.

The implication to my mind is that society perceives males are born with a surplus body part that is an optional extra that can be amputated without any consequence to the individual. Whereas females are apparently born with no surplus body parts. They are born with nothing more nor less than is needed for a normal sex life. This view is anathema to me as a man, and I believe insulting to all men whether or not they are circumcised. I conclude that we are deemed to be inferior beings. I firmly believe, and I am not alone in my thinking, that there is great value in the whole unmodified genital apparatus that a man is naturally endowed with at birth, and that it should be the personal decision of every male, and not that of his parents, as to whether or not any body part is sacrificed as an act of faith, or to conform with cultural mores, as and when he has attained adulthood.

I looked on with great interest in 2012 as the public debate about this issue reverberated around Germany and also the rest of the world. At long last the matter would be decided, and I anticipated that my position on this issue would be vindicated by politicians who are elected to do what is right and proper in a world in which there is rightly much consideration of children's rights and equality of the sexes and opposition to sex discrimination. Needless to say I was appalled when the vote was announced, and felt like a second class citizen who had been metaphorically knifed in the genitals yet again.

I note however that the Bundestag vote was not unanimous. 434 voted in favour of parents who choose to circumcise their infant/minor sons as part of their human right to freely exercise religious expression. However, 100 voted against the motion. Presumably they were effectively voting in favour of the right of every boy to enjoy physical integrity and to choose for himself whether or not to be circumcised for whatever motive?

I often wonder how representataive of society as a whole our parliamentarians actually are? I have seen a number of polls from Germany, Denmark and in the UK which suggest that the majority of ordinary people believe that the circumcision of children for non-therapeutic reasons should be banned. Notwithstanding this apparent paradox, it is my contention that it is not a question that should be put to a vote by parliamentarians or society as a whole. The majority of people don't have to live in my body or the body of any other man who was circumcised without his personal consent. Each of us may be a minority in the whole of society, but we are the majority of people who live in our own bodies, actually we are the only person living in that body.

Despite the fact that we live in a modern democratic society where the will of the majority prevails, within the UN there is the power of veto for the five permanent members of the security council. This is is seen by critics, since its creation in 1945, as the most undemocratic character of the UN. However, it persists because those member states enjoy the power that they have secured and are unlikely to give it up anytime soon. It is my belief that I and every individual should enjoy the power of veto over those who would impose their will on us with impunity as to whether or not we live our lives with the whole body we are born with.

Angela Merkel infamously remarked that Germany could become a laughing stock if it failed to overturn the Cologne court decision. Accordingly, the Bundestag cynically enacted legislation to appease the religious lobby, and which some legal experts believe is unconstitutional. Let Iceland rise above such shameful hypocrisy and move to the moral high ground as the first of the 195 nations that are signatories of the UN Convention on the Rights of the Child to give full equality to all its citizens by upholding their inalienable right to genital autonomy and self determination. What an accolade! I warmly applaud Silja Dögg Gunnarsdóttir for proposing that this matter be debated in the Alþingi in order that the anomalous provisions in the existing legislation can be revised. May Iceland venture into the uncharted waters that all other nations in this world full of smug self-

righteousness have hitherto dared not navigate. I await the outcome of your deliberations with keen anticipation.

Yours sincerely

Patrick Smyth

Cambridge, UK.

Alþingi
Kirkjustræti
150 Reykjavík

March 27, 2018

Dear Members of the Alþingi,

I wish to express my strong support for the proposed legislation to extend legal protection against child genital cutting (euphemistically known as "circumcision") to all children that is currently under consideration in your nation's parliament. This legislation represents not only a laudable effort to redress the gender discrimination that exists in Iceland by expanding the right to a childhood free from unnecessary genital surgery to boys as well as girls, but also has broader global significance as the first attempt by any parliament in the world to do so.

I would particularly like to commend your country's parliamentarian Ágæta Silja Dögg Gunnarsdóttir, who introduced the bill in the Alþingi, and her fellow co-sponsors Ágæta Ólafur Þór Gunnarsson, Ágæta Inga Sæland, Ágæta Bjarkey Olsen Gunnarsdóttir, Ágæta Ólafur Ísleifsson, Ágæta Jón Þór Ólafsson, Ágæta Guðmundur Ingi Kristinsson, Ágæta Líneik Anna Sævarsdóttir and Ágæta Björn Leví Gunnarsson. Their brave stand serves as an example to legislators in the rest of the world's nations who are failing in their duty to pass laws that ensure the protection of all children, regardless of gender, from unnecessary genital surgery.

The medical communities of several of your fellow European nations have become increasingly vocal in their condemnation of genital cutting of both female *and* male minors, noting that in both cases it is harmful, unethical and a violation of a child's right to bodily integrity. European medical organizations have furthermore pointed out that nonconsensual genital cutting of a minor represents a contravention of the central tenet of the Hippocratic Oath, *first do no harm*, and is in conflict with several international conventions, such as the U.N. Declaration of the Rights of the Child. For example, the Royal Dutch Medical Association stated in 2010: "Non-therapeutic circumcision of male minors conflicts with the child's right to autonomy and physical integrity." Their statement adds that "circumcision entails the risk of medical and psychological complications… [including] bleeding, infections, meatus stenosis (narrowing of the urethra) and panic attacks."

Similarly, the Danish Medical Association, speaking on behalf of its 29,185 members, stated in 2016: "Circumcision of boys without a medical indication is ethically unacceptable when the procedure is carried out without informed consent from the person undergoing the surgery." Their report concludes that "circumcision should not be performed before the boy is 18 years old and able to decide whether this is an operation he wants." Public opinion in Denmark also seems to be shifting in favor of equal protection, with one nationally representative poll from 2016 showing that 87 percent of Danes are in favor of a law protecting males under 18 years of age from non-therapeutic genital cutting. Clearly, your nation's proposal for equal protection is grounded both in a growing consensus within the European medical community and high levels of public support.

Regrettably, though also predictably, certain religious figures who (falsely) purport to be speaking on behalf of their entire religious tradition are attempting to derail this effort on the spurious grounds that it represents an attack on religious liberty. I urge members of the Alþingi not be swayed by this baseless accusation or browbeaten or guilt-tripped into backing down from their principled stand against child genital cutting and support for equal protection under the law for both genders. I believe strongly that parents do not have the right to impose their religion on their children via an invasive and irreversible surgery on the most private area of their bodies. Far from being an affront to religious liberty, the proposal in fact promotes it by allowing people to decide for themselves when they are of consenting age whether they wish to partake in this particular ritual of their parents' religion. Many people do not go on to follow the religion of their parents and it is an insult to assume that every child will do so automatically. Furthermore, the religious figures attacking the proposal do not speak for the entirety of their co-religionists as evidenced by growing genital integrity currents within Judaism and Islam. The existence of organizations such as Jews Against Circumcision and the growing popularity of the Brit Shalom, in which the traditional Bris rituals are recited while excepting the surgery, demonstrate that these communities are not as homogeneous in their support for genital cutting as is implied by those spokespeople who are attacking the proposal. Indeed, many anti-genital cutting and equal protection activists themselves come from Jewish and Muslim family backgrounds, such as Somali-born writer and human rights activist Ayaan Hirsi Ali and Israeli columnist Uri Misgiv (both of whom are themselves victims of child genital cutting, female and male respectively).

In solidarity with your brave legislative efforts,
Peter Bolton

-----Upphaflegt skeyti-----
Frá: Peter Salewsky
Sent: 21. apríl 2018 19:29
Til: Ritstjóri vefsins
Efni: circumcision ban

Dear Althingi members,

with keen interest I'm following reports in the media on the proposed law to ban non-medical circumcisions of minors. So far I've got the impression that this initiative is supported by a majority and has good chance to come into effect.
However, there seems to be an increasing pressure against this intended law by several organisations lobbying ritual circumcision of boys. In part these organisations blatantly threaten to damage Iceland's international reputation.
I strongly encourage you to refuse to bow down to such intimidation. Of course there will be people highly disappointed by a circumcision ban, but so will others in case of not banning this unnecessary surgical intervention without consent. Numerous people worldwide anxiously look at your country these days, hoping for a clear statement in favour of human rights.
You have the unique opportunity to make history, being the first democratic state granting all children - boys and girls equally - the right of having intact genitals. Please don't miss this chance!

Best regards,
Peter Salewsky

--
Peter Salewsky
Hauptstraße 3
06800 Raguhn-Jeßnitz
Germany

From: Peter Teitelbaum [mailto:travelclinic@rogers.com]
Sent: 1. mars 2018 13:10
To: althingi@althingi.is
Subject: Circumcision ban

I am writing to express my concern over the bill banning infant circumcision that is being considered in Iceland. While I understand the argument against it, this is a tradition that few Jews would fail to observe for their sons. Your ban effectively shuts the door to Jews - not an unknown European response to the Jewish people.

Peter Teitelbaum, MD

Ottawa, Ontario, Canada

Pro Kinderrechte Schweiz
Postfach, 8032 Zürich
www.pro-kinderrechte.ch
info@pro-kinderrechte.ch

Zurich, 17.03. 2018

Alþingi
Kirkjustræti
150 Reykjavík

Subject: Umsögn um frumvarp til laga um breytingu á almennum hegningar-lögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágætu þingmenn Alþingis / Dear Members of the Icelandic Parliament,

We have read with interest about the proposed bill for a ban of non-medical circumcision of boys in Iceland.

Related to discussions about genital mutilation of children medical facts are important – as well as ethical and legal aspects. But the views of those negative affected must kept in the center of the debate.

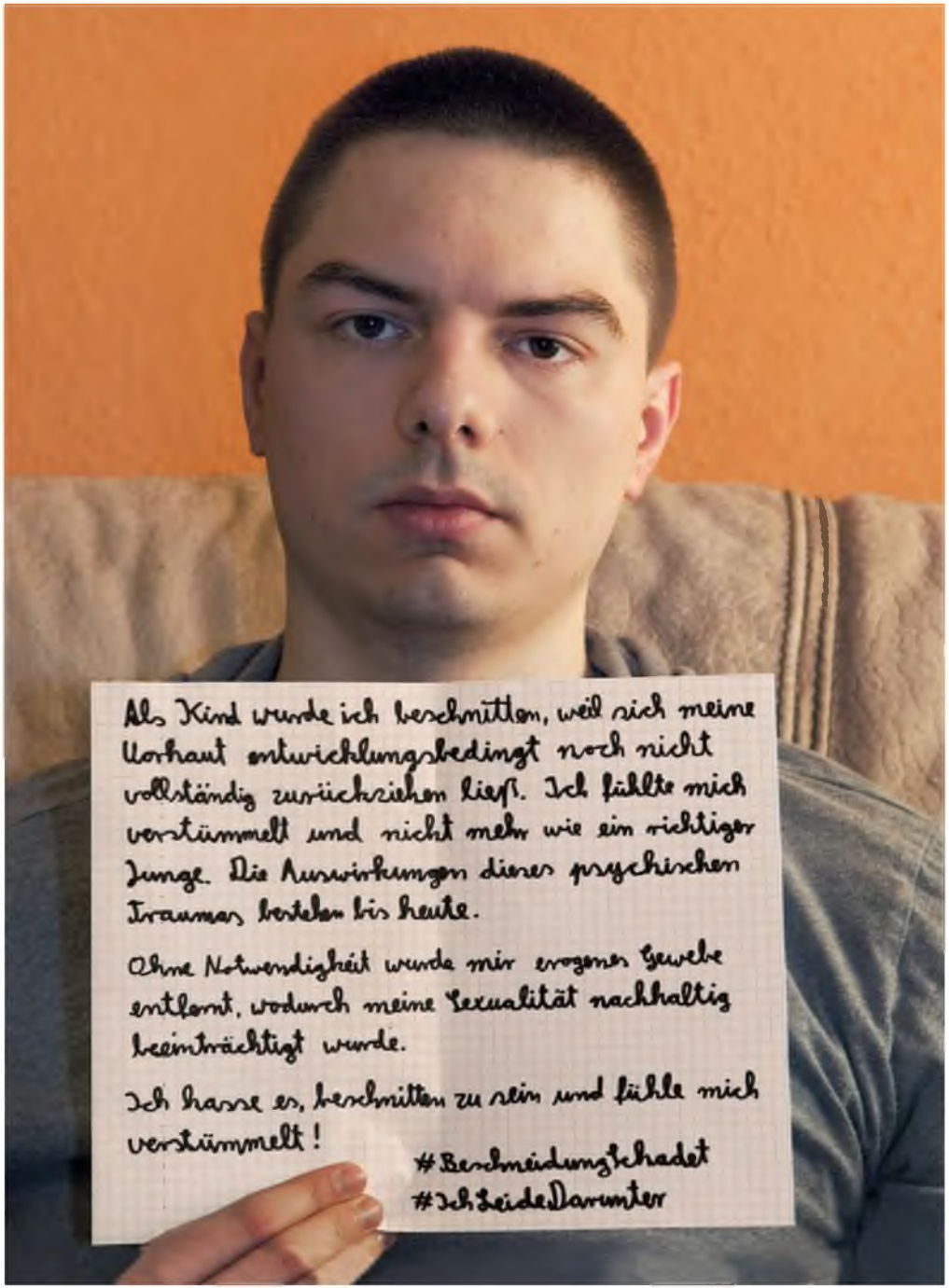
Their statements say unmistakable: The amputation of the foreskin causes lasting damage. For this reason, we send you statements of those affected – to make them finally heard.

With kind regards
Pro Kinderrechte Schweiz

Christoph Geissbühler (Managing Director)

Þessar raddir er ekki lengur hægt að hunsa!

Stöðvum umskurð allra

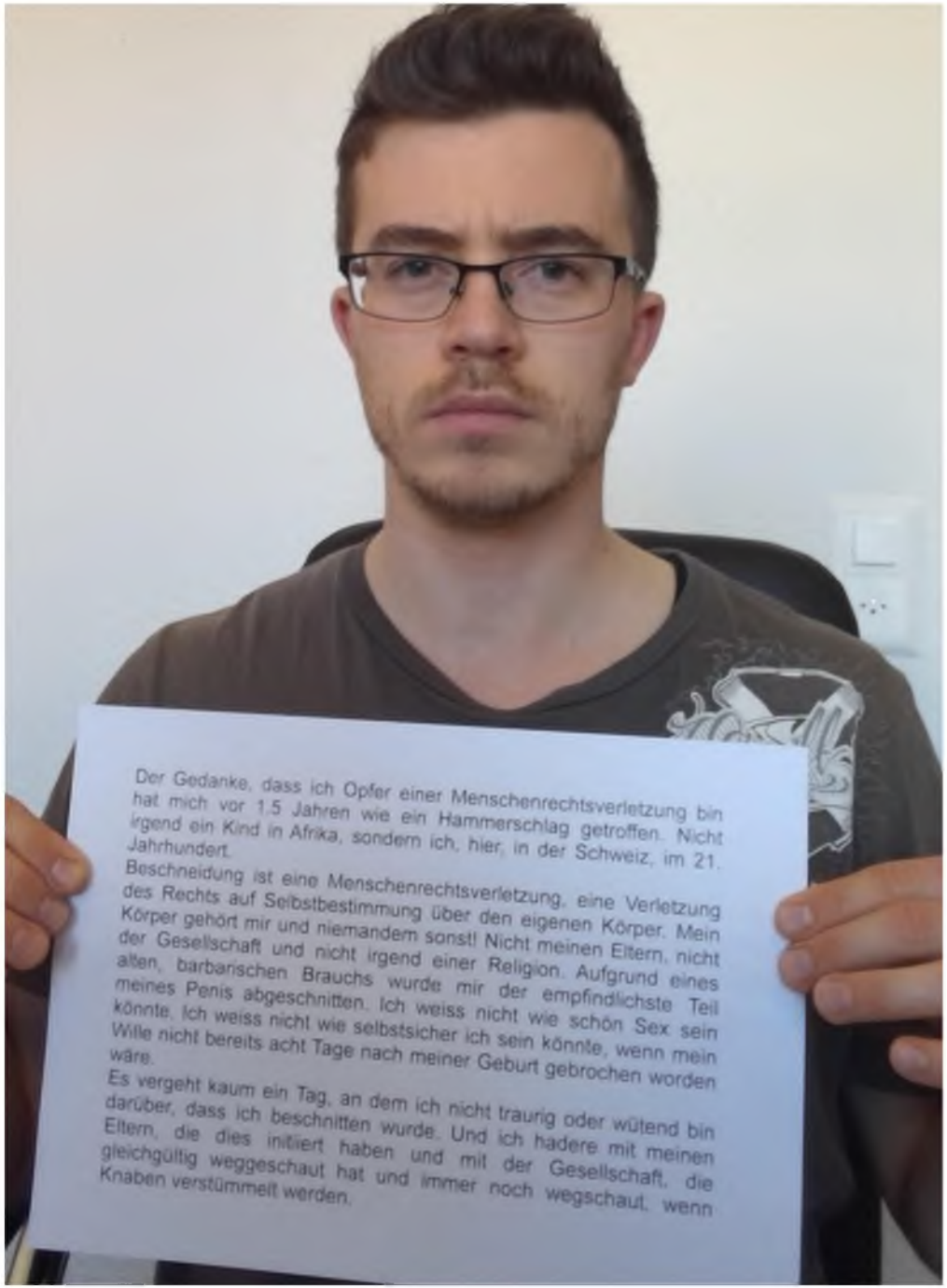


Ég var umskorinn sem barn, því ekki var hægt að draga forhúðina alla leið tilbaka. Ég var limlestur og fannst ég ekki vera alvöru drengur. Áhrif þess sálfræðilega áfalls hverfa ekki.

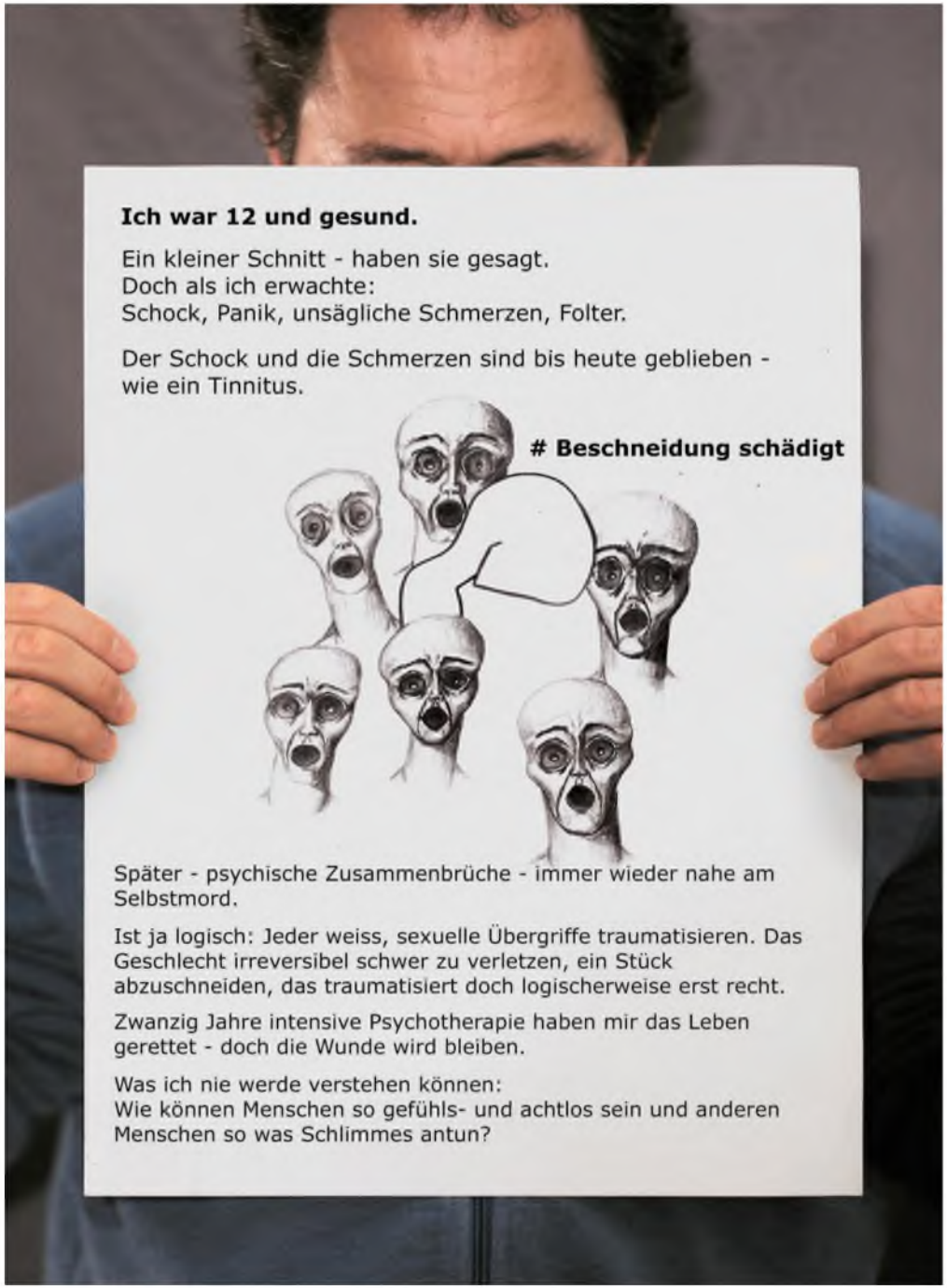
Ég var sviptur kynnæmum vef af ástæðulausu, það hefur alvarleg áhrif á kynvitund mína.

Ég hata að vera umskorinn og mér finnst ég vera afskræmdur.

Umskurður er skaðvaldur
Ég líð fyrir hann



Sú uppljómun að ég er fórnarlamb mannréttindabrots lenti á mér eins og sleggja fyrir einu og hálfu ári. Ekki eitthvað barn í Afríku, heldur ég, hér í Sviss, á 21. Öldinni.
Umskurður er mannréttindabrot, brot á sjálfsákvörðunarrétti einstaklings yfir eigin líkama. Líkami minn tilheyrir mér og engum öðrum! Hann tilheyrir hvorki foreldrum mínum, samfélaginu, né trúarbragði. Sökum gamals og villimannlegs siðs, var næmasti hluti getnaðarlims míns skorinn af. Ég veit ekki hversu dásamlegt kynlíf getur verið. Ég veit ekki hversu sjálfsöruggur ég gæti verið hefði vilji minn ekki verið brotinn á bak aftur, átta dögum eftir að ég fæddist.
Það líður varla dagur þar sem ég er ekki hryggur eða reiður yfir því að hafa verið umskorinn. Ég ríst við foreldra mína, sem stóðu fyrir því, og við samfélagið sem leit tómlega undan, það lítur enn undan á meðan drengir eru afskræmdir.



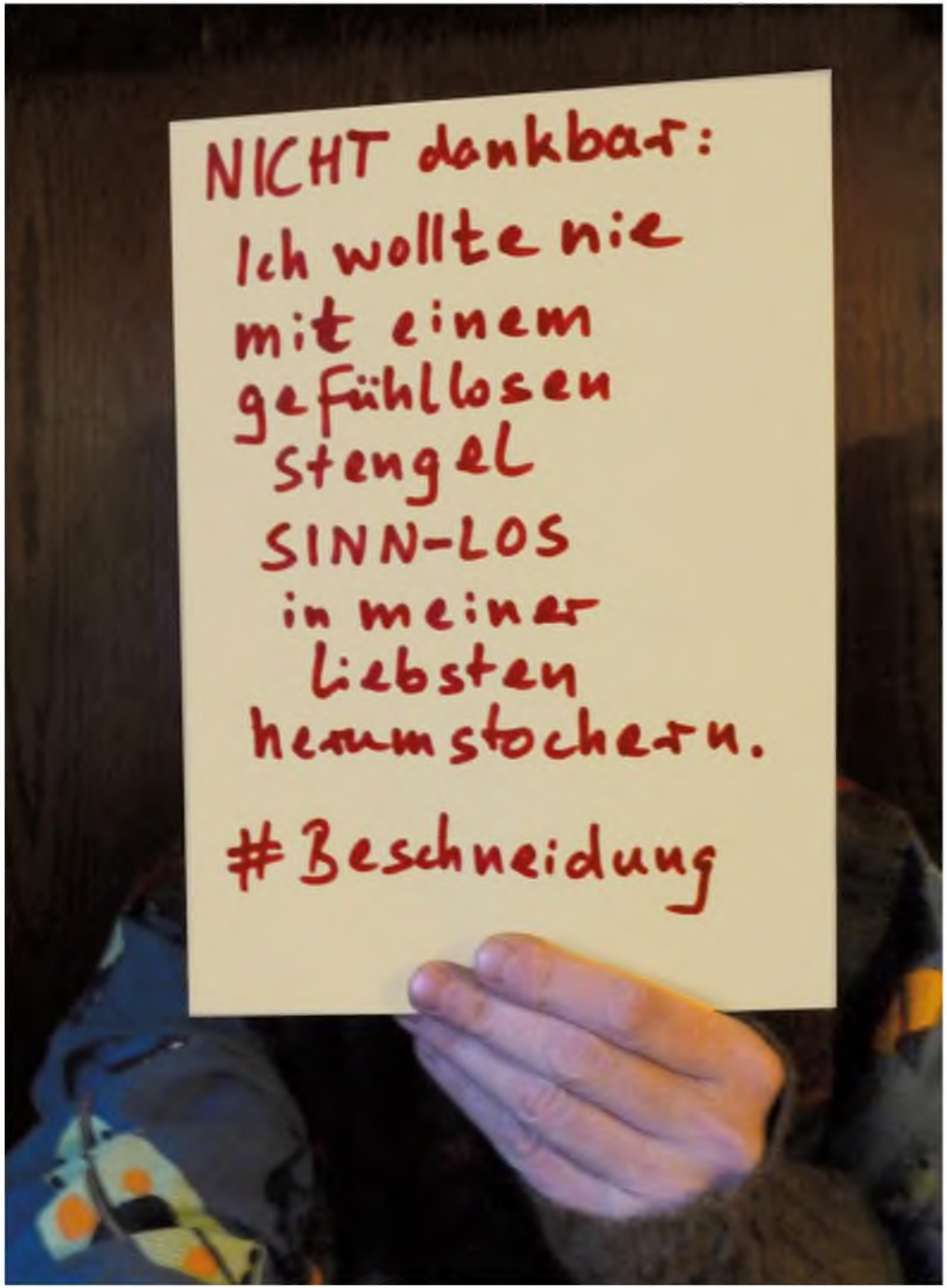
Ég var 12 ára og heilbrigður.

Lítill skurður – sögðu þau.
En þegar ég vaknaði.
Áfall, skelfing, ólýsanlegur sársauki, kvöl.

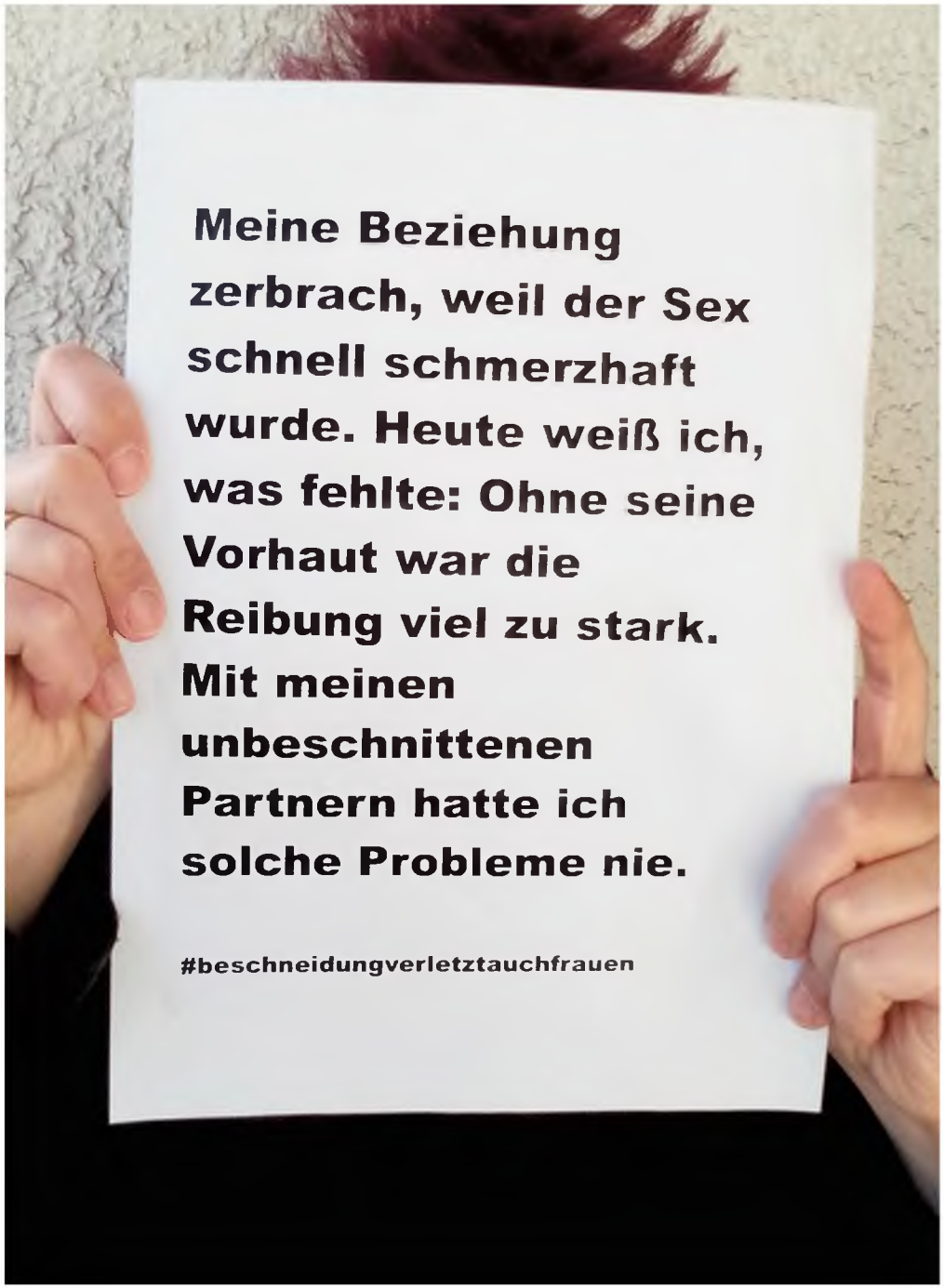
Áfallið og sársaukinn eru enn til staðar í dag – líkt og eyrnasuð.
Seinna – taugaáföll – hvað eftir annað íhugaði ég sjálfsvíg.

Það er augljóst: Allir vita að kynferðisofbeldi veldur áfalli. Það að særa kynfæri einhvers er óafturkræft, með því að skera í burtu hluta af þeim, er jafnvel verra.
Tuttugu ár af sálfræðimeðferð hafa bjargað lífi mínu – en sárið grær aldrei.

Það er eitt sem ég mun aldrei skilja: hvernig manneskjur geta verið svo tillits- og kærulausar, að gera annarri manneskju nokkuð svona illt.



EKKI þakklátur:
Ég ætlaði mér aldrei
að njóta ástar með
ástinni minni eins og
tilfinningalaus spýta.



Ástarsamband mitt splundraðist vegna þess að kynlíf okkar varð fljótt sársaukafullt. Í dag veit ég hvað vantaði:
án forhúðarinnar, varð núningurinn of kröftugur.
Ég hef aldrei átt í slíkum vandræðum með óumskornum ástmönnum mínum.

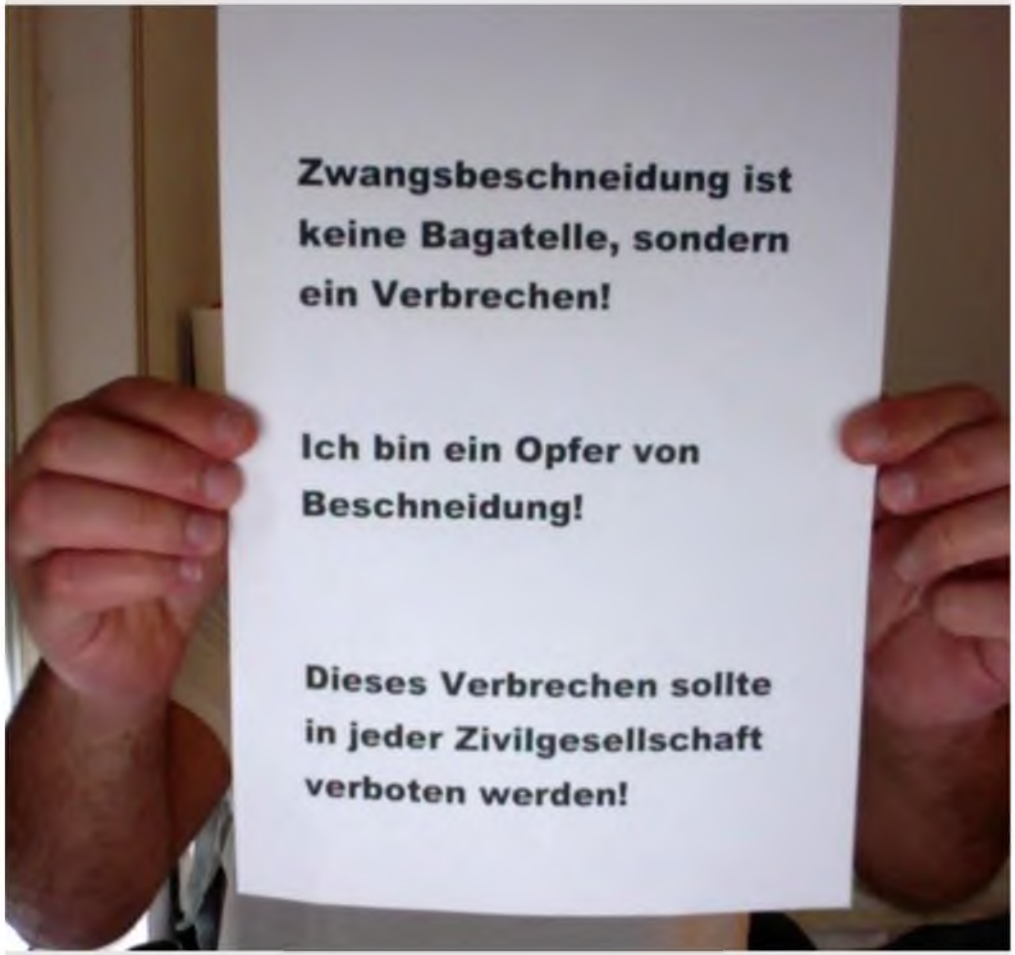
#Umskurður veldur konum líka skaða

ÉG ER EKKI ÞAKKLÁTUR
fyrir það að getnaðarlimur minn hafi verið greindur sjúkur án nokkurrar vísindalegrar ástæðu og að meint „lækning" hafi svipt mig næmasta hluta líkama míns.

ÉG ER REIÐUR
yfir því að samfélagið hafi ekki sagt mér sannleikann um það sem kom fyrir mig og að ég hafi átt að lifa með þeim lygum allt mitt líf.

ÉG SYRGI
þá staðreynd að ég fái aldrei að lifa lífi mínu með heil kynfæri, sem voru fullkomlega heilbrigð þegar ég fæddist og að ég fái aldrei að upplifa kynvitund mína eins og mér var ætlað.

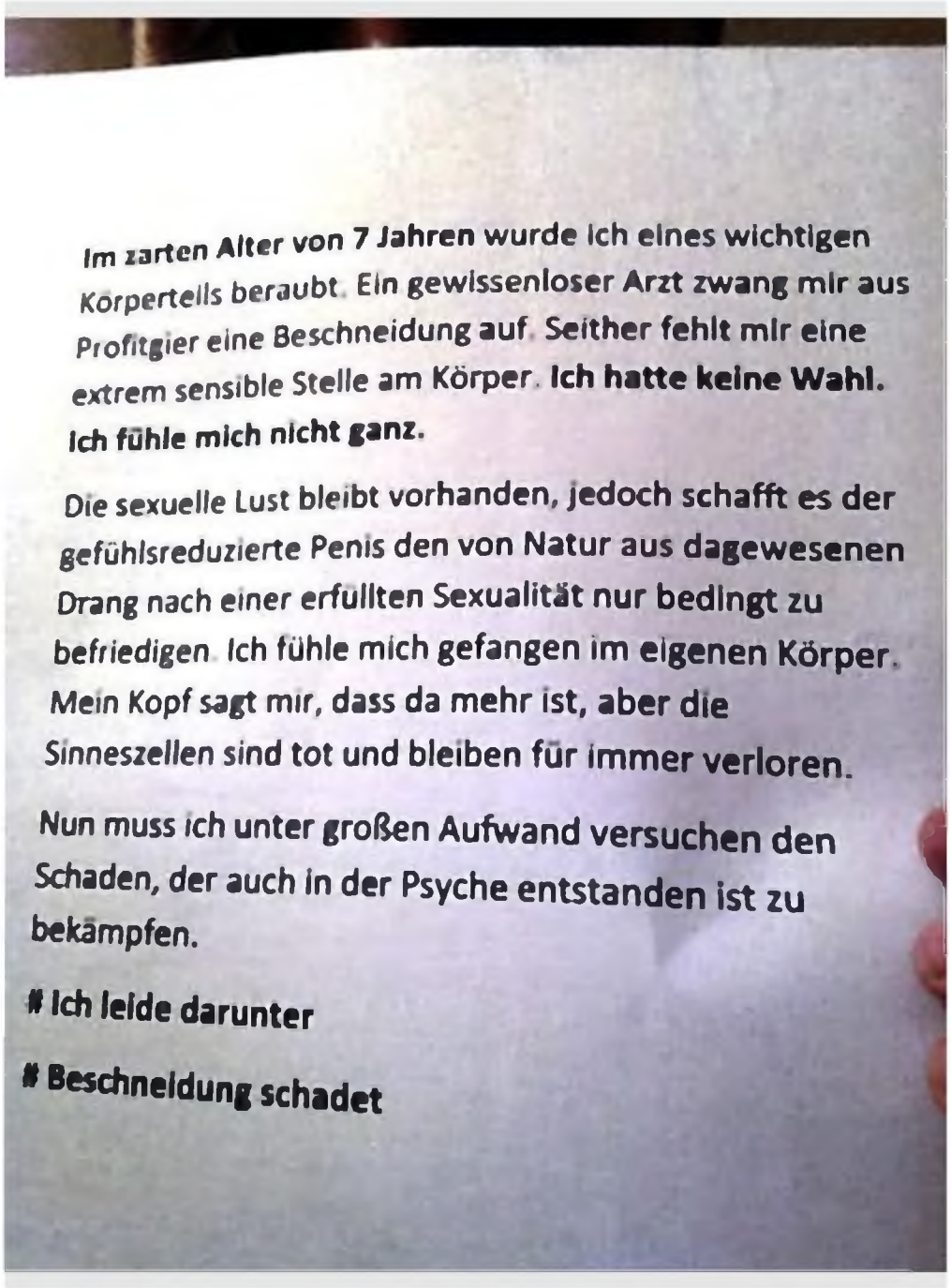
Samfélag sem neitar drengjum og mönnum sem þjást vegna umskurðar, um samúð og ber ekki virðingu fyrir sársauka þeirra og neitar á sama tíma að veita mér yfirráðarétt yfir mínu einkalífi er ómannúðlegt og fullt kynfyrirlitningar.



Þvingaður umskurður er ekki smáræði, heldur glæpur!

Ég er fórnarlamb umskurðar.

Þennan glæp ætti að banna í öllum siðmenntuðum samfélögum.

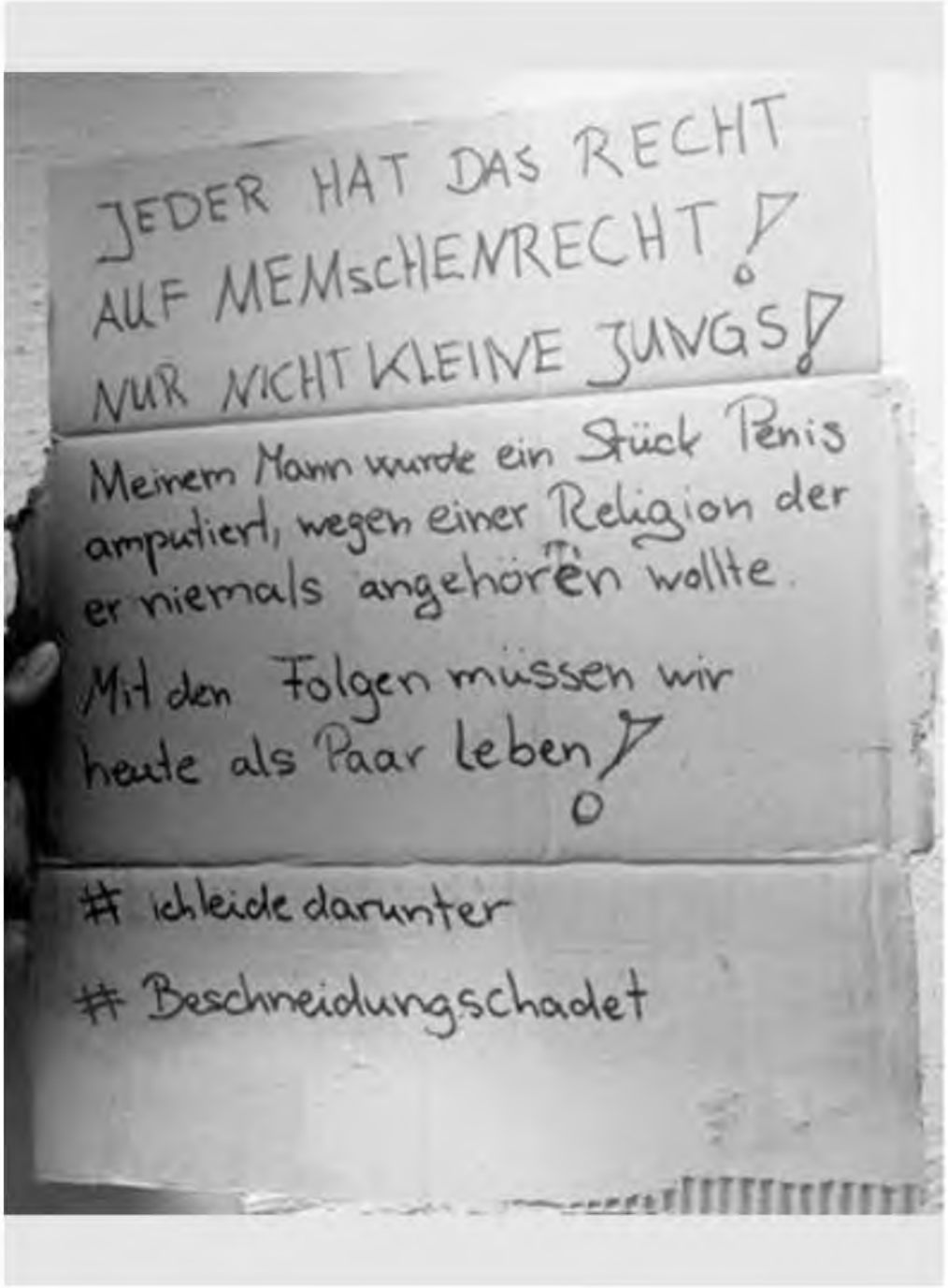


Þegar ég var 7 ára, var ég sviptur mikilvægum líkamshluta. Samviskulaus læknir umskar mig í gróðaskyni. Síðan þá hefur ákaflega viðkvæman hluta líkama míns vantað. **Ég átti engra kosta völ. Mér líður eins og ég sé ófullgerður.**

Kynferðisleg þrá er ennþá til staðar, en þar sem getnaðarlimur minn er að hluta til tilfinningalaus get ég ekki fullnægt náttúrulegum hvötum mínum. Mér líður eins og ég sé í sjálfheldu í mínum eigin líkama. Ég veit að það er meira í boði, en skynfrumurnar eru horfnar að eilífu.

Núna þarf ég að leggja mig allan fram við að draga úr því tjóni sem hefur orðið á sál minni í kjölfarið.

#Ég líð fyrir hann
#Umskurður veldur skaða

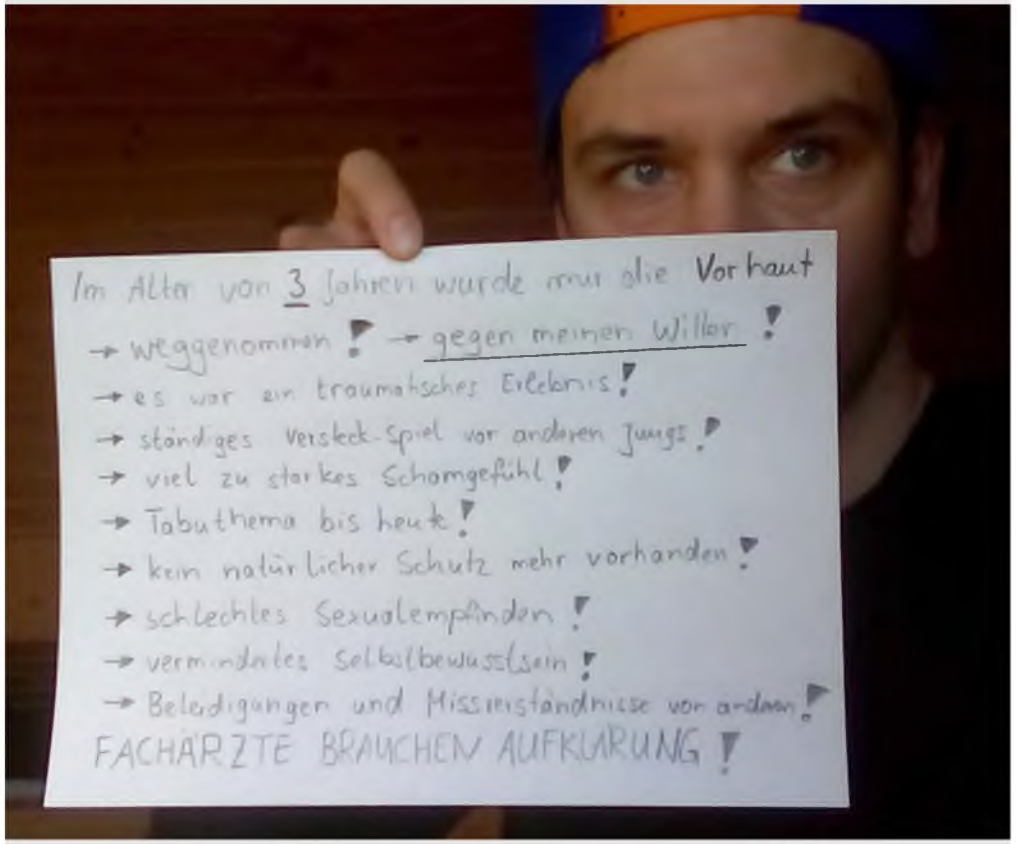


SÉRHVER MANNVERA Á RÉTT
Á MANNRÉTTINDUM!
NEMA LITLIR DRENGIR!

Eiginmaður minn missti hluta af getnaðarlim sínum vegna trúar sem hann vildi aldrei vera hluti af.

Við þurfum að glíma við afleiðingar þess sem par!

#Ég líð fyrir hann
#Umskurður veldur skaða



Þegar ég var **3 ára**, var **forhúð** mín skorin í burtu!

- <u>Gegn vilja mínum!</u>
- mikið áfall!
- þarf endalaust að fela mig fyrir öðrum gaurum!
- mikil skömm!
- tabú umræðuefni þangað til núna!
- engin náttúruleg vörn!
- skert kynvitund!
- skert sjálfsálit!
- móðganir og misskilningur!

SÉRFRÆÐILÆKNAR ÞURFA FRÆÐSLU!

Manuel T., 35 ára – Forhúð fjarlægð vegna forhúðarþrengsla á 10. aldursári.

,,Ég man ennþá eftir því þegar ég var leiddur inná skurðstofuna og þegar svæfingargrímunni var þrýst að andliti mínu. Á vöknunardeildinni, vaknaði ég við hræðilegan sársauka í klofi mínu. Ég sá, í stundarkorn, ástæðu sársauka míns en ég skildi ekki, að undir forhúðinni, er eitthvað sem kallast kóngur. Þegar ég sá hann varð ég svo óttasleginn að ég byrjaði strax að öskra. Ég skildi ekki hvaða tilgangi þessi aðgerð þjónaði og ég hélt að getnaðalimur minn væri ónýtur. Það reyndist svo vera rétt ályktun á táningsárum mínum”.

Mynd tekin við venjubundinn umskurð í Tyrklandi

Satt eða ósatt?

Fullorðnir einstaklingar eiga ekkert með það að eiga við kynfæri barna til þess að fullnægja sínum þörfum.

Mynd tekin við venjubundinn umskurð í Tyrklandi

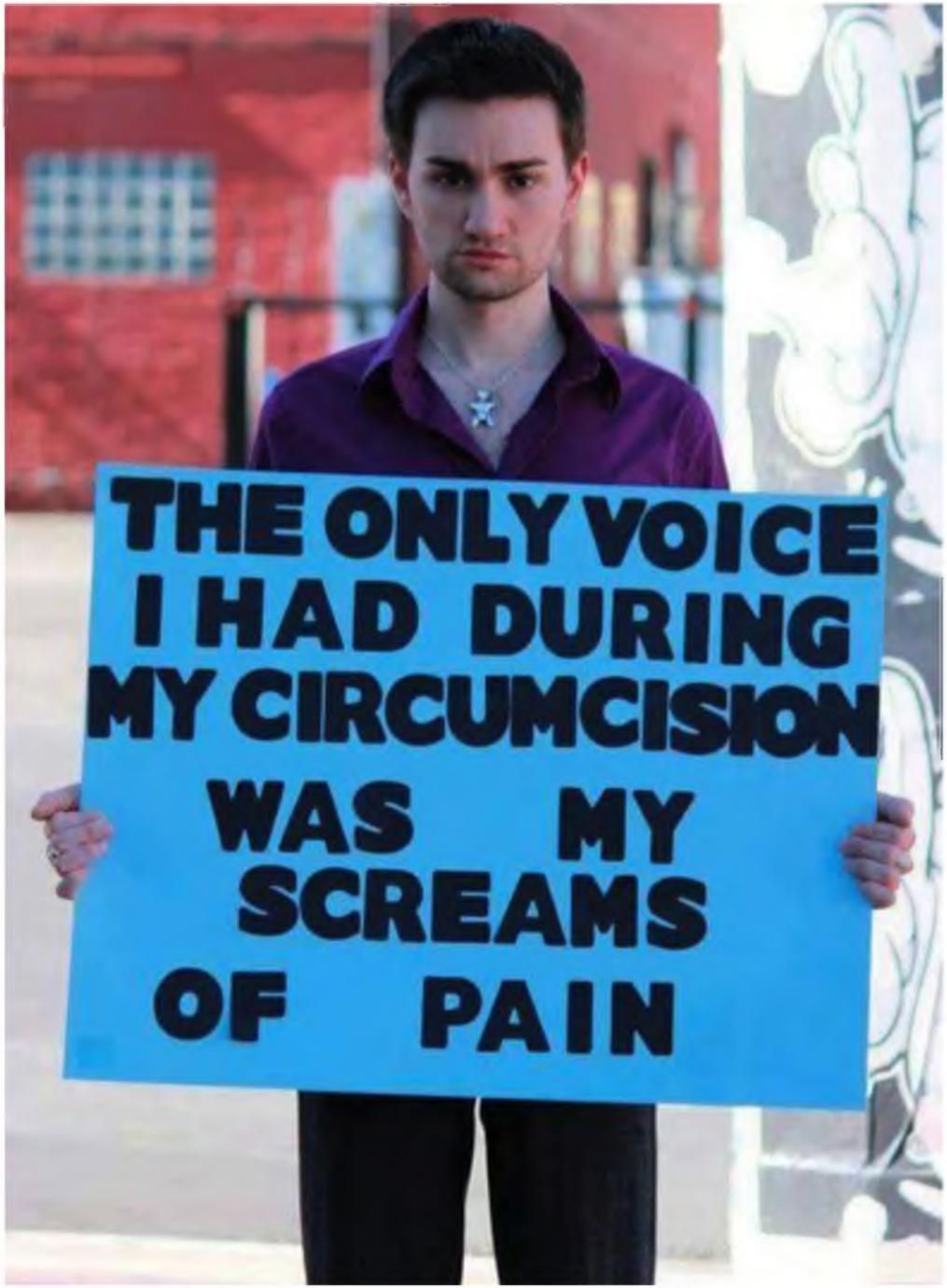
Satt eða ósatt?

Engan hluta mannslíkamanns skal fjarlægja, það á einnig við um líkama barna, nema að það sé læknisfræðilega nauðsynlegt.

Mynd tekin við venjubundinn umskurð í Tyrklandi

Satt eða ósatt?

Maður skal ekki skaða fólk eða börn. Þar á meðal drengi.



Eina röddin sem var mín megin á meðan ég var umskorinn voru sársaukaöskur mín.

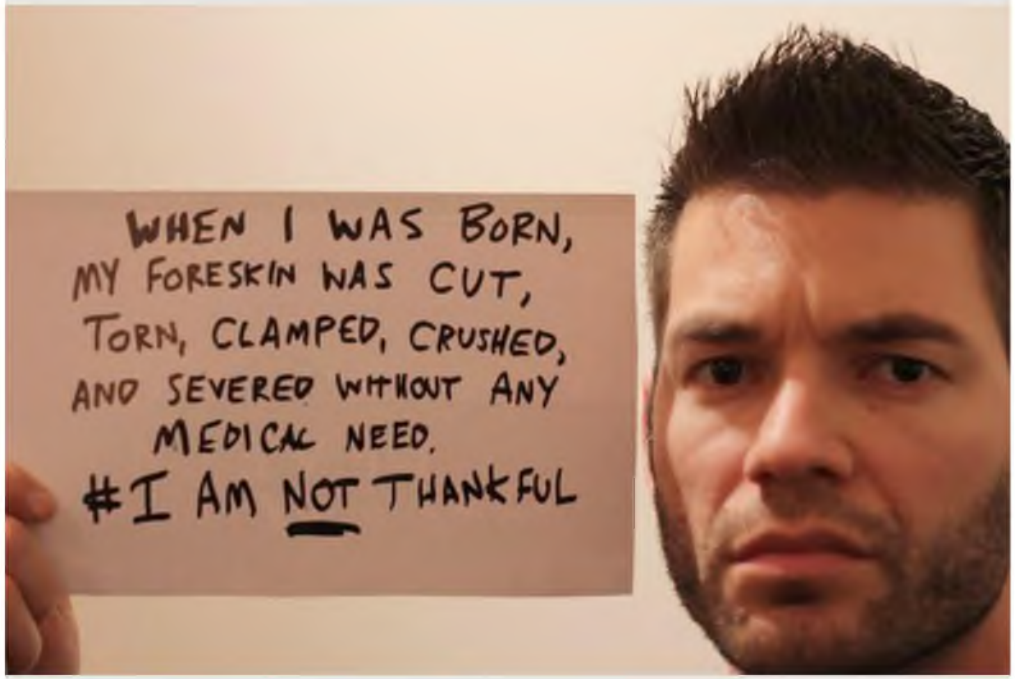
Sumir menn segjast ekki eiga við nein vandamál að stríða þegar það kemur að umskurði sínum. Slíkar umsagnir eru alveg jafn trúverðuglegar, þar sem það hefur verið sýnt fram á að einstaklingar höndla meiðsli og afleiðingar þeirra á mismunandi hátt. Hvað sem því líður, eru umsagnir þeirra sem þurfa að höndla afleiðingar umskurðs alveg jafn alvarlegar, og það þjónar engum tilgangi að etja þessum fylkingum gegn hvor annarri.

,,Ég hef aldrei heyrt neinn kvarta yfir umskurði.“

Ég heiti Ryan og ég hata að vera umskorinn.

Kynnæmasti vefur í mínum líkama var skorinn af vegna menningarhefða sem eiga rætur sínar að rekja frá Viktoríutímabilsins.

#Ég er ekki þakklátur



Forhúðin mín var skorin af þegar ég fæddist, rifin, klemmd, kramin og tekin af án heilbrigðisástæðna.

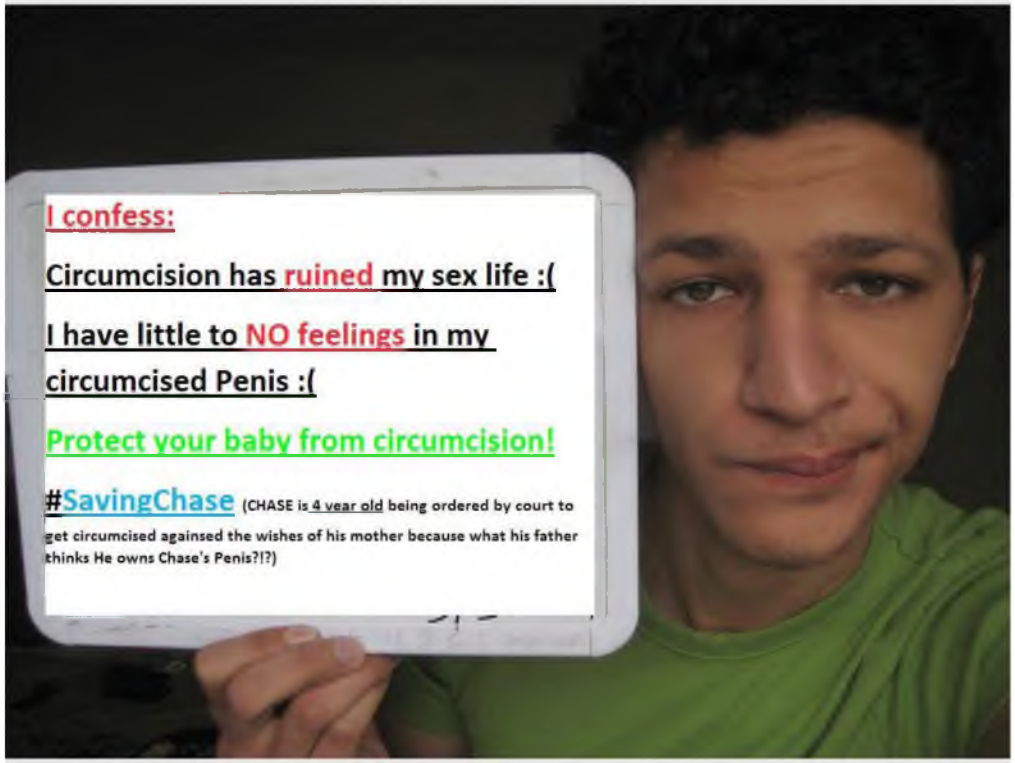
#Ég er ekki þakklátur

#Ég er ekki þakklát að í 16 ár hefur mitt kynlíf verið eyðilagt með umskurði.
Ég var í miklum sársauka og mér blæddi. Ég leitaði hjálpar til lækna sem sögðu að það væri allt í lagi með mig. Þetta var einfaldlega breyting á kynfærum sem eyðilögðu fullkomið jafnvægi tveggja líkama sem koma saman.
Ég hata umskurð.

Ég er ekki þakklátur
Þegar ég fæddist þá var ég bundinn niður, forhúðin skorin af mér á meðan ég öskraði. Skorinn var af sá hluti sem gefur kynferðislega ánægju í forhúðinni sem ég hefði átt að geta notið.
Systur mínar voru verndaðar gegn umskurði
Ég var það ekki!
Ég er hræddur um að hringrás umskurðar á kynfærum muni halda áfram í minni fjölskyldu
#Ég er ekki þakklátur #i2

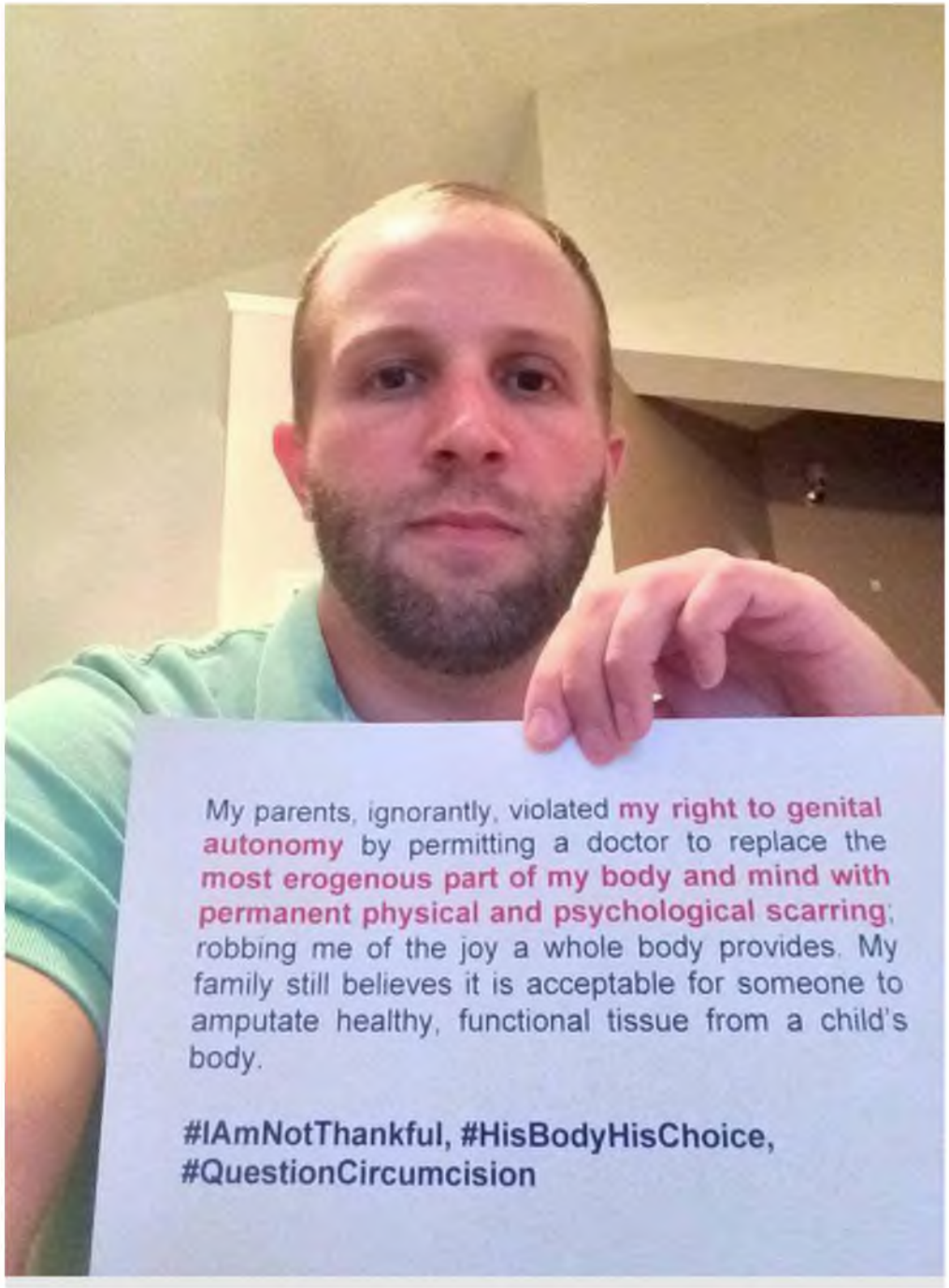
Þegar ég var barn þá var skorin af mér kynferðisleg ánægja og nautn án heilbrigðisástæðu og án míns samþykkist.

#Ég er ekki þakklátur



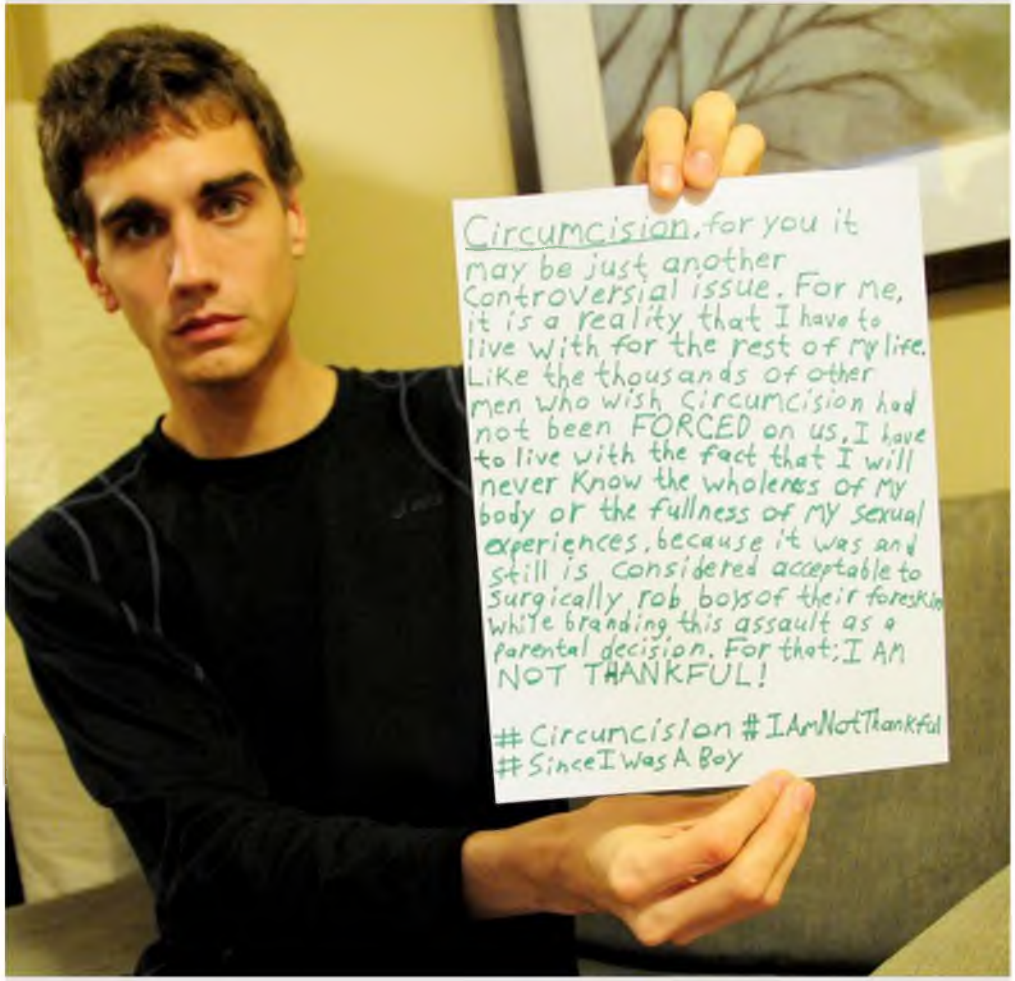
Ég játa:
Umskurður hefur eyðilagt mitt kynlíf ☹
Ég hef litlar sem ENGAR TILFINNINGAR í mínum umskorna getnaðarlim ☹
Verndaðu barnið þitt frá umskurði!
#Björgum Chase

(Chase er fjögurra ára og hefur fengið dómsúrskurð um að vera umskorinn gegn vilja móðurinnar vegna þess að faðir hans telur sig hafa eignarétt yfir getnaðarlim Chase?!?)



Foreldrar mínir, vegna fáfræðis, brutu á rétti mínum um ákvarðanafrelsi um eigið kynfæri með því að gefa lækni heimild til að skera af kynnæmasta vef líkamanns sem skildi eftir sig varanlegt líkamlegt og andlegt ör á líkama og sál; rændu ánægju af heilbrigðum líkama. Fjölskylda mín trúir enn að það sé ásættanlegt fyrir einhvern að skera af heilbrigðan hluta af líkama drengja.

#Ég er ekki þakklátur
Hans líkami hans val
#Efist um umskurð



Umskurður, fyrir þig er það kannski bara eitthvað umdeilt mál. Fyrir mér er það raunveruleiki sem að ég þarf að lifa með alla mína ævi. Líkt og þúsundir annarra karlmanna sem óska þess að umskurður hafi ekki verið ÞVINGAÐUR á sig. Ég þarf að lifa við þá staðreynd að ég mun aldrei vita hvernig allur líkami minn virkar eða fullkomna upplifun í kynlífi, vegna þess að það var og er enn talið vera ásættanlegt að skera af forhúð með því að markaðssetja það sem val foreldra. Fyrir það: ER ÉG EKKI ÞAKKLÁTUR!

#Umskurður
#Ég er ekki þakklátur
#Síðan ég var drengur

#Ég er ekki þakklátur

Í raun og veru er ég mjög reiður að órökstudd hefð hefur kostað mig hluta af fæðingarrétti mínum sem sískynja fullorðinn maður. Ákvörðun sem var tekin fyrir mig, fyrir mína ”bestu hagsmuni”, þegar ég var varla viku gamall, er sorgleg í dag því ég mun aldrei frá tækifæri til að kanna það sjálfur.
#Hans líkami hans val
Látið líkamshluta barna vera þar sem það á heima!

UKD Universitätsklinikum Düsseldorf

HEINRICH HEINE UNIVERSITÄT DÜSSELDORF

Klinisches Institut für Psychosomatische Medizin und Psychotherapie, Geb. 15.16

Universitätsklinikum Düsseldorf AöR • Moorenstraße 5 • 40225 Düsseldorf

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Alþingi
Kirkjustræti
150 Reykjavík

Contact:	Phone:	E-Mail:	Date:
Prof. Dr. Matthias Franz	+49 211-8118338	matthias.franz@uni-duesseldorf.de	02.04.2018

Subject: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágætu þingmenn Alþingis / Dear Members of the Icelandic Parliament,

we address you as medical professionals from several fields of expertise. You will shortly be discussing a legislative proposal to extend the existing protection of girls against genital cutting in every form to boys.

According to media reports, over 400 Icelandic medical colleagues support this initiative. We, the signatories, would also like to ask you to send out an important signal for the implementation of universal children's rights with your agreement to this amendment.

In Germany, six pediatric societies called on politicians to legally establish child protection regardless of gender once again in a press release last December. If Iceland made progress here, we hope to catch up soon in Germany and other countries.

We as medical professionals are well aware of the dangers to children's health that accompany every circumcision. There is no scientifically evident reason to cut off a healthy boy's healthy foreskin, which is the most erogenous zone of the male penis. Six pediatric societies in Germany have recently published new medical guidelines called "Phimosis and Paraphimosis" that have scientifically explained the functions of the male foreskin. It would

require a very profound evidence-based justification to apply the kind of irreversible change of a male's most intimate parts that a circumcision comprises to a child that can neither consent or understand the consequences.

Unequal protection of girls and boys is to be rejected for ethical reasons.
We see that this is a very sensitive issue that concerns culture and religion. We strongly object to any attempts to misconstrue efforts on behalf of the rights of all children to genital self-determination, or to misuse these efforts as a basis to profess or carry out hatred toward religious and cultural minorities.

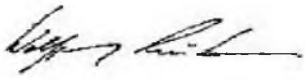
We very much appreciate the clear phrasing of the bill proposal, that this is solely about equality, the well-being, bodily integrity, and right to self-determination of children.

Best regards,

Prof. Dr. med. Matthias Franz
Specialist in Psychosomatic Medicine
Specialist in Neurology and Psychiatry
Section Psychosomatic in Childhood and Youth, DGPM
University Hospital Düsseldorf, Germany

Prof. Dr. med. Dr. h.c. Maximilian Stehr
Head Paediatric Surgery and Paediatric Urology
Cnopfsche Kinderklinik Nürnberg

Dr. med. Christoph Kupferschmid
Specialist in Paediatric Medicine, Ulm
Speaker of the ethics committee of the Deutsche
Akademie für Kinder- und Jugendmedizin



Dr. med. Wolfgang Bühmann
Specialist in Urology - Andrology
Med.Oncology - Qualitymanagment
Scientific Editor of the
Berufsverband der Deutschen Urologen

Dr. med. Kolja Eckert
Specialist in Paediatric Surgeon
University Hospital Düsseldorf, Germany

SUOMEN JUUTALAISTEN SEURAKUNTIEN KESKUSNEUVOSTO
CENTRALRÅDET FÖR DE JUDISKA FÖRSAMLINGARNA I FINLAND
CENTRAL COUNCIL OF JEWISH COMMUNITIES IN FINLAND

mosaiske.dk
DET JØDISKE SAMFUND I DANMARK

JUDISKA CENTRALRÅDET I SVERIGE
THE OFFICIAL COUNCIL OF SWEDISH JEWISH COMMUNITIES

Det Mosaiske Trossamfund

7th of February 2018

JOINT STATEMENT BY NORDIC JEWISH COMMUNITIES CONCERNING PROPOSED ANTI-CIRCUMCISION LEGISLATION IN ICELAND

Open letter to Icelandic MPs

We, the Jewish Communities in the Nordic countries strongly protest the proposed legislation banning brit mila, the Jewish tradition of neonatal circumcision of boys.

Iceland would be the only country to ban one of the most central, if not the most central rite in the Jewish tradition, in modern times. But not so in the long tradition of The Jewish people. More than one oppressive regime has, through history, tried to suppress our people and eradicate Judaism by prohibiting our religious practices.

Iceland does not have an organized Jewish Community today. Banning brit mila will be an effective deterrent and will guarantee that no Jewish community will be established.

This letter might be perceived as meddling in Iceland's internal affairs. And why should we care? The reason is that you are about to attack Judaism in a way that concerns Jews all over the world. If any country with next to no Christian inhabitants would ban a central rite in Christianity, like communion for instance, we are certain that the whole Christian world would react as well.

We urge you to vote against the bill banning Brit mila and rather look to Norway's legislation effective from January 2015 protecting the the Jews' right to brit mila.

Sincerely,

Dan Rosenberg-Asmussen
President
The Jewish Community in Denmark

Ervin Kohn
President
The Jewish Community of Norway

Yaron Nadbornik
President
Central Council of Jewish Communities in Finland

Aron Verständig

SUOMEN JUUTALAISTEN SEURAKUNTIEN KESKUSNEUVOSTO
CENTRALRÅDET FÖR DE JUDISKA FÖRSAMLINGARNA I FINLAND
CENTRAL COUNCIL OF JEWISH COMMUNITIES IN FINLAND
המועצה המרכזית של הקהילות העבריות בפינלנד

mosaiske.dk
DET JØDISKE SAMFUND I DANMARK

JUDISKA CENTRALRÅDET I SVERIGE
THE OFFICIAL COUNCIL OF SWEDISH JEWISH COMMUNITIES

Det Mosaiske Trossamfund

7th of February 2018

President
Council of Swedish Jewish Communities

The Prime Ministers Office
Her Excellency, The Prime Minister
Stjornarradshusid vid Laekjartorg
101, Reykjavik
Iceland

Friday, February 9, 2018

Her Excellency, Prime Minister Katrín Jakobsdóttir,

We, the undersigned rabbis of Jewish Communities in the Nordic countries are deeply concerned about the law proposal pending in the Icelandic Parliament to outlaw and penalise male infant circumcision.

This law proposal would make Iceland the only country in the world where male infant circumcision is illegal.

We would like to remind you of the deep historical implications that such a law would hold. Laws against circumcision have been used throughout history to erase Jews and Judaism: such as under Seleucide empire under king Antiochus IV in 175 B.C.E and later under the Roman Empire. Under the Spanish Inquisition circumcision was used as one indication to identify "conversos", Jews, who had been forced by thread of expulsion to convert to Catholicism, but held on in secret to Judaism and Jewish tradition. Later on in European history circumcision was often made difficult in an attempt to force Jews to assimilate or to leave. Despite those dark chapters in history Jews have always stood up to defend this right of religious freedom. Male infant circumcision is a central religious requirement in Judaism and is also deeply rooted in the cultural identity even of secular Jews. It binds us together as a people and with our history.

To propose that circumcision to be postponed until the age of consent goes against medical research that again and again show that the optimal time for circumcision is within the the first month of a male infants life. Postponing it to a later point makes circumcision into a major surgical procedure with risk of unnecessary complications and can hardly be seen as in the childs interest.

But, most of all, it would send a clear message to Jews and the international community that Jews are not welcome Iceland and that their basic fundamental and constitutional rights of freedom of religion, backed by the 1948 Universal Declaration of Human Rights, are not upheld by the Icelandic society.

We call on you and your government to oppose this proposed legislation and instead to introduce legislation that safeguards the right to freedom of religion and the right of parents to raise children in their religious tradition.

Respectfully,

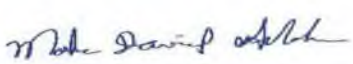
Rabbi Jair Melchior
Jewish community of Copenhagen

Rabbi Joav Melchior
Jewish community of Oslo

Rabbi Ute Steyer
Jewish Community of Stockholm

Rabbi Simon Levinson
Jewish Community of Helsinki

Rabbi Amram Maccabi
Jewish Community of Stockholm



Rabbi Moshe David HaCohen
Jewish Community of Malmö

Rabbi Uzi Levian
Jewish Community of Gothenburg

Cc

Her Excellency, The Ambassador of Iceland to Sweden, Estrid Brekkan

Nefndasvið Alþingis, nefndasvid@althingi.is
Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja)
Þingskjal: 183-114. mál
Sendandi: Ragnar Geir Brynjólfsson
Dagsetning: 22. 2. 2018

Háttvirta Alþingi og alþingismenn.

Málefni umskurnar er án efa átakamál á ýmsum heimilum hér á landi þar sem aðkomin menning blandast þeirri íslensku og vitaskuld má taka undir að það eru hagsmunir barnungra drengja að vera ekki umskornir þar sem aðgerðin er sársaukafull og ekki alveg hættulaus. Umskurðarbann að viðlögðu 6 ára fangelsi er samt líklegt til að valda trúuðum gyðingum og hugsanlega einnig múslimum vandræðum. Gera má ráð fyrir að fólk flytji af landi brott vegna trúar sinnar, komi ekki hingað sem ferðamenn eða til að setjast hér að. Einnig að einhverjir muni ferðast með drengi sína til útlanda og láta umskera þá þar.

Stjórnmálamenn ættu ekki að horfa þröngt á mál á borð við þetta sem snertir hagsmuni fleiri en eins hóps. Þeim ber skylda til að vega og meta stærra samhengi og fleiri hagsmuni og þá koma trúar- og menningarlegir hagsmunir fljótt inn í myndina, t.d. hagsmunir gyðinga. Trúfrelsi er einn af hornsteinum mannréttinda. Fólk getur ekki bæði sagst vera fylgjandi mannréttindum í einu orði og í því næsta þrengt að réttindum trúaðra eða látið eins og trúarlegir hagsmunir séu léttvægir og tilheyri sögunni. Þegar mannréttindi stangast á eins og í þessu máli hlýtur fyrsta skrefið að vera það að vega og meta hagsmuni. Í þessu máli hlýtur því að þurfa að vega óánægju og þjáningu þeirra drengja sem eru umskornir, þ.e. í aðgerðinni sjálfri og þeirra sem verða óánægðir með umskurnina síðar meir á móti óánægju þeirra gyðinga, múslima og hugsanlega fleiri sem telja á sér brotið með banni. Þar vegur einnig ánægja og lífshamingja þeirra sem finna lífi sínu farveg sem trúaðir gyðingar.

Umskurður er gamalt réttindamál gyðinga. Eftirmaður Alexanders mikla Antíokkus Epífanes á 2. öld fyrir Krists burð reyndi að banna siði þeirra, m.a. umskurn. Í fyrstu Makkabeabók stendur:
„Drengi mátti ekki framar umskera en sál þeirra saurga með alls kyns flekkun og vanhelgun“ og „Að fyrirmælum konungs voru konur, sem létu umskera syni sína, teknar af lífi. Voru ungbörnin hengd um háls þeirra. Einnig voru heimamenn þeirra og þeir sem önnuðust umskurnina deyddir. “ Gyðingar snerust til varnar og háðu orrustur um heiðir sínar og sjálfstæði. Um þetta má lesa í fyrstu og annarri Makkabeabók. Til að skilja málstað, menningu og sögu gyðinga betur mæli ég því með að háttvirtir alþingismenn lesi Makkabeabækurnar hafi þeir ekki gert það nú þegar. Þær eru ekki langar og verkefnið ætti ekki að taka mikinn tíma. Ég mæli t.d. með nýrri útgáfu biblíunnar á rafrænu formi en í þeirri útgáfu má finna þessi rit. Alþingismenn á ferð og flugi geta t.d. lesið bækurnar í snjallsíma með kindle appi.

Að bjóða upp á sérhæfða aðstoð, hugsanlega með deyfingu við umskurn drengja væri hugsanlega fær meðalvegur og gæti líklega dregið verulega úr þjáningum ungbarna en auk þess sætt fólk, t.d. strangtrúaða gyðinga eða múslima við samfélag sitt.

Virðingarfyllst,

Ragnar Geir Brynjólfsson
Baugstjörn 33, 800 Selfoss
Sími 896 5768

Þingmál. 114
Bann við umskurði drengja. Almenn hegningarlög
148. löggjafaþing

Nafn sendanda: Rakel Sigurveig Kristjánsdóttir 14. mars 2018

Umsögn.

Frumvarp til ólögleiðingar á umskurði drengja á Íslandi.

Ég styð frumvarpið líkt og ég held að meirihluti Íslendinga geri. Ég tel þetta snúast ekki aðeins um réttindi barnsins, heldur einnig um almenn mannréttindi og jafnrétti kynjanna. Ef umskurður stúlkna er ólöglegur þá á umskurður drengja auðvitað líka að vera ólöglegur, þó inngrip séu eflaust meiri við umskurð stúlkna (FGM). Það er alveg á hreinu að umskurður barna er óþarfa óafturkræf aðgerð, framkvæmd á ungabörnum sem fá ekkert val. Þessi hefð er byggð á úreltum forsendum og ekki gilt að halda henni uppi í nafni hefðar eða siða. Ef við lítum á þessa athöfn eins og hún er þá er um að ræða samkomu fólks þar sem fullorðin manneskja (hvort sem það sé prestur, læknir eða annar) tekur í kynfæri ungabarns og sker í það. Það er einnig staðreynd að börnin finna sársauka ef þau eru ekki deyfð. Hins vegar skiptir sársaukinn né huglæg fegurð athafnarinnar (sem hinir fullorðnu sjá), ekki mestu máli hér. Þetta er siðferðisleg spurning um hvaða læknisfræðilega óþarfa aðgerðir má framkvæma á börnum án þeirra samþykkis í nafni trúar eða siða sem þau hafa ekki tekið afstöðu til. Samfélög hafa, sem betur fer, lagt niður ýmsar úreltar hefðir og siði í gegnum aldirnar. Ég sé þetta sem enn af þeim siðum og munum við líta til bara og undrast að þessu hafi ekki verið breytt fyrr en 2018. Ísland ætti að vera stolt af því að taka þetta fyrsta skref og sýna gott fordæmi. Öll hreinlætis rök eru löngu úrelt þar sem fólk þrífur sig daglega. Þetta þótti kannski hreinlætisbót fyrir einhverjum hundruðum eða þúsundum ára en sem betur fer hefur okkur farið fram hvað varðar almennt hreinlæti. Það er aldrei læknisfræðilega betra að framkvæma svona inngrip á líkama ungabarna og drengir með forhúð eru ekki óþrifalegri en þeir sem hafa verið umskornir.

Öll trúar rök skipta ekki máli, eiga ekki að skipta máli og mega ekki skipta máli. Það er mjög hættulegt að gefa afslátt af mannréttindum/réttindum barana/jafnrétti kynjanna í nafni trúar í lögum lands sem á að teljast siðmenntað. Ég tel að með þessu frumvarpi, ef það verður að lögum, verður gefið fordæmi um að hér verður aldrei gefinn afsláttur á mannréttindum, réttindum barna eða jafnrétti kynjanna í nafni neinnar trúar eða siða sem fara gegn fyrrgreindum réttindum fólks. Að gera það væri bæði fásinna og siðlaust. Það þarf að vera á hreinu í lögum að mannréttindi, jafnrétti og réttindi barna eru alltaf æðri trúarsiðum og að trú eða hefðir geta aldrei réttlætt brot á þessum grunn gildum samfélagsins.

Á Íslandi er trúfrelsi. Fólki er frjálst að trúa eða trúa ekki, vera partur af trúarlegum söfnuði eða húmanískum/siðmenntuðum hópum ef það kýs, án þess að vera dæmt af öðrum sem eru annarrar trúar. Þetta eru grunn gildi. Hver og einn velur sér hvort hann trúi og fylgi trúarsiðum. Trú getur verið falleg og góð. Hver og einn má trúa og fylgja þeim trúarbrögðum sem hann kýs svo lengi sem þær athafnir sem trúin hvetur til brjóti ekki gegn lögum landsins. When in Rome do as the Romans do. Það hefur verið barist hart og lengi fyrir grunngildum mannrettinda, jafnrétti kynjanna og réttindum barna og þau ber að vernda. Þetta ætti að vera kristal tært og ég tel að þetta frumvarp sé fyrsta skrefið í að skýra þessa afstöðu.

Rakel Sigurveig Kristjánsdóttir
14. mars 2018

Sent á nefndasvid@althingi.is
Viðtakandi: allsherjar- og menntamálanefnd.

Renate Bernhard

Journalist and film maker
Interpreter for English and French
Lectures on forced marriage
female genital cutting
boy´s circumcision

Tel: 0049 178 / 38 38 98 3

RMBernhard@web.de
www.Renate-Bernhard.de

GERMANY

Alþingi
Kirkjustræti
150 Reykjavík

Solingen, 6th of April 2018

Subject:
Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Ágætu þingmenn Alþingis,

Dear Members of the Icelandic Parliament,

unfortunately I am unable to write in your language. But I do hope you will understand my English.

I would like to congratulate you on the legal initiative to ban genital cutting of boys, protecting them in the same way as your laws already protect girls.

I am a German journalist and filmmaker. I got to know about female genital cutting on a trip to Ethiopia in 1998. This was just some months before Waris Dirie came out with her book „Desert Flower“, causing a worldwide breakthrough in perception which finally recognized genital cutting as a violation of human rights.

It was indeed only after Waris Dirie came out with her book, that me and my colleague were allowed to produce a radio features and a film on this subject in the German public media. „Hibo´s Song“, a further film we made, was later shown on several international tv channels. Since that time I have been working on this subject. It has evolved. I also worked on the phenomenon of forced marriages. And my awareness for the harms of male circumcision is now round about 15 years old, started the my reading Hanny Lightfoot-Klein. I feel that all this deeply connected. That´s why I have stopped calling this specific subject of mine „fighting AGAINST genital cutting“. I am calling it „campaigning FOR the genital autonomy of all“. And I would like to encourage you to join and contribute what you can do on your side.

Before Waris Dirie came out with her book, female genital cutting was a taboo, ranging from „unheard of“ or „unbelievable“, via „not to touch or talk about critically“ to „a religious and a cultural practice to respect“.

This is 20 years ago now, 20 years in which the worldwide perception of this tradition changed profoundly. Almost nobody in Western world´s legislations doubts any more that the cutting of girl´s genitals is harmless and a ritual to respect. It took almost 50 years of campaigning for this - since the 1970ies in fact. There are laws now in almost all countries forbidding this practice - and even in those where it is still performed.

Waris Dirie caused this breakthrough with her personal strength and courage to stand up and to talk about what really changed her life: It was not her career as an international model coming originally from a desert tribe. It was, what happened to her when she was five in the dawn of one morning in the desert. It was, what her mother did to her - meaning to do the best she could imagine securing her daughter´s future: allowing her to find a husband and thus a good place in life. Her mother invited the circumciser and had her daughter´s genitals cut off with a rusty razor blade, sown with thorns from the bush - all this on a rock in the desert, where nobody else would hear Waris yelling.

This was the moment, that changed Waris´ life forever - as it does so with every child who undergoes such a violent assault of integrity, with parents arranging this to happen and telling the child that this was for its very best.

Waris didn´t silence herself like most of these children do - she stood up, she raised her voice, she changed her world - and ours with it.

I think we are now at the edge of such a breakthrough concerning the protection of boys.

Your legal initiative to protect children - boys and girls alike - not to be cut at the most sensitive and most intimate parts of their bodies will be:
- a breakthrough into a new thinking in Europe,
- a new consciousness in respecting the wisdom of nature and the physical integrity of boys as well as girls,
- a new and even deeper understanding of the Charter of Fundamental Rights: „Human dignity is inviolable.“

And children just like adults have a right of inviolable human dignity!
Boys just like girls have a right of inviolable human dignity!
It is indeed amazing that to this very day European laws fail to protect them.

Waris Dirie said: „If I can save one child, one mama, that´s my mission“.
Concentrating on one child, she changed a whole world of thinking.

There are laws now forbidding female genital mutilation. However, we still have quite a way to go. The practice is still alive and still needs to be eradicated - 200 million women on the planet have been cut! 200 million to much.

Persuading parents to protect their children seems easy.
However, looking at it from a psychological point of view it is hard work for parents to do:
They need to understand and accept that their suffering as a child was unnecessary and harmful, that their parents, who should protect them and know better, did not do so. They need to break with generational loyalty, to come to terms with feelings of loss, pain and being a victim. They must dare to go new ways in the face of a tradition, several thousand years old, which on top of that is often even backed by religious beliefs.

Doing this is indeed pioneer´s work and parents who have been cut and do want to protect their offsprings must be admired for their freedom of thinking and acting.

Parents who start to question this tradition need our support.
They need to be encouraged.
They need to be backed up and offered new ways of thinking and acting.

Laws can provide this frame, they can offer new ways of perceiving the world.

The definition of the Basic Human Rights changed the world for the better and it is still changing it. The more we respect Human Rights the more sensitive we become when they are violated.

Changing this law will help all of Europe - if not the world - to cast a critical eye on our way of protecting children against violence, realizing that we must do so much more.

How can you persuade a father not to have his daughter cut, if he was cut himself? One third of our men on this planet have been cut - one third too much! They have undergone an experience of helplessness as a little boy, cut by a group of men of the generation above them, a strong group of men, telling them, that this is what it is to be a man: a man defying violence by denying that it exists.

I am deeply persuaded, that female genital mutilation and sexual violence can only be eradicated when girls and boys alike will be protected against all forms of assault, overpowering and violence.

These girls and boys that you can help to protect by changing this law will one day be adults, sexual partners and parents.
If you protect them by voting for this new law, they will hopefully not have to go through an experience of violence inflicted on them in this helpless situation of a child being overpowered by adults. They will thus be powerful human beings not deprived of the full range of sexual sensitivity that nature offers us. And they will be parents who will never again have the idea, that they should do to their children what their parents did to them, when they were children.

In changing this law you can support Waris´ mission: save one child and you will change a whole world of thinking with it.

I can only encourage you to vote for this new law.

If I can be of any help in this procedure, presenting my views on the subject, I am happy to follow your invitation.

Yours sincerely

Renate Bernhard

From: Richard Clarfield [mailto:rickclarfield@gmail.com]
Sent: 1. mars 2018 15:45
To: althingi@althingi.is
Subject: Your circumcism law is flawed because you are assuming it is only a health decision

Your circumcision law is flawed because you are assuming it is only a health decision

In the religions of Judaism and Muslim, there is NO CHOICE.

I know a man born to a mixed marriage and whose mother would not allow circumcision until it was his choice.

Since he wanted to be a full member of his religion, he had to get circumcised at the age of 15

In retrospect, his choice would have been to be circumcised at birth.

Rick Clarfield

(416) 937-4056

rickclarfield@gmail.com

RÍKISSAKSÓKNARI

SJF/ Reykjavík, 28. mars 2018

Tilvísun ríkissaksóknara: 201803-0167

Allsherjar- og menntamálanefnd Alþingis hefur sent ríkissaksóknara til umsagnar frumvarp til laga um almenn hegningarlög (bann við umskurði drengja), 114. mál.

Frumvarpið sem slíkt er ekki haldið neinum formgöllum í refsiréttarlegu tilliti að mati ríkissaksóknar. Hvort efni eru til að bregðast við þeirri háttsemi sem frumvarpið beinist að, þ.e. umskurði drengja, með sérstöku refsiákvæði í almennum hegningarlögum, er álitaefni sem löggjafinn tekur ákvörðun um, og þá væntanlega með hliðsjón af aðstæðum hér á landi. Einnig telur ríkissaksóknari rétt að horfa til framkvæmdar á öðrum Norðurlöndum í þessu efni.

Þá er á það bent að sú háttsemi að fjarlægja forhúð drengja, umskera þá, gæti átt undir núgildandi ákvæði almennra hegningarlaga um líkamsárás, auk refsiákvæða barnaverndarlaga, við vissar aðstæður.

Sigríður J. Friðjónsdóttir
ríkissaksóknari

RÍKISSAKSÓKNARI · REYKJAVÍK ·

nefndasvid@althingi.is

Póstfang: Suðurlandsbraut 4, 108 Reykjavík
Sími: 444-2900
Bréfsími: 444-2906
Kennitala: 530175-0229
Netfang: saksoknari@saksoknari.is

From: Family Krell [mailto:krells@shaw.ca]
Sent: 28. febrúar 2018 22:56
To: althingi@althingi.is
Subject: Circumcison Ban?

To Whom It May Concern:

I find that in this day and age when you know that Circumcisons are practiced by Jews and Muslims and others.....that you would try and ban this religious practice. If you were to proceed with a ban on this religious practice.....know that you are attacking the rights of over a billion people on a global basis and hurting the religious rights of some of your very own citizens.

Time for you to consider more important things other than focusing on this. Do not ban circumcision.

Thank you

Ron Krell

Calgary AB

Canada

From: Roz Amunategui [mailto:rockingroz@bellsouth.net]
Sent: 28. febrúar 2018 23:49
To: althingi@althingi.is
Subject: What are you showing the world?

Circumcision is an important part of some religions and it makes and sounds like Iceland has a devious reason to be looking for reforms when none are needed. It seems nonsensical when there are so many important issues in the world that you would want to look petty and closed minded. Males not circumcised have greater health risks as definitely do their mates. The government should be devoting their time to secular issues. Just saying

Rosalind ?Roz? Amunategui

29.3.2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Cutting the genitals of all non-consenting infants and children is a human atrocity that must end if we are ever to hope for a sane world. Iceland is to be commended for taking a stand against this inhumane assault on innocent children. Please vote that this legislation opposing cruelty is ended in your country. You are leading the way to healing humanity.

Rosemary Romberg - author of Circumcision: The Painful Dilemma

http://www.peacefulbeginningsrosemary.wordpress.com

Reykjavík 18.4. 2018

Alþingi
Kirkjustræti
150 Reykjavík

Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja), þingskjal 183, 114. mál.

Ég skrifa þessar athugasemdir við fyrirliggjandi frumvarp sem sérfræðingur í gyðingdómi fornaldar og frumkristni. Allir kannast við þann andsemítisma eða gyðingahatur sem gyðingar hafa mátt þola í gegnum tíðina. Í nútímanum náði slíkt hatur auðvitað hámarki í Þýskalandi nasismans í seinni heimsstyrjöldinni. En einmitt eftir það áfall í mannkynssögunni, þá hræðilegu afhjúpun á mannlegu eðli, byrjuðu sérfræðingar í sögu frumkristni fyrir alvöru að rannsaka hina fyrstu kristnu sem gyðinga, að rannsaka frumkristni sem upphaflegan hluta af gyðingdómi. Á þetta ekki síst við um Pál postula, en það er engum blöðum um það að fletta að Páll postuli er einn af helstu hugmyndasmiðum kristindómsins. Eitt af stærstu viðfangsefnunum í pálsfræðum um þessar mundir er einmitt spurningin um tengsl Páls við gyðingdóm og hið gyðinglega lögmál, og eitt av stærstu vandamálunum sem pálsfræðingar standa frammi fyrir er sá mótsagnarkenndi boðskapur sem virðist vera í bréfum Páls í þessu sambandi. Annars vegar virðist hann hafna lögmálinu, umskurninni og gyðingdómi, sbr. 2. kafla Rómverjabréfsins þar sem hann virðist skv. hefðbundinni túlkun saka gyðinga um hræsni í lögmálseftirfylgni sinni og hafna gildi umskurnarinnar. Hins vegar ítrekar hann gagnsemi þess að vera gyðingur sem og gagnsemi umskurnarinnar (Róm 3.1) og hann leggur áherslu á raunveruleg forréttindi gyðinga, sbr. Róm 9.4-5.

Eftir seinni heimstyrjöldina varð mörgum ljóst að það voru tengsl á milli tilraunar nasista til að útrýma gyðingum og andgyðinglegra hugmynda meðal kristinna manna. Einhver umræða og endurskoðun fór líka af stað varðandi sambandið á milli kristinna og gyðinga. En slík endurskoðun skilaði sér seint inn í rannsóknir á frumkristni og gyðingdómi fornaldar. Hjá flestum fræðimönnum mátti sjá hið hefðbundna viðhorf að Páll hafi á ákveðnum tímapunkti snúið baki við gyðingdóminum og gengið til liðs við nýjan átrúnað, kristindóminn. Páll gerðist alltso „kristinn“ og stór hluti af starfi hans fór í það að gagnrýna gyðinga og færa rök fyrir því að gyðingdómurinn væri einungis „gamall“, úreltur sáttmáli sem ekki er lengur í gildi. Páll hætti að vera gyðingur og tók að boða „lögmálsfrítt fagnaðarerindi“ fyrir allt mannkyn, skv. þessari skoðun.

Hópur pálsfræðinga sem fer ört stækkandi, sérstaklega meðal ungra fræðimanna í Bandaríkjunum, hefur gagnrýnt þetta viðhorf, en þetta er hópur sem kennir sig við nálgun sem kallast „Páll innan gyðingdóms“ viðhorfið („Paul within Judaism“) þar sem megináherslan liggur í því að skoða Pál algjörlega innan gyðingdóms. Almennt má segja að þeir fræðimenn sem fylgja „Páll innan gyðingdóms“ viðhorfinu eigi það sameiginlegt að ganga út frá þeirri forsendu að Páll hafi að öllu leyti tilheyrt gyðingdómi, ekki að hann hafi yfirgefið gyðingdóminn. „Páll innan gyðingdóms“ viðhorfið leggur þannig áherslu á það að kristindómurinn hafi ekki verið til á tímum Páls, enda talar hann aldrei um

„kristna“. Hvað lögmálið varðar er Páll einungis neikvæður gagnvart því í tengslum við spurninguna um það hvort fólk af heiðnum uppruna eigi að fylgja því eður ei. Hann er m.ö.o. ekki neikvæður gagnvart lögmálinu í samhengi gyðinga, einungis fólks af heiðnum uppruna. Það sama gildir um umskurnina. Það er mikilvægt í þessu sambandi að hafa í huga að Páll mælir ekki almennt gegn umskurninni, einungis gegn því að karlmenn af heiðnum uppruna láti umskerast og gerist þannig gyðingar. Gyðingar eiga hins vegar áfram að umskerast og gildi umskurnarinnar er ótvírætt fyrir gyðinga, sbr. Róm 3.1: „Hvað hefur þá gyðingurinn fram yfir aðra? Eða hvert er gagn umskurnarinnar? Mikið á allan hátt“. ”Mikið á allan hátt”, þ.e.a.s. í samhengi gyðinga, ekki annarra. Umskurnin, sem framkvæmd er á áttunda degi á nýfæddum drengjum, er tákn sáttmála Guðs við Ísrael og er og hefur alltaf verið órjúfanlegur þáttur í trúariðkun gyðinga. Hún er grundvallaratriði í sjálfsmynd og auðkenni gyðinga. Því hefur oft verið haldið fram og er oft haldið fram í umræðum dagsins um umskurn að Páll hafi mælt almennt gegn umskurn. En ef vel er að gáð kemur í ljós að þetta er alrangt. Páll hafnar ekki umskurninni sem slíkri, ekki fyrir gyðinga. Því er líka oft haldið fram að Páll hafi boðað að umskurnin skipti ekki máli, að hún sé aukaatriði í heildarmyndinni. Ekkert gæti verið fjarri sanni: Eins og ég hef bent á er umskurnin skv. Páli grundvallaratriði fyrir gyðinga, sbr. Róm 3.1. Annað grundvallaratriði hjá Páli er að karlar af heiðnum uppruna skuli ekki umskerast, að þeir gerist ekki gyðingar. Hvort formerkið sem um er að ræða er umskurnin m.ö.o. grundvallaratriði í guðfræði Páls postula, þ.e.a.s. sú grundvallarforsenda að gyðingar gangist undir umskurn, en aðrir ekki.

Kjarnaatriðið í ofangreindu er þetta: Kristin túlkunarsaga og þar með túlkunarsaga Vesturlanda á gyðingdómi til forna og frumkristni hefur verið undir miklum áhrifum frá andsemítisma, m.a. þeirri viðteknu skoðun að Páll postuli hafi hafnað umskurninni og þar með gyðingdómi, enda felur höfnun á umskurninni sjálfkrafa í sér höfnun á gyðingdómi. Fræðimenn eru smátt og smátt að afhjúpa þennan andsemítisma í túlkunarsögunni og leiðrétta þessa skaðlegu hugmyndafræði. Fyrirliggjandi umskurðarfrumvarp er svo sannarlega ekki skref í rétta átt í þessu sambandi. Ef það verður að veruleika felur það í sér glæpavæðingu á gyðingdómi sem væri vatn á myllu gyðingaandúðar, ekki síst í Evrópu þar sem andsemítismi hefur farið vaxandi á undanförnum misserum. Það má með sanni segja að slík glæpavæðing hafi ekki sést frá lokum seinni heimsstyrjaldarinnar. Flestir geta væntanlega verið sammála um það prinsípatriði að það beri ekki að skaða börn. En málið er ekki svo einfalt. Það þarf að skoða málið í víðara samhengi. Það þarf að skoða mögulegar afleiðingar glæpavæðingarinnar fyrir þjóðfélagshópa eins og gyðinga sem hafa mátt sæta ofsóknum í gegnum aldirnar. Ég óttast að slíkar afleiðingar séu öllu verri en umskurnin sem slík, enda hafa aðrar þjóðir heimsins ekki stigið þetta óheillavænlega skref. Í þessu ljósi fer ég þess á leit við viðeigandi aðila að þeir samþykki ekki frumvarpið í núverandi mynd.

Virðingarfyllst,

Dr. Rúnar M. Þorsteinsson

Prófessor í nýjatestamentisfræðum við Guðfræði- og trúarbragðafræðideild Háskóla Íslands

28.3.2018

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum

.(bann við umskurði drengja), 148. löggjafarþing, 114. mál

,Ágæta Alþingi / Dear Members of the Parliament

,Ágæti þingmenn

.Ég er Salam Jamal, Marokkó frá Sultanate Óman. Múslima

.Ég þakka viðleitni ykkar við að reyna að stöðva umskurn karlkyns stráka

Umskurn er siði og hefðir, stunduð af múslimum þrátt fyrir að engin stjórn sé í Kóraninum

Ég vona að hætta og vernda börnin í heiminum frá kynfærum í nafni trúarbragða eða lyfja eða .undir einhverju nafni

.Kveðjur: Salam Jamal

Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja)

28. mars 2018

Samtökin ‘78, félag hinsegin fólks á Íslandi og Intersex Ísland, félag intersex fólks á Íslandi, hvetja bæði allsherjar- og menntamálanefnd og þingheim allan til að samþykkja frumvarpið sem um ræðir með eftirfarandi breytingum.

Í stað þess að frumvarp til laga um breytingu á almennum hegningarlögum sé:

1. málsl. 218. gr. a orðast svo: Hver sem með líkamsárás veldur tjóni á líkama eða heilsu barns eða konu með því að fjarlægja kynfæri að hluta eða öllu leyti skal sæta fangelsi allt að 6 árum.

Leggja Samtökin ‘78 og Intersex Ísland til að breytingin verði:

1. málsl. 218. gr. a orðast svo: Hver sá sem veldur tjóni á líkama eða heilsu barns eða fullorðins einstaklings með því að framkvæma læknisfræðilega óþarft inngrip á kynfærum eða æxlunarfærum þess, án fulls og upplýsts samþykkis einstaklingsins, skal sæta fangelsi allt að 6 árum.

Samtökin ‘78 og Intersex Ísland hafa það í stefnu sinni að banna eigi öll óafturkræf og óþörf inngrip á börnum, sem og fullorðnum einstaklingum, sem ekki er þörf fyrir af læknisfræðilegum ástæðum. Það er réttur hverrar manneskju að fá að taka upplýsta ákvörðun um breytingar á eigin líkama.

Samtökin ‘78 og Intersex Ísland líta svo á að umskurður drengja sé „aðlögunaraðgerð“, þ.e. aðgerð sem hefur það að markmiði að laga líkamann að fyrirfram ákveðnum hugmyndum um útlit kynja og kynfæra. Leggjumst við því sterklega gegn því að slíkar aðgerðir séu framkvæmdar á börnum, sem eðli málsins samkvæmt geta ekki veitt upplýst samþykki. Virða ber rétt hvers einstaklings til þess að undirgangast ekki slíkar aðgerðir. Að því leyti samræmast okkar sjónarmið frumvarpinu, þ.e. við teljum eðlilegt að umskurður drengja sé bannaður þar sem ekki er hægt að vita hvort að einstaklingurinn sjálfur samþykkir aðgerðina eða ekki.

Samtökin ‘78 og Intersex Ísland telja hins vegar að frumvarpið gangi ekki nægilega langt í að vernda börn fyrir óafturkræfum og óþörfum inngripum. Nefndin ætti að skoða það alvarlega hvort að frumvarpið eigi ekki frekar að banna öll óafturkræf inngrip sem ekki er þörf fyrir af læknisfræðilegum ástæðum, þar sem sömu rök og tilgreind eru í greinargerð frumvarpsins geta vel átt við öll slík inngrip.

Núverandi ákvæði hegningarlaga nær ekki ekki yfir öll form limlestingar á kynfærum kvenna (e. female genital mutilation (FGM)) eins og það er skilgreint af Alþjóðaheilbrigðisstofnuninni (e. World Health Organisation (WHO))[1] en ákvæðið nær ekki yfir fjórðastigs limlestingu á kynfærum kvenna sem er eftifarandi:

“Type IV — All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.”

Íslensk þýðing:

„Stig IV — Öll önnur skaðleg inngrip á kynfærum kvenna sem þjóna ekki læknisfræðilegum tilgangi, til dæmis, ástunga, götun, rista í, skröpun og brennslu“

Með breytingartillögu okkar munu lögin einnig ná yfir fjórðastigs limlestingu á kynfærum kvenna ásamt því að veita intersex börnum vernd með því að tryggja sjálfsákvörðunarrétt og líkamlega friðhelgi allra barna.

Virðingarfyllst,

Daníel E. Arnarsson
Framkvæmdastjóri Samtakanna ’78

Kitty Anderson
Formaður Intersex Ísland

Þorbjörg Þorvaldsdóttir
Ritari Samtakanna ‘78

[1] http://www.who.int/reproductivehealth/topics/fgm/overview/en/

Alþingi
Kirkjustræti
150 Reykjavík

March 26, 2017

Ágæta Alþingi / Dear Members of the Parliament

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál. / Regarding the proposed legislation banning non-therapeutic circumcision

I am writing in support of the proposed limit on non-therapeutic circumcisions to persons 18 years and older.

If the custom of amputating parts of a child's healthy genitals did not exist and someone tried to introduce it today for religious or cultural reasons or by claiming "potential health benefits", there would be worldwide outcry and laws would be passed immediately to stop its spread. It would be recognized as the abusive practice that it is. Sadly, this barbaric custom does exist and those now attempting to protect children from this harmful practice are being defamed as anti-semitic, Islamaphobic and akin to Nazis.

I urge Iceland to rise above this defamatory rhetoric and to stand up for the clear human rights, equal rights and medical ethics which are at stake here.

I am from the UK but, for over a decade have lived in the United States. I am an "intactivist" and I fight for the human rights of boys to keep their whole genitals, to be given the same protection as girls and for doctors to abide by basic standards of medical ethics if they are asked to amputate healthy parts of boys' genitals.

Circumcision Violates Basic Standards of Medical Ethics

Much of the rhetoric and criticism of Iceland's proposal emanates from the United States and the United States prides itself on its power to influence other nations. Given how deeply

circumcision is culturally entrenched in the United States, it is not surprising that Iceland will be subjected to a large amount of pressure from the United States. Icelandic lawmakers should be aware that Americans who speak out against the proposal - while they may frame their objections in religious freedom terms for Jews and Muslims - are also defending their own non-religious bias and belief in myths that a circumcised penis is “healthier” “cleaner” and that the procedure is “harmless”.

American doctors are complete outliers in the developed world on the issue of genital cutting and I have seen, first hand, while giving birth to two boys in the United States, how greedily they promote and solicit the genital mutilation of boys and present it as a “normal” part of being a boy in the United States. Indeed, many American doctors and nurses, when asked why they are soliciting this medically unnecessary surgery, state that boys should have their genitals altered at birth to “match dad” or “fit in in the locker room”. It simply never occurs to them that in the absence of disease, amputating a healthy, functional part of a boy’s genitals without his consent, violates basic standards of medical ethics.

American doctors are nonchalant about anesthesia - and despite clear medical evidence of the pain of circumcision, continue to perform this surgery with no anesthetic or anesthetic that has been shown to be ineffective. Moreover, they obfuscate and dismiss the complications of this procedure as “rare” while at the same time admitting that “the true incidence of complications… is unknown” [American Academy of Pediatrics Task Force on Circumcision. Male circumcision. Pediatrics. 2012;130(3)]. Bizarrely, despite not knowing the risks the American Academy of Pediatrics felt qualified to tell the American public that the “health benefits of newborn male circumcision outweigh the risks”.

Clearly, what was and remains of utmost importance to the American Academy of Pediatrics is that health insurance continues to pay for a medically unnecessary procedure. In their 2012 report they asserted that the so-called potential health benefits “warrant third-party reimbursement of the procedure”. In this way, American doctors can continue to profit. Circumcision is a multi-billion dollar industry in the United States for the pediatricians and obstetrician/gynecologists who perform it on approximately 3000 boys daily. It is particularly profitable for the pediatric urologists who deal with the botches and complications. Boys are scarred for life and those who grow up and complain about what was done to them are dismissed and mocked by society for daring to complain.

I had no idea that a so-called advanced nation could be so willfully blind until I met my American husband and discovered that this is what Americans do to their boys at birth. My husband is circumcised and an intactivist. We protected our sons - which, in the case of our first son, involved my husband having to argue with a nurse about removing him from the hospital circumcision schedule - something she insisted only a doctor could do!

I urge Icelandic lawmakers to listen to doctors in the rest of the developed world outside the United States who do not have a vested cultural, religious or financial interest in circumcision but can take an objective view on the pain, complications, harm, and ethics of amputating healthy, functional parts of boys' genitals.

Equal Rights Issues

Female genital mutilation ("FGM") has been banned in most parts of the developed world, including Iceland, and it is preposterous to claim that boys do not deserve the same protection. There are many forms of FGM - including practices much less invasive than male circumcision such as ritual nicks of the clitoris or clitoral hood (prepuce). All forms of FGM are outlawed. It is therefore the height of hypocrisy to claim that the foreskin (male prepuce) can be completely amputated from a boy when we take such a restrictive view of FGM. We are almost a quarter of the way through the 21st century, and it is time to do away with such harmful double standards.

Human Rights to Bodily Integrity and Religious Freedom

It is not reasonable to claim that the human rig3ht to religious freedom outranks the human right to bodily integrity. People are not free to kill in the name of religion, nor should they be free to maim in the name of religion. Being born without a foreskin is a birth defect called Aposthia. How can it be claimed that anyone has a right to mimic a birth defect on a child?

Religious groups with a vested interest in the practice claim that circumcision is "harmless". This is blatantly untrue. Not only does it ignore all those who have suffered a botched circumcision or complications from a circumcision, it ignores the fact that the amputation of a healthy, functional, erogenous part of a boy's genitals is, per se, harm. Even if the procedure is not botched or the boy never suffers a complication, he is still missing a body part and is deprived of its functions including its function during masturbation and intercourse and its protection of the glans. Circumcision harms boys and religion should not be used as a

justification for allowing it. Indeed, the ban on FGM, a largely Islamic practice, shows that religious and cultural freedom regarding children's genitals has already been regulated on the grounds of the harm that it inflicts.

In short, all rights and freedoms have limits. In a civilized, enlightened society, freedom of religion must end where someone else's body starts. Those who wish to offer up body parts as part of their religion or culture should be free to offer up their own body parts but not those of children.

Iceland should stand firm in protecting boys from a medically unnecessary, harmful and unethical surgery and put them on an equal footing with the protection given to girls. Boys should be allowed the same open future as girls and, upon reaching 18, decide for themselves if they would like genital surgery for any perceived religious, cultural, health, aesthetic or other reasons that they consider important enough to warrant it.

Sincerely,

Sarah Rouse
Rockville Centre, NY, USA.

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From: sharon komash [mailto:sharon.komash@gmail.com]
Sent: 3. febrúar 2018 19:16
Subject: Against Circumcision of Children - Jews support bill 183

Dear Parliament Member,

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls.

As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israeli's to leave our children intact (not-circumcised).

Circumcision of a child unable to consent is **genital mutilation**. It is an irreversible surgery that **robs the child of an important body part.**

Thank you for having the courage to protect children and fight for this important bill.

Sincerely,

Sharon Komash

Frá: Sharon Liran [mailto:Sharon@all2md.com]
Sent: 3. febrúar 2018 12:08
Til: Silja Dögg Gunnarsdóttir ; Ólafur Þór Gunnarsson ; Inga Sæland ; Bjarkey Olsen Gunnarsdóttir ; Ólafur Ísleifsson ; Jón Þór Ólafsson ; Guðmundur Ingi Kristinsson ; Líneik Anna Sævarsdóttir ; Björn Leví Gunnarsson ; Ritstjóri vefsins
Efni: Support of Bill 183 - Banning Circumcision

Dear Sirs.

My name is Sharon Liran and I am an Israeli and a Jewish woman. I would like to support your act to promote bill 183 – banning the circumcision of minors, under age children.

I think it is a moral act and I believe all countries should follow your lead, hopefully my country, Israel , as well. I have two boys who were not circumcised as I find this act to be barbarian, immoral, dangerous, painful and illegal .

The statistics in Israel to get hurt by the circumcision is 1 to 200 babies – every two days a baby gets to the hospital because of this horrible procedure , some hurt so badly that it an irreversible damage! There is no justification for this procedure – HIV can be prevented by having safe sex, and the foreskin has a major part in the sexual enjoyment of both man and woman.

Circumcision of a child unable to consent is genital mutilation and a sexual assault! It is an irreversible surgery that robs the child of an important body part. Thank you for having the courage to protect children and fight for this important bill.

With kind regards

Mrs. Sharon Liran.

Siðmennt

Félag siðrænna
húmanista á Íslandi

Hallveigarstöðum
Túngötu 14
101 Reykjavík
sidmennt@sidmennt.is
sidmennt.is

Alþingi
Nefndasvið
Austurstræti 8-10
150 Reykjavík

Reykjavík, 14. febrúar 2018

Efni: Umsögn Siðmenntar um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja),
148. löggjafarþing 2017 - 2018. Þingskjal nr. 183. - 114. mál.

Álit Siðmenntar:
Siðmennt, félag siðrænna húmanista á Íslandi, hvetur Alþingi til þess að samþykkja frumvarpið.

RÖKSTUÐNINGUR:
Umræða um umskurð blossar upp öðru hvoru og oft í tengslum við alþjóðlegar herferðir gegn umskurði. Árið 2005 samþykkti Alþingi bann við umskurði kvenna. Í öllum umsögnum sem bárust var einróma tekið undir með innihaldi frumvarpsins.

Orðanotkun svo sem limlesting, líkamsmeiðing, ofbeldi og önnur sterk lýsingarorð voru notuð til að rökstyðja stuðning við bannið árið 2005. Almenn sátt virtist ríkja um það á sínum tíma.

Nú ber svo við að í umræðu um lagafrumvarp sem bannar umskurð drengja heyrast raddir um að sýna siðavenjum og trú það umburðarlyndi að banna ekki umskurð drengja.

Siðmennt hefur skýra sýn á málið:
Þar sem um er að ræða alvarlegt og óafturkræft inngrip er óásættanlegt að börn undir lögaldri séu umskorin.

Siðmennt tekur undir skoðun flutningsmanna frumvarpsins þegar þeir segja:

> *Það er skoðun flutningsmanna að umskurður á ungum drengjum feli í sér brot á réttindum þeirra, nema slík aðgerð sé talin nauðsynleg af heilsufarslegum ástæðum.*

Siðmennt telur hins vegar að lögráða einstaklingar eigi að geta óskað eftir umskurði eftir upplýsta skoðun og ákvörðun þar um.

Rétt er að taka fram að í þeim tilfellum sem umskurður er framkvæmdur t.d. af heilsufarsástæðum eða af lögráða einstaklingi skuli hann framkvæmdur af sérfræðingi á heilbrigðissviði.

Umburðarlyndið

Tenging umskurðar kvenna við trú (íslam – þó ekkert í kóraninum styðji slíkt) er fyrir hendi en fyrst og fremst er um að ræða hluti menningar, hefða, venja og siða. Einnig hefur verið talið að umskurður drengja sé hluti manndómsvígslu þeirra.

Rétt er að minna á að þó að ýmsar siðavenjur eða hefðir hafi verið stundaðar í árhundruð eða þúsundir ára þá er það engin réttlæting að þær eigi að standa óhreyfðar um alla eilífð.

Umburðarlyndi gagnvart siðvenjum og trúarbrögðum er góðra gjalda vert. En þegar kemur að slíku inngripi á líkama ungra drengja er það skýrt að réttur barnsins skal vera siðum og trú yfirsterkari.

Álit annarra

Auk skoðunar sem Siðmennt hefur sett hér fram er mikilvægt að heyra skoðanir annarra.

Umboðsmaður barna hafði forgöngu árið 2013 fyrir samþykkt allra embætta umboðsmanna barna á Norðurlöndum þar sem lagst er gegn umskurði drengja. Í bréfi þeirra segir:

> *Umskurður á ungum börnum brýtur gegn grundvallarréttindum barna samkvæmt Barnasáttmála Sameinuðu þjóðanna, sem nýlega var lögfestur hér á landi.*
>
> *Umskurður felur í sér óafturkræft inngrip í líkama drengja sem getur haft í för með sér mikinn sársauka, auk þess sem slíkri aðgerð fylgir hætta á sýkingum og öðrum vandamálum.*

Siðmennt

> *Eðlilegt að drengir sem vilja láta umskera sig af trúarlegum eða menningarlegum ástæðum taki ákvörðun um slíkt þegar þeir hafa sjálfir náð aldri og þroska til þess að skilja hvað felst í slíkri aðgerð.*

Læknasamtök víða um heim, m.a. annars á Norðurlöndum, hafa einnig lýst andstöðu sinni gegn umskurði drengja. Í grein sem birtist bandaríska blaðinu „Pedriatric" árið 2012 skrifuð 38 læknar frá 16 Evrópulöndum grein um málefnið. Þar segir:

> *Circumcision conflicts with children's rights and doctors' oath and can have serious long-term consequences, state an international group of 38 physicians from 16 European countries in Pediatrics today. They comment on the American Academy of Pediatrics' new policy on infant male circumcision.*
> http://intaction.org/circumcision-policy-denounced/

Þessar raddir undirstrika mikilvægi þess að gæta hagsmuna barna í hvívetna.

Fulltrúi Siðmenntar er ávallt reiðubúinn að ræða innihald umsagnarinnar ef eftir því er óskað.

F. h. Siðmenntar

Bjarni Jónsson
Framkvæmdastjóri

Efni: 19/1940 Umsögn til Alþingis vegna frumvarps um bann við umskurði drengja.

Nú á 148. löggjafarþing 2017–2018 liggur fyrir frumvarp til laga er varða hegningarlög og bann við umskurn drengja. Innleiðing þessara laga væri skýlaust brot á Stjórnarskrá Íslands.
Stjórnarskrá Íslands tryggir trúfrelsi allra þegna landsins. Í stjórnarskrá Íslands stendur:
„Allir eiga rétt á að stofna trúfélög og iðka trú sína í samræmi við sannfæringu hvers og eins. Þó má ekki kenna eða fremja neitt sem er gagnstætt góðu siðferði eða allsherjarreglu“.
Eins og alþekkt er þá er þá er umskurn sveinbarna á áttunda degi grunnatriðið í iðkun gyðingatrúar. Þeir trúa því að þetta sé partur af því hlutverki sem þeim er ætlað og umskurnin er sáttmálstákn milli Guðs og þeirra. Samanber skírnar-sáttmáli Kristinna manna við Guð. Þegar þeir m.a. skíra ungbörn sín. Það er óvéfengjanleg staðreynd að umskurn er hluti af iðkun Gyðingartrúar eins og skírn er hluti af iðkun Kristinnar trúar. Gyðingar trúa því að umskurn sveinbarna fylgi sérstök blessun og velvild Guðs fyrir þá. Gyðingar eru ekki þekktir fyrir að þvinga sinni trú uppá aðra. Vera má að trúlausir, kristnir eða menn annara trúar telji að Guð komi þar hvergi nálægt og að enginn blessun Guðs fylgi umskurn sveinbarna þeirra. Skoðun og trú þessara hópa er ekki rétt hærri en trú gyðinga. Þannig er ekki hægt að banna trúariðkun eins hóps vegna lífsskoðunar annars hóps. Um þetta snýst einmit ákvæðið í stjórnarskránni. Annað væri mismunun. Þvert á móti tryggir Íslenska stjórnarskráin að trú allra sé metin að jöfnu. Þegar Gyðingar iðka trú sína með því að umskera sveinbörn sín er ekki hægt að væna þá um að þeir séu að „kenna eða fremja neitt sem er gagnstætt góðu siðferði eða allsherjarreglu“. Um allan heim og í öllum löndum eru drengir umskornir af ýmsum ástæðum. Um 55% Bandaríkjamanna eru umskornir, um 33% Kanadamanna og margir telja að um þriðjungur manna í heiminum séu umskornir. Umskurn hefur aldrei verið bönnuð nema af grimmustu harðstjórum mannkynssögunar og hefur ávallt tengst ofsóknum gegn Gyðingum. Bæði á okkar tímum og í gegnum aldirnar hefur það ekki talist annað en gott siðferði að umskera drengi. Með því að setja lög gegn umskurn drengja væri hvort tveggja, farið gegn almennu siðferði og gegn ákvæði stjórnarskrár Íslenska lýðveldisins um trúfrelsi allra. Nýjar stefnur og ný hugmyndafræði má ekki vera forsenda fyrir því að ákvæði Stjórnarskrárinnar séu ekki virt. Stjórnarskráin verndar okkur frá fjótræði og bráðræði borgaranna. Kapp er best með forsjá, sá sem hraðar sér misstígur sig. Góðir Alþingismenn munið að þið hafið svarið eið að halda stjórnarskrá Íslands. Það er augljóst að þessu frumvarpi ber að hafna.

Steinþór Als , Laugavegur 137. 105 Reykjavík, S:8976123

-----Original Message-----
From: Steven Reiter
Sent: 20. apríl 2018 15:50
To: althingi@althingi.is
Subject: Proposed ban on circumcision

Dear Icelandic Parliament,

I don not support the proposed ban on circumcision. The proposed ban will encourage Hatred, Xenophobia, and Antisemitism. Please create an environment where all your citizens can flourish.

Thank You

Steven Reiter Ph.D.

Dear Members of the Islandic Parliament

Please allow us to address you regarding an issue that, being Jews, lies close to our heart, i.e. the planned prohibition of circumcision of boys in Iceland. The male circumcision belongs to the most central identity-establishing attributes of Judaism; it is of ultimate meaning in our religion.

Its prohibition would signify a massive interference with religious freedom, and Iceland would be the first country of Europe to introduce such a law. A prohibition would render Jewish life in Iceland impossible.

Some 25 to 33 percent of the male world population are circumcised. It therefore appears to be relevant to us to mention at this point that the male circumcision reduces the risks of venereal diseases and infections, and that a prohibition of circumcision of boys for medical reasons thus does not seem to be appropriate.

It goes without saying that we respect the sovereignty of the State of Iceland. As Swiss Jews, we however also feel committed to raise our voice in support of the Icelandic Jews on this issue that matters so much to us.

Consequently, we very kindly request you to acknowledge the fact that the foreseen prohibition encounters resistance outside of Iceland as well, and that this draft bill, after examination of all arguments, should be reconsidered.

Herbert Winter
President Swiss Federation of Jewish Communities

Frá: Tal K [mailto:talkabesa@gmail.com]
Sent: 21. febrúar 2018 08:17
Til: Silja Dögg Gunnarsdóttir ; Ólafur Þór Gunnarsson ; Inga Sæland ; Bjarkey Olsen Gunnarsdóttir ; Ólafur Ísleifsson ; Jón Þór Ólafsson ; Guðmundur Ingi Kristinsson ; Líneik Anna Sævarsdóttir ; Björn Leví Gunnarsson ; Ritstjóri vefsins
Efni: Against Circumcision of Children - Israeli citizen support. :)

Hello,

My name is Tal, I've been living my whole life in Israel, my parents come from a strong Jewish background, but I support your bill against circumcision of children.

I believe a helpless baby shouldn't get any kind of surgery unless it is meant to save his life. I believe a tradition shouldn't be forced on a person and one should choose it for themselves. Thank you for being rational and caring for our next generation of children.

You have my full support.

Have a good day!

Tal.

Re : Þingskjal: 183-114. mál Umsögn um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja

March 28th 2018

Dear Members of the Icelandic Parliament,

We are writing to you regarding the proposed legal ban on ritual circumcision in Iceland. The Jewish Community in Denmark finds that the proposed legal ban is in opposition to The European Convention of Human Rights. Ritual circumcision of boys is protected by international conventions.

Jewish circumcision of boys is a religious and cultural cornerstone in the Jewish faith. It is an essential and highly valued sign of Jewish identity. The ritual has been carried out among Jewish communities around the world for at least 3000 years. The ritual itself signifies the covenant between God and the Jewish people, and to this day, even the majority of secular Jews keep this tradition. The ritual itself is considered a joyous occasion for the family, and virtually all Jewish men are happy to be part of this tradition.

An infringement on the right to continue this old and highly valued tradition is both legally and medically unfounded and would be a serious violation of the freedom of minority groups to live as citizens with a religious faith that differs from that of the majority population.

We refer to the Danish professor Hans Gammeltoft Hansen's article in Juristen, 5, 2017, pp. 156: "In my opinion, unless a medical consensus is reached that circumcision has negative health consequences, a case at the European Court of Human Rights will (and should) conclude that a legal ban against male circumcision is not compatible with the ECHR, art. 9."

The Danish Health Authority has concluded that male circumcision does not entail negative health consequences to justify a legal ban: "The Health Authority finds that there is insufficient evidence to recommend circumcision of all boys. Also, the procedure does not entail sufficient potential risks, when carried out by competent doctors, for the Authority to recommend a legal ban on ritual circumcision of boys."

Since the Health Authority came to this conclusion in 2013, no serious scientific studies have shown harmful side effects of Jewish circumcision of boys. Several new studies support the fact that Jewish circumcision of healthy infant boys, if performed correctly and under sanitary conditions, has no adverse effects on the physical and mental health of the baby or in adulthood, nor does it adversely affect sexual function later in life.

The risk of complications in connection with the procedure itself is extremely low. Among the youngest age groups, the risk of complications reported is 0.2% in a study from the Danish Rigshospitalet. Among these, **no** serious complications are reported (Thorup *et al.*, 2013). The risk of complications increases with the age at which the procedure is carried out (Thorup *et al.*, 2013, Bretthauer, 2015, Weiss *et al.*, 2010).

Since 2013, three systematic reviews have been published which unequivocally show that there is no general difference in circumcised and uncircumcised men's sexual function and experience of sex. One of

these studies was conducted by Danish scientists and published in Danish Medical Journal (Shabanzadeh *et al.*, 2016). This review examines all previous studies on the subject and concludes that circumcision of healthy boys/men does not lead to sexual dysfunction. This conclusion is confirmed by two other scientific reviews (Friedberg *et al.*, 2016, Yang *et al.*, 2017). The first of these, furthermore, concludes that male circumcision reduces men's risk of being infected by HIV and certain other STD's.

Other scientific studies reach the same conclusion – that there is no general difference in the penile sensitivity of circumcised and uncircumcised men (Bossio, 2015). The newest research shows, furthermore, that there are no adverse mental effects connected to circumcision of boys, as has been suggested by some (Ullman *et al.*, 2017).

Strong evidence indicates certain beneficial health effects of circumcision of boys/men. These benefits are primarily linked to reduced risk of transmission of infectious deceases, HIV and HPV among others (Zhu *et al.*, 2017, Albero *et al.*, 2012, Grund *et al.,* 2017). In both Denmark and Iceland, the health authorities use other methods to prevent these deceases. But since some widely recommended prevention methods (vaccine and condoms) are viewed with skepticism among certain groups, the health and prevention benefits of male circumcision should not be entirely discarded.

On these grounds, the Danish Jewish Community agree with Gammeltoft Hansen's conclusion, according to which a legal ban on ritual circumcision of boys will not be consistent with the ECHR.

Some have argued that circumcision of boys is in conflict with the child's right to physical integrity as described in the United Nation's Convention on the Rights of the Child. In the above quoted article, Gammeltoft Hansen rejects this notion. Furthermore, it should be noted that no country in the world considers this the correct interpretation of the Convention of the Rights of the Child despite of the fact that an estimated 30% of all men in the world are circumcised. Non-medical circumcision is not a common practice in Scandinavia, but 58% of all American men are circumcised.

We are certainly aware that the matter of ritual circumcision is highly controversial in a society where this tradition is not common. It is often overlooked, however, that the issue at the heart of this controversy is the question of parents' right to pass on their religious faith and spiritual worldview to their children and the child's right to be raised in the religion, tradition and culture of his parents and family. Jewish circumcision of boys does not differ from many other choices without notable health consequences for the child which parents make for their children throughout their upbringing.

We shall be very happy to address any questions you may have.

Best regards,

Dan Rosenberg Asmussen
Chairperson

Links:
https://stps.dk/da/nyheder/2013/omskaering-af-drengeboern/~/media/92A1A9B3C9E34F22A855659470CD81FE.ashx
https://www.retsinformation.dk/Forms/R0710.aspx?id=162591
https://beggesider.files.wordpress.com/2017/01/thorup-et-al-2013.pdf
https://tidsskriftet.no/2015/11/kommentar-og-debatt/omskjaering-av-gutter
https://www.ncbi.nlm.nih.gov/pubmed/20158883
https://beggesider.files.wordpress.com/2017/01/bossio_jennifer_a_201509_phd.pdf
https://www.ncbi.nlm.nih.gov/pubmed/26724395
https://beggesider.files.wordpress.com/2018/03/shabanzadeh-during-frimodt-mc3b8ller-2016-dmj-male-circumcision-does-not-result-in-inferior-perceived-male-sexual-function-e28093-a-systematic-review.pdf
https://beggesider.files.wordpress.com/2017/01/pros-and-cons-of-circumcision-_-an-evidence-based-overview.pdf
https://beggesider.files.wordpress.com/2017/01/28653427-circumcision-does-not-have-effect-on-premature-ejaculation-a-systematic-review-and-meta-analysis.pdf
https://beggesider.files.wordpress.com/2018/03/ullmann-et-al-2017.pdf
https://beggesider.files.wordpress.com/2018/03/zhu-et-al-2017.pdf
https://beggesider.files.wordpress.com/2017/01/male_circumcision_and_genital_human-5.pdf
https://beggesider.files.wordpress.com/2018/03/piis2214109x17303698.pdf

Frá: tomer benner [mailto:benner_tomer@yahoo.com]
Sent: 2. febrúar 2018 12:09
Til: Silja Dögg Gunnarsdóttir ; Ólafur Þór Gunnarsson ; Inga Sæland ; Bjarkey Olsen Gunnarsdóttir ; Ólafur Ísleifsson ; Jón Þór Ólafsson ; Guðmundur Ingi Kristinsson ; Líneik Anna Sævarsdóttir ; Björn Leví Gunnarsson ; Ritstjóri vefsins
Efni: Against Circumcision of Children - Jews support bill 183

Dear Parliament Member,

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls.

As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israeli's to leave our children intact (un-circumcised).

Circumcision of a child unable to consent is genital mutilation. It is an irreversible surgery that robs the child of an important body part.

Thank you for having the courage to protect children and fight for this important bill.

Sincerely,

Tomer Benner

UMBOÐSMAÐUR BARNA

Allsherjar- og menntamálanefnd Alþingis

Reykjavík, 28. mars 2018

Efni: Frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 114. mál.

Vísað er í tölvupóst frá nefndasviði Alþingis, dags. 7. mars sl., þar sem óskað er eftir umsögn umboðsmanns barna um framangreint frumvarp.

Með frumvarpinu er lögð til sú breyting á ákvæðum almennra hegningarlaga, nr. 19/1940, að bann verði lagt við umskurði drengja en um útvíkkun er að ræða á núgildandi banni við að fjarlægja kynfæri að hluta eða öllu leyti hjá stúlkum.

Á undanförnum árum hefur orðið mikil framþróun á sviði mannréttinda og ekki síst í málefnum barna. Barnasáttmálinn kveður á um mannréttindi barna sem eru sjálfstæð og óháð réttindum annarra. Börn eiga rétt á að segja sína skoðun í málum sem þau varða og fá stigvaxandi rétt til að hafa áhrif á eigið líf, sbr. 12. gr. Barnasáttmálans, sbr. lög nr. 19/2013.

Umboðsmaður vísar jafnframt til sameiginlegrar yfirlýsingar umboðsmanna barna á Norðurlöndunum og sérfræðinga í barnalækningum frá 30. september 2013. Þar var sett fram það álit að umskurður drengja án læknisfræðilegra ástæðna brjóti gegn ákvæðum Barnasáttmálans. Í yfirlýsingunni er vísað til þess að Mannréttindaráð Sameinuðu þjóðanna hafi hvatt aðildarríki Sameinuðu þjóðanna til að stöðva inngrip sem eru skaðleg friðhelgi og heilbrigði barna, drengja jafnt sem stúlkna. Í yfirlýsingunni kemur einnig fram að það sé grundvallaratriði að réttindi foreldra séu ekki ríkari en réttur barna til líkamlegrar friðhelgi. Það sem er barni fyrir bestu skuli ávallt hafa forgang, jafnvel þó það takmarki rétt fullorðinna til að iðka trú sína eða halda í heiðri siði.

Gerir yfirlýsingin jafnframt grein fyrir því að umboðsmenn barna ásamt þeim sérfræðingum í barnalækningum sem rituðu undir hana vilji beita sér fyrir því að eingöngu verði heimilt að umskera drengi í þeim tilvikum þar sem drengur hefur náð þeim aldri og þroska að geta skilið nauðsynlegar læknisfræðilegar upplýsingar og hefur veitt samþykki sitt fyrir aðgerðinni. Loks

óskuðu umboðsmenn og sérfræðingar eftir umræðu sem einkennist af gagnkvæmri virðingu, milli allra þeirra sem hlut eiga að máli, um hvernig unnt er að veita drengjum sjálfsákvörðunarrétt um framkvæmd umskurðar.

Í yfirlýsingunni eru ekki settar fram tillögur um hvernig bann við umskurði skuli útfært en ekkert Norðurlandanna hefur í löggjöf innleitt slíkt bann. Mikil umræða hefur átt sér stað á Norðurlöndunum um mögulegt bann við umskurði drengja og hefur umboðsmaður barna í Noregi. gefið út að hann styðji framangreint frumvarp.

Í Svíþjóð eru í gildi sérlög um umskurð drengja og kemur þar fram að um þær aðgerðir gildi viðeigandi lög um heilbrigðisþjónustu. Lögin gera kröfu um að forsjáraðilar séu upplýstir af heilbrigðisstarfsmanni um hvað felst í slíkri aðgerð. Einnig á að upplýsa drenginn á sama hátt, í samræmi við aldur og þroska. Þá má ekki framkvæma aðgerð gegn vilja drengs. Þeir einir mega framkvæma umskurð sem eru læknar með starfsleyfi eða þeir sem hafa fengið sérstakt leyfi til þess að framkvæma umskurð sem veitt er af *Inspektionen för vård och omsorg* sem jafnframt fer með eftirlit með leyfishöfum. Nánar er svo kveðið á um framkvæmdina í reglum *Socialstyrelsen.* Framkvæmi einstaklingur umskurð án tilskilins leyfis varðar það sektum eða allt að sex mánaða fangelsisvist. Ákvörðun sænskra stjórnvalda um að heimila umskurði drengja að tilteknum skilyrðum uppfylltum byggir m.a. á skýrslu *Socialstyrelsen* um umskurð frá árinu 2007. Í skýrslunni kom fram að töluvert hlutfall af aðgerðum í Svíþjóð þar sem drengir eru umskornir fari fram utan heilbrigðisstofnana og að mörg dæmi séu um alvarlegar afleiðingar þess. Því taldi *Socialstyrelsen* nauðsynlegt að í löggjöf verði kveðið á um heimild til að framkvæma umskurði á drengjum í viðeigandi og öruggum aðstæðum til að tryggja vernd þeirra og velferð.

Með frumvarpinu er lagt til að 1. málsl. 218. gr. a. verði svohljóðandi: *Hver sem með líkamsárás veldur tjóni á líkama eða heilsu barns eða konu með því að fjarlægja kynfæri að hluta eða öllu leyti skal sæta fangelsi allt að 6 árum.* Umboðsmaður áréttar hér meginreglu íslensks réttar um skýrleika refsiheimilda en ekki er ljóst af frumvarpinu eða greinargerð með því hvort umrætt ákvæði eigi að taka eingöngu til foreldra barns sem taka ákvörðun um að láta umskera barn sitt eða einnig til þeirra sem framkvæma umskurð samkvæmt beiðni foreldra. Umboðsmaður telur brýnt að tekið sé til skoðunar hvort það að svipta barn umönnun og vernd foreldra sinna með þesusm hætti sé raunverulega til þess fallið að tryggja réttindi barna.

Með hliðsjón af öllu framangreindu áréttar umboðsmaður barna að brýnt er að stuðla að því að sjálfsákvörðunarréttur barna og réttur þeirra til andlegrar og líkamlegrar friðhelgi sé virtur í hvívetna og að gripið sé til viðeigandi ráðstafana til að tryggja þann rétt á öllum sviðum samfélagsins. Þá fagnar umboðsmaður þeirri miklu samfélagslegu umræðu sem framlagning frumvarpsins hefur stuðlað að um réttindi barna í íslensku samfélagi og það flókna samspil ýmissa réttinda sem á reynir í þessu samhengi. Sú mikilvæga og nauðsynlega umræða er þó enn á upphafsstigum og þarf tíma til að þroskast.

Loks er vert að geta þess að umboðsmaður barna hér á landi hefur gefið út álit sem varða líkamleg inngrip á börnum eins og aðgerðir á intersex börnum. Þar kemur fram skýr afstaða

umboðsmanns um að ekki sé rétt að gera aðgerðir á kynfærum barna fyrr en þau hafa náð aldri og þroska til að taka upplýsta ákvörðun. Börn njóta réttar til mannlegrar reisnar og friðhelgi einkalífs og er sá réttur m.a. tryggður í 71. gr. stjórnarskrárinnar og 16. gr. Barnasáttmálans. Í þeim rétti felst einnig réttur til líkamlegrar friðhelgi. Í þessu samhengi er rétt að íhuga hvort æskilegt sé að fara þá leið að kveða á um bann við umskurði drengja með breytingu á almennum hegningarlögum eins og frumvarpið gerir ráð fyrir. Að mati umboðsmanns barna færi betur á því að slíkt yrði gert með setningu sérstakrar löggjafar um kynrænt sjálfræði, eins og fjallað er um í stjórnarsáttmála ríkisstjórnarinnar, sem myndi tryggja einstaklingum, börnum jafnt sem fullorðnum, rétt til líkamlegrar friðhelgi og sjálfræðis um breytingar á kynfærum og kyneinkennum.

Virðingarfyllst,

Salvör Nordal,
umboðsmaður barna

Nefndasvið Alþingis
Austurstræti 8-10
150 Reykjavík

28. mars 2018

Efni: Umsögn UNICEF á Íslandi um frumvarp til laga um almenn hegningarlög (bann við umskurði drengja).

UNICEF á Íslandi vísar til erindis nefndarsviðs þar sem samtökunum var gefið tækfæri til að gefa allsherjar- og menntamálanefnd Alþingis umsögn um mál nr. 114, frumvarp til laga um almenn hegningarlög (bann við umskurði drengja).

UNICEF á Íslandi vill byrja á því að fagna þeirri umræðu sem hefur átt sér stað í þinginu um Barnasáttmálann og réttindi barna í kjölfar þess að málið var lagt fram. Sú umræða hefur tekið á mörgum hliðum sáttmálans og er það gleðilegt að sjá hversu margir þingmenn hafa kynnt sér Barnasáttmálann og réttindi barna á Íslandi. Slík umræða mun skila sér í ríkari umræðu um velferð og réttindi barna í fleiri málum í meðförum þingsins.

Réttindi barna eru að mörgu leiti háð túlkun og menningar- og lagalegu umhverfi aðildarríkja Barnasáttmálans. Mikilvægt er að reglulega eigi sér stað umræða þar sem ólíkir málaflokkar, starfshættir, reglur, siðir og venjur eru endurmetin út frá réttindum barna, þekkingu og menningarlegu samhengi á hverjum og einum stað, á hverjum tíma.

Samtökin eru sammála því markmiði laganna sem lítur að því að banna læknisfræðilega óþörf inngrip í líkama barna. UNICEF á Íslandi vill þó taka fram að skoða þurfi þessi mál á heildstæðari hátt og taka inn í umræðuna öll óþörf læknisfræðileg inngrip í líkama barna. Eru samtökin þá að horfa til réttinda allra barna, meðal annars intersex barna og þeirra aðgerða sem framkvæmdar eru á kynfærum þeirra áður en þau ná aldri til að hafa áhrif á þá ákvörðun.

UNICEF á Íslandi leggur til að umræðan um efni frumvarpsins fari fram á almennari grundvelli en frumvarp þetta gerir og að tryggt sé að ólíkum trúarbrögðum sé sýnd nærgætni í þeirri umræðu. Þar sem að frumvarpið beinist að inngripum sem tengjast siðum tiltekinna trúarhópa er nauðsynlegt að víkka umræðuna og umfang frumvarpsins með það að markmiði að gæta jafnræðis og mismuna ekki börnum eftir trú eða lífsskoðunum sem foreldrar þeirra kunna að fylgja. Hætt er við því að með því að gera umskurð refsiverðan samkvæmt hegningarlögum gefi það ákveðnum trúarhópum þá upplifun að þeir séu ekki velkomnir eða að þeim sé mismunað hér á landi. UNICEF leggur því til að efni frumvarpsins verði frekar komið fyrir í heilbrigðislögum.

Virðingarfyllst,

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Nefndasvið Alþingis
v/Austurvöll
B.t. allsherjar- og menntamálanefndar,
101 Reykjavík

Reykjavík, 28. mars 2018
Tilvísun: UTN18020022/26.M.001; 36.A.001; 73.F.001; 97.B.142
MGP/--

Utanríkisráðuneytið sendir nefndasviði Alþingis hér með eftirfarandi umsögn um frumvarp til laga um breytingu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja, 148. löggjafarþing 2017-2018, þingskjal 183 – 114. mál), sbr. umsagnarbeiðni allsherjar- og menntamálanefndar nr. 10123 frá 12. mars sl.:

Framangreint frumvarp felur í sér að 1. málsliður 218. gr. a í almennum hegningalögum nr. 19/1940, sem leggur refsingu við því að valda tjóni á líkama eða heilsu stúlkubarns eða konu með því að fjarlægja kynfæri að hluta eða öllu, er breytt svo að efni greinarinnar nái einnig til drengja. Orðast málsgreinin svo: *Hver sem með líkamsárás veldur tjóni á líkama eða heilsu barns eða konu með því að fjarlægja kynfæri að hluta eða öllu leyti skal sæta fangelsi allt að 6 árum.*

Í umsögn sinni beinir utanríkisráðuneytið sjónum sínum í fyrsta lagi að alþjóðlegum skuldbindingum, í öðru lagi viðbrögðum utan úr heimi vegna framlagningu frumvarpsins og, í þriðja lagi, er þess freistað að meta hvaða áhrif í alþjóðlegu tilliti frumvarpið kynni að hafa verði það samþykkt í óbreyttri mynd. Eðli máls samkvæmt fjallar utanríkisráðuneytið ekki um læknisfræðilega eða trúarlega þætti málsins sem þó er mikilvægt að vega og meta í umfjöllun um frumvarpið.

Mannréttindi eru grundvallarstef í utanríkisstefnu Íslands, þ.m.t. réttindi barna, og sér þess víða merki í málafylgju Íslands á erlendum vettvangi, hvort heldur sem er innan alþjóðastofanana eða tvíhliða gagnvart einstökum ríkjum. Ísland er einnig aðili að ýmsum alþjóðlegum samningum sem vernda mannréttindi og mannhelgi, þ.m.t. samningi Sameinuðu þjóðanna um réttindi barnsins (barnasáttmála SÞ) og Mannréttindasáttmála Evrópu.

Í umfjöllun um frumvarpið, og raunar í áranna rás, hefur verið bent á, meðal annars af hálfu umboðsmanna barna á Norðurlöndunum, að umskurður drengja kunni að stangast á við einstaka ákvæði barnasáttmála SÞ, meðal annars 12. gr. og 3. mgr. 24. gr. Utanríkisráðuneytinu er ekki kunnugt um að reynt hafi á túlkun barnasáttmálans að þessu leytinu til fyrir þar til bærum úrskurðaraðila líkt og dómstóli. Raunar er ekki fjallað um umskurð í barnasáttmálanum, heldur fjalla ofangreindar greinar um rétt barna til að hafa áhrif á eigið líf og vernd gegn hefðum sem eru skaðlegar heilbrigði barna. Hér er ennfremur

mikilvægt að gera skýran greinarmun á umskurði drengja og umskurði stúlkna, en hið síðarnefnda er aðgerð af allt öðrum toga og telst líkamsárás í laganna skilningi og refsivert athæfi.

Í samræmi við áherslur stjórnvalda í mannréttindamálum, þ.m.t. réttindi barna, telur utanríkisráðuneytið rétt að túlka vafaatriði börnum í hag og segja má að andi barnasáttmálans og ofangreindra ákvæða samræmist illa umskurði á drengjum. Sömuleiðis má líta til þess að frumvarpið miðar að því að veita drengjum ákveðna lagalega vernd sem stúlkubörn og konur njóta nú þegar með afgerandi hætti. Í þeim tilvikum þar sem ekki er um nauðsynlega læknisfræðilega aðgerð á drengjum að ræða væri því ákjósanlegast ef ákvarðanir um inngrip af þessu tagi yrðu ekki teknar fyrr en viðkomandi einstaklingur hefði nægilegan þroska til að taka upplýsta ákvörðun um hvort framkvæma skuli aðgerðina.

Að þessu sögðu verður ekki framhjá því litið að umskurður á drengjum ristir djúpt í lífi fjölmennra trúar- og menningarhópa og hefur um aldir. Því hefur Alþjóðaheilbrigðisstofnunin talið nauðsynlegt að umskurður á drengjum séu framkvæmdur á eins öruggan máta og mögulegt er, af þjálfuðu heilbrigðisstarfsfólki og við bestu læknisfræðilegu aðstæður sem völ er á. Þessi afstaða er í samræmi við framkvæmdina sem er í gildi á hinum Norðurlöndunum sem ekki hafa farið þá leið að banna umskurð á drengjum, heldur gert að skilyrði að slíkar aðgerðir séu einungis framkvæmdar af viðurkenndum læknayfirvöldum með samþykki drengsins eða forráðamanni hans.

Viðbrögð við framlögðu frumvarpi erlendis frá hafa verið töluverð. Sendiráð Íslands í Evrópu og Norður-Ameríku, einkum í Þýskalandi, Bandaríkjunum og Bretlandi, hafa móttekið fjölda erinda frá einstaklingum og samtökum sem flest eiga það sammerkt að vera gagnrýnin á frumvarpið. Í þeim efnum er algengast að vísað sé til trúfrelsis og mikilvægi þess að trúfrelsi annarra sé virt. Fjölmiðlaumfjöllun í þessum ríkjum hefur einnig verið nokkur og mörg af stærstu samtökum Gyðinga verið áberandi í umræðunni. Einnig hafa þó borist nokkur erindi, greinar og viðtöl sem lýst hafa stuðningi fyrir frumvarpið.

Sendierindrekar einstakra ríkja gagnvart Íslandi hafa spurst fyrir um frumvarpið og í einstaka tilvikum lýst áhyggjum sínum af afleiðingum þess verði það að lögum. Þá hafa borist ábendingar frá háttsettum einstaklingum innan alþjóðakerfisins um að, þrátt fyrir augljósan góðan ásetning og með réttindi barns að leiðarljósi, gætu lög í þessa veru verið túlkuð sem andúð gegn ákveðnum trúar- og menningarheimum og þannig alið á öfgahyggju á tímum þar sem mannréttindi eiga mjög undir högg að sækja á heimsvísu.

Í viðbrögðum sínum hefur utanríkisþjónustan lagt áherslu á eðli þingstarfa í rótgrónu lýðræðisríki þar sem réttur þingmanna til að leggja fram lagafrumvörp og þingsályktunartillögur er ríkur hluti af lýðræðishefðinni. Jafnframt hefur, að höfðu samráði við Alþingi, verið bent á leiðir til að koma sjónarmiðum og erindum á framfæri í hinu þinglega ferli, sem er sé mjög gegnsætt og opið fyrir ólíkum skoðunum, meðal annars í umsagnarferli.

Ekki er einfalt að meta hver viðbrögð yrðu erlendis frá ef frumvarpið yrði óbreytt að lögum. Þó er ljóst á umskurður á drengjum á sér mjög djúpar rætur í trúar- og menningarlífi Gyðinga og Múslima, en einnig óháð trú líkt og í Bandaríkjunum og mörgum ríkjum Afríku. Hér er því ekki um fámenna jaðarhópa að ræða, heldur hóp sem gæti talið um þriðjung mannkyns. Af þessum sökum er ekki útilokað að málið setti Ísland í neikvætt ljós á meðal fjölmargra aðila og hefði áhrif á íslenska hagsmuni – til skemmri tíma hið minnsta.

Utanríkisráðuneytið gerir sér glögga grein fyrir megintilgangi frumvarpsins og styður

viðleitni löggjafans að stíga skref í þessa átt, enda í anda mannréttindastefnu stjórnvalda. Í þeim efnum teldi ráðuneytið þó ákjósanlegra að gæta meira jafnvægis gagnvart andstæðum sjónarmiðum og fara þá leið sem önnur Norðurlönd hafa farið – að geta þess í lögum að umskurður á drengjum sé einungis heimilaður ef aðgerðin er framkvæmd af þartilbærum og viðurkenndum læknayfirvöldum og með samþykki drengs eða forráðamanni hans.

F.h.r.

Matthías G. Pálsson

Nefndarsvið Alþingis
b.t. allsherjar- og menntamálanefndar Alþingis
Austurstræti 8-10
150 Reykjavík
2018-03-12

Umsögn Vantrúar um frumvarp til laga um breytingu á almennum hegningarlögum, nr. 19/1940 (bann við umskurði drengja), 148. löggjafarþing - þingskjal 183 - 114. mál

Við hvetjum Alþingismenn að hafa í huga að þó eitthvað sé réttlætt með vísun til hefðar, trúar eða trúartexta, þá er það ekki sérstök rök fyrir því að háttsemin sé lögleg ef góðar ástæður hafa komið fram til að banna hana, til dæmis ef hún er skaðleg og/eða stangast á við réttindi annara.

Sem dæmi má benda á að í ýmsum þekktum trúarritum er sagt að grýtingar og aflimanir séu refsingar sem beita eigi en sú háttsemi myndi brjóta gegn ákvæðum stjórnarskrár Íslands um dauðarefsingar og ómannúðlegar refsingar.

Fullyrðingar um að þetta sé á einhvern hátt brot á trúfrelsi foreldra á ekki við rök að styðjast þar sem að trúfrelsi felur ekki í sér rétt til þess að brjóta gegn heilsu, rétti eða frelsi annarra (samanber 9. greinar Mannréttindasáttmála Evrópu).

Fullyrðingar um að trúarbrögð sem boða ólöglega háttsemi verði ólögleg eða að áhangendur þeirra trúarbragða bannaðir hér á landi eiga ekki við rök að styðjast. Einungis er verið að leggja bann við þá háttsemi sem löggjafinn telur valda öðrum einstaklingi skaða.

Sem dæmi þá kenna vottar Jehóva að blóðgjafir séu óheimilar. Þrátt fyrir það er læknum skylt að gefa börnum votta blóð við vissar kringumstæður. Trúarbrögð þeirra eru samt ekki ólögleg og vottar Jehóva eru hvorki bannaðir né óvelkomnir hér á landi.

fyrir hönd Vantrúar,
Sindri Guðjónsson, formaður Vantrúar

20.3.2018

Til Nefndasviðs Alþingis

Ég, Vilhjálmur Örn Vilhjálmsson, sem er búsettur í Danmörku, óska hér með eftir því að það erindi sem birtist hér:

https://postdoc.blog.is/blog/postdoc/entry/2213333/

á einu blogga minna, verði móttekið sem umsögn mín um þingmál, þ.e. sem umsögn um breytingartillögu á almennum hegningarlögum nr. 19/1940 (bann við umskurði drengja); Þingskjal: 183-114. mál .

Virðingarfyllst,

Vilhjálmur Örn Vilhjálmsson, Ph.D.
Jelsbuen 1
2620 Albertslund
Danmark

20.3.2018 | 09:00

Bréf til Alþingis vegna umskurðarbannstillögunnar

Það er afar áhugavert að lesa bau bréf sem háttvirtu Alþingi hafa þegar borist vegna tillögu nokkurra þingmanna til að banna umskurð drengja - og um leið gera foreldra þeirra að ótíndum glæpamönnum. Ég hef nú lesið þessi bréf. Ágæt bréf eru þarna inni á milli, en fyrir utan bréf frá samtökum gyðinga erlendis og þeirra sem þekkja til umskurðar, þá er þarna þunnur þrettándi frá öfgamönnum, kynlegum kvistum og sérvitringum. Mér þykir leitt að sjá slík bréf.

Mér þykir líka leitt að sjá að bréf hafi ekki borist frá gyðingum á Íslandi eða múslímum, en afstaða þeirra er hins vegar vel þekkt og ekki þarf að fara í grafgötur með þær. Réttur þeirra er tryggður. Á Íslandi er trúfrelsi. Tillaga fólksins sem eyðir tíma Alþingis með tillögu um umskurðarbann er fyrst og fremst árás á trúfrelsi og á aldagamla siði minnihlutahópa. Tillaga, sem ætlað er að banna umskurð drengja er í rauninni ekkert annað en lögbrot. Réttur til umskurðar er tryggður með trúfrelsi.

Þegar maður les skoðanir margra Íslendinga um þetta mál verður manni fljótlega ljóst að fordómar og kynþáttahatur ræður ferðinni hjá mjög mörgu fólki í þessari umræðu um bannið. Það er í raun meira áhyggjuefni en trúarlegur umskurður að mínu mati.

Nú skulu nefnd þrjú dæmi um furðulegustu bréfin sem send hafa verið Alþingi í þeim tilgangi að hafa áhrif á störf löggjafavaldsins í landinu.

1) Eitt bréfanna er frá **Gísla Gissurarsyni**, lesið bréf hans til Alþingis. Sami maður hefur skrifað um gyðinga á veraldarvefnum og kallað þá "sub-Humans", sem er ensk þýðing á því sem nasistar kölluðu *Untermenschen* og áttu þeir m.a. við gyðinga er þar orðskrípi var notað. Gísli Gissurarson hefur algjörlega dæmt sig úr leik og bréf hans til Alþingis er móðgun við öll frelsisgildi sem Íslendingar hafa ákveðið að fylgja (sjá frekar hér).

2) Annar bréfritari er **Jacob Sysser**, sem skrifar bréf til Alþingis sem höfðaði greinilega svo til eins þingmanns pírata, Jóns Þórs Ólafssonar, að hann birti það á FB sinni (MYND). Sysser sem ættaður er frá Rússlandi, en búsettur í Riga og Helsinki, og er ekki gyðingur. Hann hefur heillast af jiddísku sem hann hefur lært og sótt námskeið í, en fyrir utan það eru sambönd hans við söfnuði gyðinga engin. Þegar hann skrifar Alþingi, mætti á orðalaginu halda að hann væri erindreki frjálslyndra gyðinga, en hann talar í raun einvörðungu fyrir sjálfan sig.

Yaron Nadbornik formaður gyðingasamfélagsins í Finnlandi hefur tjáð mér að Sysser sé ekki þekktur í neinum söfnuði gyðinga í Finnlandi, enda sé þar enginn svokallaður frjálslyndur söfnuður.

Yaron Nadbornik, formaður gyðingasamfélagsins í Finnlandi telur fráleitt að Sysser tali fyrir hönd gyðinga. Sysser er að hans sögn ekki meðlimur safnaða eða samtaka gyðinga í Finnlandi.

Jacob Sysser er hins vegar þekktur fyrir að vera deilugjarn og þrætugjarn á FB síðum manna sem fjalla um jiddísk málefni - en hann hefur engin sambönd við gyðinga og talar ekki fyrir hönd þeirra. Þess má geta að frjálslyndur söfnuðir gyðinga í Danmörku og Svíðþjóð styðja nær heils hugar umskurð. Jacob Sysser er einvörðungu að rita sína persónulegu skoðanir sem koma gyðingum ekkert við. En íslenskir þingmenn hoppa strax á skoðanir hans og telja hann vera umboðsmann frjálslyndra gyðinga. Þetta sýnir á hvaða stigi umræðan er. Þess ber að geta að Skoðun Syssers var birt á Kjarnanum . Ritstjóra Kjarnans var boðin skoðun Syssers á ensku, en hafnaði henni. Hann tjáði þá Sysser að ef grein hans væri þýdd yfir á íslensku, yrði hún birt. Sysser hefur greinilega fundið einhvern sem gat þýtt yfir á íslensku. Þannig varð skoðun manns sem ekki er gyðingur að skoðun frjálslyndra gyðinga um allan heim. Ekki er nú öll vitleysan eins.

Alþingi
Kirkjustræti
150 Reykjavík

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál.

Rennes, 24 March 2018

Ágætu þingmenn Alþingis / Dear Members of the Parliament,

Because of the path my life has taken, I strongly support the bill on the ban on circumcision for males under 18. I was born in France in the 1980's. Up until my late teenage years I had intact genitals but because I suffered from a congenital malformation of the penis I had to be circumcised even though nothing was wrong with my foreskin itself. Ever since this happened, I have found sex not as pleasurable as before, I have suffered from the impact on my body image, I have not felt whole and suffered from the resulting psychological harm. So as a man who can compare the state of being intact and the state of being circumcised, I can testify that circumcision can cause harm, both physical and psychological.

What happened to me prompted me to think about the subject of circumcision. While girls are 100% protected from any cutting of their genitals, I cannot see any reason why boys should not benefit from the same right, why we should keep on considering this infringement on their right to bodily integrity as acceptable. Because of my personal story, I feel strong empathy towards the case of women and men who fight for the right of boys to keep intact genitals. To me having the right to keep one's body intact is simply a basic human right.

Please do what is right and help everybody take a step towards more respect of the individual and one's right to an unharmed body. I am looking towards Iceland with the greatest of hope today.

Thank you for your attention,

Yours sincerely,

Vincent Arnoult

it is not even a disguised way to get rid of jews in Iceland, as we are the only people to celebrate this ritual on male newborns.

a new strategic way to celebrate antisemitism and the elimination of the jewish community.

doctors recommend it as a healthy practice, Icelanders should take this chance to promote it, not to abolish it.

Viviane Amar

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-----Upphaflegt skeyti-----
Frá: Werner [mailto:werner@mogis-verein.de]
Sent: 25. febrúar 2018 16:21
Til: Ritstjóri vefsins
Efni: Bill for banning circumcision of minors

Dear Members of Parliament,

first I'd like to introduce myself:

My name is Werner Erndl, I am Member of "MOGiS e.V.", a German association of victims of sexualized violence against children. In this association I am also member of the working group of men affected from circumcision.

"MOGiS e.V. - A Voice of Those Affected" was fouded in 2009 to represent victims of child sexual abuse. Nowadays we understand ourselves as representatives for those affected of attacs against their sexual

autonomy during childhood.

MOGiS e.V. is member of the German National Coalition for realization for the UN-Convention on the Rights of the Child, we are member of the DgfPI (German Society for prevention and intervention at child abuse and neglecting) and the so called "Bundesforum Männer", the Federal Forum of Men. There we work constructively with specialist lectures and taking part in working groups.

Since 2012 - after the German debate on circumcision - we organize the yearly "World Wide Day of Genital Autonomy", a day that is celebrated on five continents now and supported by NGOs all over the world.

So far to our general work.

I am writig you to support the bill on banning circumcision of boys for non-medical reasons. And to help with material you might see as needful and helpful.

In January 2015 there was a colloquium in Paris, France, with the title "Circumcision - A gesture for the future". This colloquium was organized by the *Association des Médecins Israélites de France (AMIF)* and the *Fonds Social Juif Unifié (FSJU)* and was visited by representatives of the whole european jewish clergy.

Our friends of Droit au corps, a french organization of intactivists, where also present at this event. They transcribed the speeches and translated them from French into English.

The very essence of all that is that the jewish clergy knows and acknowledges that the circumcision of babies

- causes an unavoidable pain to the newborn:

Quote *Mr. Bernard Lobel* (1:46:34):
"The third argument was about the pain, that the baby has no pain and also has no memory of that pain ...

The literature is very poor. I researched on these 3 topics and the responses are remarkable: Today, we know that children do feel pain, and we have a lot of testing to appreciate, many elements which show that the baby is suffering"

- endangers it's life and health

Quote *Mr. Grapin-Dagorno* (1:20:20):
"In newborns, the main complications are mainly of medical bleeding.
Children who really arrive in hemorrhagic shock. It happens. It's not very common, but it happens from time to time. Once we had that little one who had necrosis of the glans. [Inaudible] was called for a child who has a very [inaudible] shock some but not attributed to cardiogenic shock from the pain. Well, that's really rare. [...] And if not on circumcisions that are made in non-surgical conditions, bah you can see everything, [...] near-total ablation of the skin, rods completely buried, amputation of the glans, necrosis of the glans [...] Anyway, there's many and varied complications. And it is not entirely unusual."

- has no medical benefit for the newborn

Quote *Mr. Lobel *(1:43:34): " Apart from the religious rules that require, it is difficult to say that we will protect the child against AIDS in the 7^th or 8th day, or cancer of the penis, and thus what the medical reasons that could offer for circumcision on the 8th day."

- They also know and acknowledge that it is not necessary to circumcise on the 8th day:

Quote *Mr. Zerbib* (2:14:55): "We must not hesitate to refuse a circumcision, to delay it, because in terms of the law all that may endanger the child's life is a priority to avoid at all costs, we must know that we can back, do not do to 8 days if the health of children is at stake"

Here you can find a link to all the public documents:

- The video

http://www.akadem.org/sommaire/themes/vie-juive/les-etapes-de-la-vie-juive/la-circoncision/la-circoncision-en-pratique-04-02-2015-67120_371.php

- The french transcription and the verbatim from memory for the passages when the camera had to be switched off

https://docs.google.com/document/d/1HLQHJfcrqSI6uMSJZ7QAnBjm1ISVV-ZWjQTo0DkA9_A/edit

- Machine made translations into English of all that are attached to this e-mail as Microsoft Word documents.

We hope that all this information may help you in case that the attacks and the pressure you have to stand should increase.
The question is not, how many cases of human rights violation happen.
The question is only IF those cases happen.
The question is not, which gender the mutilated child has. The only interesting this is, IF it is a child or an adult.

The question is not, how deep the cut is. It is only important, if a child's genital shall be cut.

Religios freedom is not limited by banning the violation of children's human rights.

May this bill be successful and an example for other parliaments in the world.

Thank you so much and good luck!

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Freundliche Grüße

Werner Erndl

MOGiS e.V. - Eine Stimme für Betroffene

Kopernikusstraße 11
18057 Rostock

Alþingi
Kirkjustræti
150 Reykjavík

March 27, 2017

Ágæta Alþingi / Dear Members of the Parliament

Efni: Umsögn um frumvarp til laga um breytingu á almennum hegningarlögum (bann við umskurði drengja), 148. löggjafarþing, 114. mál. / Regarding the proposed legislation banning non-therapeutic circumcision

I wish to express my strong concurrence with the excellent comments expressed by David Balashinsky, Brian Earp, John Geisheker and Marilyn Milos concerning the above-referenced legislation.

I write separately to convey my own, personal views as a father, and to emphasize (1) the central reality that this proposed legislation is meant to address — a reality that the opponents of this legislation have either treated disingenuously or ignored entirely — the complete lack of a meaningful ethical difference between the non-therapeutic cutting of a girl's genitals and the non-therapeutic cutting of a boy's genitals and (2) the threat to a ***girl's*** right to bodily integrity and autonomy that is presented by the stubborn, unjustified refusal of proponents of male genital cutting to recognize a boy's right to bodily integrity and autonomy.

The proposed legislation simply amends the law restricting non-therapeutic[1] circumcision[2] to those who have reached the age of consent by changing "girls" to "children" to make clear that this age restriction is gender neutral. The many different types of female genital cutting that are already prohibited in Iceland, the United States and most of the rest of

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[1] A "non-therapeutic" procedure is one that is not needed to treat a presently existing, adverse physical, clinical condition. Virtually all genital cutting performed on children is non-therapeutic.

[2] In English at least, "circumcision" is an unhelpful euphemism. As I understand it, the purpose and effect of the proposed legislation is to restrict all non-therapeutic genital cutting to adults capable of giving informed consent. Accordingly, I hereafter use the term "genital cutting" to refer broadly to the non-therapeutic procedures that are the subject of the age restriction imposed by the proposed legislation. As discussed further below, the term "female genital mutilation" or "FGM" is also used to refer to female genital cutting. Because the most commonly performed type of male genital cutting — the type that has been part of a Jewish initiation ritual since approximately 140 A.D. — involves complete amputation of the foreskin or prepuce, removing an intrinsic, essential and functional part of the penis, rendering the glans an external anatomical structure and permanently altering the penis in form and appearance, the term "male genital mutilation" or "MGM" is also used to refer to male genital cutting.

the world include procedures — referred to as "Type 4" FGM — that are no more than the "pricking," "piercing," or "scraping" of the female genital area, and typically do not involve the removal of healthy tissue, or a permanent change to the appearance, form or function of the genitals.[3] A physician is currently a defendant in a criminal action pending in U.S. federal court in Michigan because she is accused of having performed Type 4 FGM on a seven year old girl. If convicted, this physician faces the possibility of a lengthy prison sentence for performing Type 4 FGM on a child.

Although many who engage in Type 4 FGM defend the practice as a matter of parental choice or religious obligation, it is widely considered intolerable and criminalized in Western society, and for good reason. It may be considered a relatively "minor" type of female genital cutting, but let us have no illusions about what is necessarily involved with it. A female, aged between infancy and the age of consent (or even older), is forced to spread her legs so that her most private parts can be cut to satisfy the religious or cultural preferences of her parents or some other third party. What she thinks — or what she may think in the future — about the cutting of her genitals counts for nothing. Her verbal or other protests and her cries are ignored. If she tries to resist, physical force and restraint is used against her.

All of these aspects of Type 4 FGM, as well as the cutting itself, are rightly recognized as so potentially damaging to a girl, so appallingly barbaric, and so inconsistent with her right to control what happens to her own body that when the individual rights involved are weighed against one another, the unavoidable conclusion is that it would be impossible for anyone to decide in good faith that the girl's right to bodily integrity is outweighed by her parents' supposed right to express their religion or culture by forcing a sharp object into her genitals.

But then consider what is necessarily involved with the most commonly performed type of male genital cutting — total foreskin amputation. Again, let us have no illusions about it. A boy, typically an infant, but possibly aged up to the age of consent, is forced to spread his legs so that his most private parts can be cut to satisfy the religious or cultural preferences of his parents or some other third party. What he thinks — or what he may think in the future — about the cutting of his genitals counts for nothing. His verbal or other protests and his cries are ignored. If he tries to resist, physical force and restraint is used against him.

In addition, the total foreskin amputation forced upon him permanently removes unique, healthy, functional, erogenous tissue — skin, nerves, blood vessels, smooth muscle tissue, sebaceous glands — all of which is (by various possible methods) cut, crushed and torn from his penis without possibility of replacement or regeneration.[4] About half the surface area of the penis is taken, leaving a discolored scar that will be a lifelong reminder to the boy of his mutilation. Total foreskin amputation converts the glans from a mostly internal anatomical structure to a permanently external one, radically changing the form and appearance of the penis, and significantly diminishing its functionality. The self-lubricating function of the penis is eliminated, as is the ability to engage in sexual acts that require manipulation of the uniquely flexible foreskin (e.g., movement of the foreskin against the glans and other anatomical surfaces). Sensation in the foreskin is, of course, reduced to zero upon its amputation. Total foreskin amputation is indisputably more invasive and extensive, and its guaranteed adverse physical consequences are more significant, than Type 4 FGM.

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[3] WHO, "Female genital mutilation fact sheet," updated January 2018, available at http://www.who.int/mediacentre/factsheets/fs241/en/

[4] The sensitive anatomical structure that connects the foreskin with the rest of the penis — the frenulum — may or may not be completely removed as part of total foreskin amputation.

Total foreskin amputation is also more painful than Type 4 FGM — so painful that it requires sedation or general anesthetic when performed on a man or older boy. Because sedation and general anesthetic are considered unsafe to give to an infant, infant boys can get only the local anesthetic or analgesic that are considered insufficient to manage the pain of an adult or older child. This is the reason some physicians and others who support amputating the foreskins of male infants cling to the long-discredited myth that infants do not feel pain the way older children and adults do. Often, male infants are given no pain relief at all, because those who amputate their foreskins simply cannot be bothered to incur the cost and time to do so.

Because infants subjected to total foreskin amputation are not given appropriate pain management, and because the cutting involved must be extremely precise in order to avoid damaging the parts of the penis that are not intended to be destroyed, the infant involved must be forcibly restrained to the point of complete immobilization. This is nearly always achieved by placing the infant in a device — called a "circumstraint" — that firmly binds his arms and legs. Because he cannot be given general anesthetic or sedated, the infant is necessarily conscious and fully aware of what is being done to him throughout the amputation, unless and until he passes out from the pain, which is a common occurrence.[5] The pain causes some boys to choke, vomit or stop breathing.[6]

Indeed, the pain of having his penis torn apart is undoubtedly ***more*** intensely and terrifyingly stressful to an infant who cannot be made to understand that the pain (which he cannot, in any event, escape) is temporary and the amputation is an event he (probably) will survive. With no way to control the infant's fear, it escalates quickly to full-blown panic. The "fight or flight" response that is triggered results in a stress test for the boy's entire cardiovascular system. The resulting screaming can cause boys to go cyanotic and suffer collapsed lungs. It is by no means an exaggeration to say that total foreskin amputation performed on an infant is both physical and mental torture.

Each and every argument asserted in support of the proposition that total foreskin amputation is a religious obligation or a parental choice is an argument that has already been asserted in support of the proposition that Type 4 FGM is a religious obligation or a parental choice. As all such arguments in support of Type 4 FGM have been thoroughly rejected — indeed, condemned — by the Western governments that have considered them as invalid or otherwise insufficient in the face of a girl's inherent right to a body free of Type 4 FGM, how can you accept such arguments in support of total foreskin amputation, a practice that is clearly more invasive, extensive, painful and physically harmful, without condoning a blatantly sexist and unjustifiable double standard?

The most charitable comment that can be made about the complete failure of the opponents of this legislation even to recognize, let alone coherently address this question, is that it demonstrates a complete lack of concern about Type 4 FGM, and a complete lack of awareness of their own egregious cultural biases in favor of male genital cutting. A less charitable comment, although possibly more accurate, is that supporters of male genital cutting are well aware of how the restrictions on Type 4 FGM make non-therapeutic infant foreskin amputation completely indefensible, and their preferred solution to their conundrum

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[5] When infant boys pass out from the pain of MGM, the incident is often falsely represented to parents by genital cutting doctors and nurses as sleep.

[6] Janice Lander, *et al.*, *Comparison of Ring Block, Dorsal Penile Nerve Block, and Topical Anesthesia for Neonatal Circumcision*, JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, 1997;278(24): 2157-2162.

will be to seek the de-criminalization of Type 4 FGM. Indeed, there are already signs that apologists for male genital cutting will not hesitate to throw a girl's right to an intact body under the bus if doing so will be seen to provide ethical cover for total amputation of a boy's foreskin. In a 2016 article, two American physicians — both outspoken supporters of total foreskin amputation — argued that the law outlawing FGM in the United States "is likely unconstitutional."[7]

Specifically, these physicians argued that both Type 4 FGM and removal of a girl's clitoral hood — which just so happens to be the type of female genital cutting that most closely resembles a boy's total foreskin amputation — should be tolerated. As these physicians put it: "[I]n a liberal society that accepts male circumcision, room for discussion surrounding the acceptability of [FGM] exists." Or, to put it more precisely, in a world in which the legitimacy of male genital cutting is simply presumed, proponents of male genital cutting will inevitably come to see a girl's right to be free of non-therapeutic genital cutting as a threat to be eliminated. Although they hastened to add that they "do not condone the forcible practice of [FGM] if a child developmentally capable of providing assent declines to do so," that merely begs the question of who may decide whether a particular girl is "developmentally capable of providing assent," or more precisely, capable of asserting her own right to avoid a procedure as intrinsically abhorrent as clitoral hood removal in the face of what is likely to be overwhelming parental pressure to submit to the surgery and a US medical establishment that suddenly seems unwilling to stand up for her.[8] Also left unexplained is why girls not yet "developmentally capable of" dissenting from parental authority in this way do not have a fundamental right to keep their clitoral hoods. And of course, the authors' obvious bias in favor of male genital cutting prevented them from making any statement suggesting that even a boy "developmentally capable of providing assent" has a right to refuse total foreskin amputation.

In 1858, on the eve of the U.S. Civil War, Abraham Lincoln famously said:

"A house divided against itself cannot stand. I believe this government cannot endure, permanently, half slave and half free. . . . It will become all one thing or all the other. Either the opponents of slavery will arrest the further spread of it, and place it where the public mind shall rest in the belief that it is in the course of ultimate extinction; or its advocates will push it forward, till it shall become lawful in all the States, old as well as new — North as well as South."

Similarly, a world where the right to bodily integrity is recognized for girls but not for boys cannot endure. The world will soon be forced to decide: either all children have the right to an intact body, or none do. Like it or not, you cannot now step back from this historical moment without risking grave consequences for the rights of all children, male and female. Your failure to act decisively will only prolong an untenable situation, and invite opponents of a boy's right to bodily integrity to make their challenges to a girl's right to bodily integrity become louder and more serious.

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[7] Arora KS, Jacobs AJ Female genital alteration: a compromise solution Journal of Medical Ethics 2016;42:148-154.

[8] As recently as 2010, the American Academy of Pediatrics also argued that Type 4 FGM should be permitted by Federal and State laws because it is "much less extensive than routine newborn male genital cutting." Pediatrics 2010;125:1088-1093 at p1092. (www.pediatrics.org/cgi/doi/10.1542/peds.2010-0187).

A person's right to express his religious or cultural beliefs must end where the flesh and blood of another person — especially a child — begins. Let this irrefutable principle guide your decision.

Respectfully submitted,

William Cooney
Rockville Centre, NY, USA

From: Yaron Revah [mailto:yaron20@gmail.com]
Sent: 4. febrúar 2018 06:12
To: Yaron Revah <yaron20@gmail.com>
Subject: Against Circumcision of Children - Jews support bill 183

Dear Parliament Member,

I am writing to express my strong support for bill 183 which will criminalize circumcision (genital mutilation) of underage boys and girls.

As a Jewish Israeli, I wish to let you know that there is a rapidly growing movement among Jews and among Israeli's to leave our children intact (not-circumcised).

Circumcision of a child unable to consent is genital mutilation. It is an irreversible surgery that robs the child of an important body part.

Thank you for having the courage to protect children and fight for this important bill.

Sincerely,

Yaron Revah

Your Whole Baby™

27 March 2018

Alþingi
Kirkjustræti
150 Reykjavík

RE: Circumcision Legislation

Ágæta Alþingi,

Kveðjur frá Bandaríkjunum! We are writing to express our support of the proposal to outlaw non-therapeutic male circumcision of minors in Iceland. Our organization's mission is to educate people on the harms of circumcision, the functions of foreskin, and the proper care of intact male genitals in infancy and childhood. We are based in Texas and have thousands of participants in every state of the USA, along with many supporters around the world.

At Your Whole Baby, we advocate for the protection of male, female, and intersex babies and children from non-therapeutic genital surgeries, regardless of parental religious motivations. Some religious leaders have claimed that this legislation is an infringement on the freedom to practice religion. We recognize that while the inability to continue practicing one aspect of their religion is a consequence of this law, it is not the purpose of or motivation for it. Instead, we recognize the legislation is designed to protect human rights, genital autonomy, and the child's right to their own religious freedom.

Although male infant circumcision is prevalent in modern American medical culture, our rates have dropped from over 80% in the 1980s to 58% in 2010.[1] State by state, our government-funded insurance (Medicaid) has stopped paying for this unnecessary procedure; as of 2018, 17 of 50 states no longer provide Medicaid payments for non-therapeutic circumcision.[2]

We applaud Iceland's proposed legislation as progressive, and we believe that your courageous effort can help lead the world toward legal protection of the bodily integrity of all children.

Best Regards,

Jen Williams
Founder & Director
Your Whole Baby, 501(c)(3)

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[1] Centers for Disease Control and Prevention. (2011.) Trends in in-hospital newborn male circumcision—United States, 1999–2010. *MMWR 60*(34), 1167–8.
[2] Circumcision Resource Center. (n.d.) Medicaid funding for circumcision. Retrieved from http://www.circumcision.org/medicaid.htm

P.O. Box 854, Leander, TX 78646 @ info@yourwholebaby.org www.yourwholebaby.org 1-512-956-9921