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Current critiques of the WHO policy on female genital mutilation

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Abstract

In recent years, the dominant Western discourse on "female genital mutilation" (FGM) has increasingly been challenged by scholars. Numerous researchers contest both the terminology used and the empirical claims made in what has come to be called "the standard tale" of FGM (also termed "female genital cutting" [FGC]). The World Health Organization (WHO), a major player in setting the global agenda on this issue, maintains that all medically unnecessary cutting of the external female genitalia, no matter how slight, should be banned as torture and a violation of the human right to bodily integrity. However, the WHO targets only non-Western forms of female-only genital cutting, raising concerns about gender bias and cultural imperialism. Here, we summarize ongoing critiques of the WHO's terminology, ethicolegal assumptions, and empirical claims, including the claim that non-Western FGC as such constitutes an extreme form of discrimination against women. To this end, we highlight recent comparative studies of medically unnecessary genital cutting of all types, including those affecting adult women and teenagers in Western societies, individuals with differences of sex development (DSD), transgender persons, and males. In so doing, we attempt to clarify the grounds for a growing critical consensus that current anti-FGM laws and policies may be ethically incoherent, empirically unsupportable, and legally unsustainable.

Key words: female genital mutilation, female genital cutting, the right to bodily integrity, cultural bias, intersex genital cutting, differences of sex development, male genital cutting, male circumcision, transgender

Introduction

The last several years have seen dramatic shifts in the scholarly literature on medically unnecessary female genital cutting (FGC),[1] often referred to as female genital mutilation or "FGM" when performed in non-Western contexts or by non-Western actors (see Appendix 1). Historically, the focus has been on sexual and other health risks associated with the most extreme, primarily African forms of FGC, analyzed within a particular ethicolegal discourse geared toward promoting human rights for women and girls, including the right to be free from gender-based violence (3). In the last decade or so, several streams of interdisciplinary research have converged to complicate what has been called "the standard tale" about FGC (4) – according to which it is primarily an instrument of male dominance over female sexuality – as scholars have begun to integrate insights from studies into a wider range of medically unnecessary genital cutting practices. These include practices affecting persons with so-called intersex/variations of sex characteristics (IVSC) or differences of sex development (DSD) (5–7), those born with characteristically male genitalia (both boys/men and transgender women),[2] and women and adolescent girls seeking "cosmetic" genital procedures in Western countries (see Appendix 2 for a selective bibliography of this comparative research).

The emerging critical consensus appears to be that many popular beliefs about African, Middle Eastern, and Southeast Asian forms of FGC, including what they involve, why they are done, and how they affect women's health and sexuality, are based on

[1] According to the Brussels Collaboration on Bodily Integrity (1), "an intervention to alter a bodily state is medically necessary when (a) the bodily state poses a serious, time-sensitive threat to the person's well-being, typically due to a functional impairment in an associated somatic process, and (b) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat." Definition based on (2).

[2] There is now growing recognition that some people born with penises may not identify as boys/men, such as transgender women and some genderqueer individuals (8–10). At the same time, "the potential harms of neonatal or early-childhood [penile] circumcision for trans women who elect a penile inversion surgery—as a part of gender-affirming care, for example—has yet to receive much attention … the preemptive removal of a large proportion of sensitive, elastic genital tissue from the penis that could otherwise have been used in the construction of a neovagina—i.e., the penile foreskin—is undoubtedly of relevance to the welfare interests of such women" (11).

misleading, oversimplified, or false empirical assumptions (often involving inappropriate extrapolations from non-representative cases), or top-down theoretical models that fail to account for the observable diversity of genital cutting practices across societies (12–16). Consequently, mainstream legal, ethical, and policy responses premised on such beliefs have increasingly been criticized as culturally biased, incoherent, unsustainable, and even harmful to affected individuals and populations, including children and vulnerable minority women. In this review, we highlight some of the key areas in which dominant ways of thinking about FGC have been challenged by recent scholarship, and point to important open questions that need to be carefully addressed in future research.

Terminology and definitions

One recurring point of contestation is the very terminology to be used in describing the cluster of practices in question. The most common starting point in referring to this cluster is the World Health Organization (WHO) typology of "female genital mutilation," defined as "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (17) (see Appendix 1). These procedures range from ritual pricking or nicking of the clitoral hood, without removal of any genital tissue (an instance of FGM Type IV on the WHO typology) to partial removal of the clitoral hood (FGM Type Ia) to cutting of the labia without modification of the clitoris (FGM Type IIa) to excision of some portion of the external clitoris – i.e., the clitoral glans and sometimes part of the shaft/body – with or without modification of the labia (FGM Type Ib) to narrowing of the vaginal opening, with or without modification of the external clitoris (FGM Type III). The appropriateness of applying the term "mutilation" to all of these procedures as such (that is, without regard to their severity, their typical or likely consequences, the means by which they are carried out, the context in which they occur, the reasons for which they are done—apart from ill-defined "medical reasons"—or even the

capacity of the affected person to consent), has been questioned on several grounds. Concerns that have been raised in the scholarly literature include the following:

(1) The term is **imprecise**, conflating multiple distinct procedures done by different groups in different ways for different reasons, with widely varying consequences for health and sexuality (15,18–25).

(2) The term is **inaccurate** (on standard dictionary definitions), as some included procedures, such as ritual nicking or pricking, do not remove tissue, may cause no lasting functional impairments, and often result in no visible change to the morphology of the external female genitalia (26–29).

(3) The term is **misleading** with respect to the characteristic motivations of those performing or authorizing the cutting, insofar as it implies an intent to harm or disfigure: parents of all cultural backgrounds who request a genital cutting procedure for their child—female, male, or intersex/DSD—virtually never take themselves to be causing net bodily harm or disfigurement; rather, the typical aim is to improve or enhance the child's body in line with locally-prevailing sociomedical, religious, aesthetic, or (other) cultural norms (however objectionable those norms may be to some, including local dissenters and cultural outsiders) (16,19,22,30–39).

(4) The term is **harmful**: it may constitute, or lead to, needless stigmatization of affected women and their bodies/sexuality; many women regard the term as insulting or derogatory, or they may internalize the concept and its connotations, which can have negative consequences for their self-image and self-esteem (Box 1), increase the risk of re-traumatization, and frustrate their ability to enjoy sexual encounters or experiences (16,37,40–45).

(5) The term is **ethnocentric**: it is not applied to forms of medically unnecessary FGC that are more familiar to Western cultures, including forms that may be equally or more invasive or nonconsensual, for example, "cosmetic" labiaplasty—increasingly

performed on young adolescent girls in the US, UK, and elsewhere (46–48)—or clitoral reduction surgeries for intersex/DSD children assigned female at birth (6,20,22,49–61).

(6) The term is **sexist**: the language of "mutilation" is applied indiscriminately to all non-Western forms of medically unnecessary genital cutting affecting females—regardless of severity, intent, or outcome—in official laws and policies, and even in the medical literature, while no form of medically unnecessary intersex/DSD (see Figure 1) or male genital cutting (MGC) is officially described as "mutilation," no matter how severe, degrading, involuntary, unhygienic, risky, disabling, or disfiguring (see Box 2) (52,55,56,62–65).

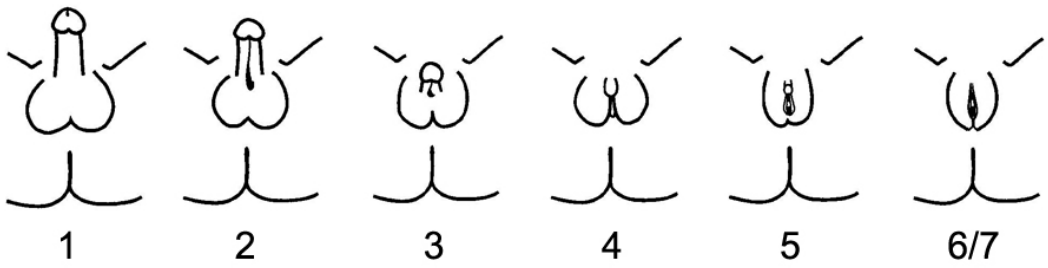

Figure 1. Differences of sex development resulting from androgen insensitivity, ranging from characteristically male genitalia (left) to characteristically female genitalia (right) (66). Some children are born with a clitoropenile organ that is neither determinately male (a penis) nor female (a clitoris). At what degree of feminization or masculinization of this organ should it be considered morally or legally permissible to cut a child's genitals when it is not medically necessary to do so? (67)

For these reasons, in this review, we will use the term "FGC" to refer collectively to the practices included within the WHO typology; where possible, we will use more precise language to refer to particular procedures.

Box 1. Potential negative effects of "mutilation" terminology: a case study

In my opinion, the word 'mutilation' used in reference to [what happened to me] is a degrading and disempowering term that strips women of their dignity and self-worth. Basically, it is a label that has the power to negatively influence one's self-identity. If you understand labelling theory, you will understand how damaging/influential a term or classification can be to an individual …

Having just about survived my ordeal of forced body alteration I was very aware of the violation to my body. However, the introduction of the term 'mutilation' into my consciousness affected me mentally and physically. It made me view myself as an ugly, mutilated, and frowned-upon member of society. There started my journey of self-hate, which presented itself in many forms including bulimia and social anxiety to name but a few. To be called the 'mutilated' girl by health professionals stripped me of any dignity and covered me in shame on numerous occasions. Thankfully, I no longer see myself as a victim or survivor of 'FGM' – I refuse to allow that term to take away my power or to define who I am.

-- personal testimony,
Jay Kamara-Frederick (68)

Box 2. Comparison to male genital cutting (MGC). Adapted from (56,69); internal refs. omitted.

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), to circumcision as it is traditionally performed on male newborns in Judaism and more generally in the United States (tearing of the membrane that fuses the immature foreskin to the head of the penis followed by clamping and excision of the majority of the foreskin), to *metzitzah b'peh* (the same followed by direct oral suction of the wound, risking herpes infection and brain damage, performed among some ultra-Orthodox Jews), to non-sterilized, un-anaesthetized circumcisions performed in the bush during rites of passage in Eastern and Southern Africa, to mass cutting of pre-teen boys carried out on school tables in the Philippines (*tuli*), to forced circumcision of men following political conflict in various countries, to subincision (slicing open the underside of the penis lengthwise, often through to the urethra) in Aboriginal Australia, to castration (now rare but still 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 medicalized, often not), depending on the group in question.

The most common form of MGC is penile circumcision. Penile circumcision involves the partial or total removal of the foreskin of the penis—an elastic sleeve of sensitive tissue that normally covers and protects the penile glans—occasionally to address a medical problem, but most often for ethnoreligious or cultural reasons. In rural settings, such as among the Xhosa of South Africa, deaths as well as penile amputations are common: between 2006 and 2013, more than five thousand Xhosa boys were hospitalized due to botched circumcisions in the Eastern Cape alone, with 453 recorded deaths among this group and 214 penile amputations.

Medical claims

As noted in the previous section, one critique of the WHO definition of "FGM" is that it artificially lumps together and effectively conflates a wide range of disparate practices with different effects carried out by different groups with different tools under different conditions for different reasons. The main unifying factor, then, is the female sex of the affected person. However, the balance of research suggests that "there is too much variability in the types of procedures performed for generalizations about either sex to be useful" in characterizing medical outcomes (70). For example, "it is a vast oversimplification to propose categorically that girls are always harmed by genital surgery and that boys never are. The fact of the matter is that [the harms overlap]" (cf. Appendix 1 and Box 2). As Zachary Androus, an anthropologist who specializes in cross-cultural comparisons of genital cutting, has argued, "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" (70).

Such facile categorization has led to a related concern, which is that when potential health risks of non-Western forms of FGC are raised in the medical literature, as well as in news articles, policy papers, and activist materials, they are usually given in a "laundry list" fashion (3). That is, they are given with little or no attempt to discriminate between the various forms, the quality of evidence for particular claims (15,71–74), the actual likelihood of each risk, and so on. This creates the (false) impression that "FGM" is a monolithic practice with the same adverse consequences of similar severity, regardless of the method or type of cutting or the circumstances in which the cutting is performed (75). What could explain this homogenizing tendency?

One possibility is that there has been a widespread failure to distinguish the moral concept of wrongfulness from that of harmfulness (76). Many people, including policymakers at the WHO, appear to believe that all non-Western FGC is categorically wrongful and a

severe violation of human rights (perhaps especially when done to minors). Meanwhile, studies in psychology suggest that actions are intuitively seen as wrongful only to the extent that they are interpreted as harmful (77,78). Thus, if one is committed to the view that non-Western FGC is extremely wrongful regardless of type or method, there may be a strong psychological pressure to interpret such FGC as extremely harmful without distinction. But this is a non-sequitur. Wrongfulness and harmfulness can come apart:

> one way a person can be wronged is if they are harmed without adequate excuse or justification. But a person can also be harmed without being wronged: for example, if someone accidently and non-negligently bumps into them on a busy sidewalk, causing them to fall and scrape their knee. Finally, a person can be wronged without being harmed: for example, if someone "softly" sexually penetrates them while they are asleep (assuming no prior consent) in such a way that they could never find out, nor suffer any physical or emotional injury. (79)

If that view is right, then at least some forms of FGC could be wrongful, in the sense of showing moral disrespect or violating a person's rights, irrespective of the medical consequences, including the expected level of harm (or benefit) (80,81). A related view is that any nonconsensual interference with a person's sexual anatomy,[3] whether by cutting or "merely" by touching (86,87), is morally impermissible unless the person is non-autonomous (incapable of consent) and the interference is medically necessary (that is, cannot ethically be delayed until consent becomes possible) (1). Indeed, one of us has defended this view in other publications, focusing on the moral importance of consent in many cultures and the special or "private" status of the genitals in the same (88–92). However, even if one accepts such an argument on normative grounds—at least in the relevant cultural contexts or

[3] As a reviewer notes, tattoos and piercings are often restricted for minors, at least in many Western legal jurisdictions, with the exception of ear piercing, which is usually allowed. One possibility, of course, is that ear piercing should not be allowed in such jurisdictions, at least in very young children who cannot provide their own informed consent, so as to bring it in line with other medically unnecessary skin-breaking procedures that might be imposed on pre-autonomous individuals (82). But even if one thinks that infant ear-piercing (for example) should be permitted if the parents give their permission, there could still be reason to oppose medically unnecessary procedures affecting the genitals in particular due to their widely-perceived special or "private" significance in many cultures (83–85). We expand on this view in the concluding section.

ethicolegal environments—this does not absolve them of the need to be precise and accurate when making empirical claims about the medical aspects of genital cutting (39,93).

Simply put, not all risks associated with different types of genital cutting are of the same kind or degree of magnitude, and there is wide variation both within and across types depending on how the cutting is performed. Thus, the actual effects of a given act of cutting on the physical or mental health of an individual depends on "numerous factors, both internal and external to the individual, that transcend the traditional bounds of phenotypic sex" (94). These factors may include:

> (a) the child's age or maturity at the time of cutting; their expectations about, attitudes toward, and appraisals of the cutting experience and the persons who authorized it or carried it out; their emotional sensitivity or resilience; the strength of their identification with the cultural group or sub-group in which they are being raised; their subsequent body image concerns, adult sexual preferences, values concerning bodily integrity and sexual autonomy, and other individual difference variables (*internal*), as well as
>
> (b) the psychological context, ceremonial aspects, and physical setting of the cutting; the means and extent of tissue removal and the type of tissue removed; the use or disuse of pain control, the existence and severity of any complications (beyond the intended effects of the cutting), and other specifics of the intervention itself (*external*). (94)

Failure to consider these factors, or to distinguish the specific risks associated with different types of cutting (for example, citing obstetric complications linked to infibulation in the context of a discussion about ritual nicking) is not just misleading. Rather, it may be harmful to women and girls affected by FGC insofar as it inclines them to "assume the worst" about

their condition, regardless of the type of cutting they experienced or how it was carried out. This, in turn, may lead to negative expectancy effects, catastrophizing cognitions or other maladaptive responses to genital pain (79,95), or other psychologically-mediated harms, which can only add to any adverse effects of the original cutting (40,42).

Another medical claim that has received significant critical attention in recent years is the assertion of the WHO that at least some forms of "FGM" involve the "total removal of the clitoris" (e.g., Type 1b, Type IIb, Type IIc). This claim is false and anatomically unfounded. The clitoris is a "multiplanar" organ (96) whose external, visible portion is analogous to the tip of an iceberg: most of its true length, including the majority of its erectile tissues and structures relevant to orgasm, are internal to the body, beneath the surface of the vulva (97). These tissues and structures are therefore beyond the scope of any recognized ritual form of FGC (74,98) and typically remain intact after cutting. As such, they can often be stimulated, whether directly or indirectly, and may be functional—that is, conducive to sexual pleasure and orgasm—within the normal range of what is measurable for women who have not experienced FGC (31,42,98,99).

This is not to deny that (net) negative outcomes may follow from cutting or removal of the external clitoris, especially if this was unwanted (100,101). To the contrary: "even if it is physiologically possible to have an orgasm after one's external clitoral glans has been excised (or to experience at least some degree of pleasure during sex due to the stimulation of other parts of the vulva/vagina that have not been removed), this does not mean that sex would be no different if one still had one's glans" (88). Among other concerns, any time a sharp object is brought into contact with sensitive genital tissue, the risk of nerve damage, numbness or unpleasant sensations during sexual stimulation, and other problems, is increased by some amount. Some may find any such risk to be intolerable given the nature of the body part in question. Accordingly, "some women who have had [a part] of their genitals removed in childhood—even if they can still enjoy sex—feel upset, angry, violated, and

mutilated" simply because of what was inflicted on an intimate part of their body when they were too young to understand the implications (88). Such feelings of anger and resentment can, themselves, negatively affect sexual enjoyment over and above any physiological effects of cutting and/or removing nervous tissue.[4]

That being said, many women who have been affected by FGC, often upon migrating to a Western country and beginning to explore their sexuality for the first time, are misled to believe that they do not have a clitoris and are (therefore) physiologically incapable of having an orgasm (42). This inaccurate, harmful premise has been upheld by the WHO despite years of scholarly criticism and continues to be reproduced in its official typology. This typology should be revised to reflect what is known about female genital anatomy (120).

Motivations and meanings

According to the WHO, regardless of type, severity, explicit parental motivations, or the cultural or historical background of the community in which it occurs, non-Western FGC "reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women." It also "violates [the] right to be free from torture and cruel, inhuman or degrading treatment" (17). As Ellen Gruenbaum notes, this blanket characterization has had considerable purchase "in the popular media," where explanations for non-Western forms of FGC "are frequently simplistic, emphasizing a single, underlying explanation, such as 'male dominance', and inferring that the purpose is to prevent women's

[4] Similar feelings and associated sexual harms, including decreased sexual satisfaction, have been documented among men, for instance, who were circumcised as children—that is, without their consent—as opposed to in adulthood, with their consent (102,103). As a reviewer notes, some studies suggest that removal of the penile foreskin does not detectably affect certain quantitative somatosensory outcomes based on testing of the penile glans (104). However, similar tests reliably show that the foreskin is, itself, the most sensitive part of the penis to light touch (105–108), so its removal necessary changes the sensory profile of the organ in a way that may be regretted (109,110). Like the clitoral prepuce, the penile prepuce (foreskin) covers, protects, and lubricates the clitoropenile glans (111–115); and like the female genital labia, the foreskin can be manually or orally manipulated during sex, masturbation, or foreplay, eliciting particular subjective sensations that are not possible if this tissue is removed (47,88,116). Insofar as a person positively values the specific sensations afforded by manipulation of the labia or foreskin, the sheer state of being genitally intact, or having a choice about the matter, the non-voluntary removal of these tissues would necessarily harm the person, even in the absence of surgical complications or other (further) effects on genital sensation or function (117–119).

sexual fulfilment" (19). In this, the media fail to distinguish between the various types of FGC and the wide diversity of associated motivations and outcomes, tending instead "to privilege the most serious and damaging practices—especially severe infibulation—the most unhygienic methods, and the most coercive circumstances" (19).

The resulting stereotype of "FGM" in the Western discourse has been effective in motivating support for advocacy campaigns and zero-tolerance legal measures (see the following section); but it is not empirically supportable as a universal account of the symbolic significance of FGC. To begin with, as L. Amede Obiora notes, FGC "does not easily fall within the traditional definition of a gender-specific human rights violation [as it] is usually performed for socio-cultural reasons by predominantly female private actors with the apparent consent of the circumcised or her proxy" (34). Of course, the mere fact that a given practice is carried out primarily by women does not entail that is unrelated to gendered asymmetries in power; women often do participate, however unwittingly, in their own subordination (121). In line with this perspective, it is sometimes argued that women who support, manage, oversee, and even perform FGC in their communities must be victims of brainwashing or false consciousness, having internalized their inferior status to men (25,122). However, this argument is not as straightforward as it may seem.

To begin with, women from affected communities who endorse FGC (usually the majority), regularly report believing that modified genitalia—in both males and females—are more hygienic, more civilized/respectable, and more aesthetically appealing (24,31,33,36). In this, they may note that Westerners have their own surgical practices to "enhance" female genitalia (sometimes performed on minors) (46,123–125), and, in the case of males and intersex/DSD infants, happily allow medically unnecessary genital cutting even when it is clearly nonconsensual (52,56). Perhaps it is the Westerners, then, who are suffering from false consciousness (or at least an undeserved sense of moral superiority). Moreover, since these Westerners have not, themselves, experienced FGC in a non-Western context, they lack

a certain epistemic authority over "what it is like" to undergo such FGC and/or live with its consequences. Hence, they may have certain erroneous preconceptions (126). Either way, as Minow argues:

> Dueling accusations of false consciousness can escalate with no end … You say that women in my culture have false consciousness, but you say this because of your own false consciousness—or I think this because of my own false consciousness, and so forth. These kinds of exchanges are essentially incorrigible. No facts of the matter can prove or disprove false consciousness without a prior agreement about what one ought to want. (122)

Unfortunately, carefully collected "facts of the matter" are not often raised by Western opponents of FGC to critically test the false-consciousness hypothesis, which may in any event be unfalsifiable (127). Rather, it is typically assumed that support for FGC by affected women must be irrational, or, at best, a regrettable psychological adaptation to an unjust situation. However, this assumption has itself been argued to rest on a patriarchal stereotype that ignores, devalues, or denies women's agency despite robust evidence of its existence in the relevant spheres (25,32,35,54,128,129). Minow continues:

> To anyone committed to the advancement of women, questioning a woman's ability to make choices is itself a disturbing reminder of the rationales for denying women choices. Those rationales, historically, pointed to women's vulnerabilities, lack of education, inadequate rationality, overweening emotionality, or other impairments. To question the choices of women who wear scarves, defend and engage in genital cutting, or undergo arranged or polygamous marriages is to echo those arguments for denying women any self-determination. (122)

In addition to this worry, numerous other concerns about the characterization of non-Western FGC as being rooted primarily in male dominance, sexist discrimination, or a controlling desire to undermine female sexual enjoyment have been raised in the literature. These include the following:

(1) The characterization seems to reflect longstanding racist and colonial stereotypes of "primitive" African societies, in which black and brown women, constructed as passive victims of male-oriented cultural practices, need to be rescued from the men in their own villages, who are believed to be brutal and barbaric (25,61,71,130,131).

This is in spite of the fact that:

(2) Virtually all societies that practice medically unnecessary FGC *also* practice medically unnecessary MGC, usually in a parallel ceremony serving similar social functions (16,64,132). In the context of adolescent rites of passage—the typical situation—both boys and girls are expected to show courage in the face of pain and discomfort, thereby "earning" their place among the adults and making themselves eligible for marriage and other social privileges (23,32,34). In this, the rites themselves are on some interpretations both gender-inclusive and egalitarian (more on this below) (74).

(3) Depending on the group, either the male or the female form of cutting may be more severe, risky, or potentially detrimental to sexual enjoyment (56,133–135). The most dangerous and deadly form of genital cutting anywhere in the world appears to be, not FGC, but MGC as it is practiced, for example, among the Xhosa of South Africa (69,136,137) (see Box 2).

(4) When practiced as a rite of passage into adulthood (or as part of a Muslim religious initiation), neither MGC nor FGC is typically intended to undermine the initiate's capacity for sexual pleasure (13,31,138). While a desire to "tame" sexual impulses perceived to be excessive is associated with some forms of genital cutting in some communities, the association is not limited to FGC, but applies to MGC in various contexts as well (16,56,63,139–143). Moreover, in some contexts, FGC is commonly believed to *enhance* sexual sensitivity or enjoyment (138,144,145) (see Box 3).

(5) Almost invariably, where they occur together, men are in charge of the male rites and women are in charge of the female rites, often with little or no mutual knowledge or influence over the workings of the other (35,146,147). Men are usually strictly forbidden from participating in the female ceremonies (and vice versa); and they are often more likely to support transitions to less severe forms of FGC—or even the complete abandonment of FGC—than are the women in their own communities (148–153).

Thus, nowhere in the world are girls "singled out" for degrading genital cutting, much less "inhuman" treatment. Rather FGC is nearly always performed in conjunction with MGC, with the genital cutting and associated ceremonies in both cases often symbolically linked (132,154,155), seen as a means to "civilize" the child by "perfecting" the natural body (36,156). Indeed, the cutting is sometimes understood to distinguish the child from "lower" animals or from nature more generally, thus symbolically humanizing or spiritually elevating him or her: the conceptual opposite of "inhuman" treatment (138,157).

The fact that a practice occurs *within* a society that has unequal gender roles (as nearly all societies do) does not entail that the existence or persistence of the practice itself is best *explained* by such inequality. Generally speaking, there is no consistent relationship between the extent of gender inequality in a given society and whether it practices a form of FGC (16,158). This point has recently been emphasized by the Public Policy Advisory Network on Female Genital Surgeries in Africa, a non-partisan collaboration of scholarly experts on genital cutting. They write: "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 [that selectively target] females" (16). Indeed, if there is a relationship between gender inequality and genital cutting, it may be in the opposite direction to what is typically assumed. After all, some of the most starkly patriarchal societies—traditionally characterized

by greater male power or authority in both public and private spheres—practice *only* MGC, while females are openly excluded from the perceived privilege of having their genitals cut, as in Orthodox Judaism (159–162) (see Box 4).

Box 3. FGC as sexual enhancement? A case study

> Cholida [is an Indonesian doctor] specializing in female circumcision. She also trains midwives and female religious teachers to perform the procedure. She explained that circumcision offered by [her] foundation involves a needle prick to the skin covering the clitoris [WHO FGM Type IV]. A covered clitoris, Cholida said, hampers sexual sensations and gathers bacteria. … "We graze the clitoral hood. Medically and logically, which would be more sensitive? Something covered or uncovered?" Cholida asked. "When we open up the clitoris, sensation is automatically increased. Women often have trouble orgasming. Circumcision takes care of that. Isn't that a form of equality?"
>
> -- reporting by Adi Renaldi and Iqbal Kusumadirezza, translated by Jade Poa (163)

Box 4. MGC and patriarchy. Adapted from (63).

> In his analysis of why Jewish women are not circumcised, Harvard professor 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" (160). Thus, as philosopher 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." As he goes on to state, "A true egalitarian would think it unfair that a boy is cut while a girl is not [and] either extend the burden [of circumcision] to girls or remove it from boys" (159). The sociologist and gender expert 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" (162).

Finally, the introduction and perpetuation of FGC in some societies may, contrary to the assertion of the WHO, best be understood as a form of *opposition* to gender inequality (30,58,164). Because FGC nearly always occurs in societies that also practice MGC, but not vice versa, some scholars believe that the former may have been introduced in imitation of the latter (132,165): a way for women to have their own transformative ceremony which they

alone would control; a separate source of female power, bonding, and solidarity beyond the reach of male influence; a ritual though which the wisdom of mothers and grandmothers could be transmitted over the generations in seclusion from male knowledge or interference (4,30,34,164). Elisabetta Grande writes that age-groups of boys sharing the same circumcision experience "internalize a strong sense of solidarity." Similarly, female genital cutting "strengthens in various ways the bonds among women of the same or of different generations and becomes an important source of group solidarity, mutual aid, exchange and companionship, that in turn is the primary and most important form of *resistance against* male dominance" (58) (emphasis added).

As Obiora notes, explanations of FGC that reduce the practice to an instrument of patriarchy "can be criticized for contradictory and circular propositions that are intrinsic in the idea that men exert a totalized control over the construction of social life." The explanation "obscures the variable ways in which men and women are bound together in social units, institutions, and categories that cross-cut gender divisions [and] essentializes social tensions even when they defy gender boundaries and manifest along generational, socio-economic, or other lines" (34); see also (166–168). Moreover, relying on such a pseudoexplanation risks undermining the efforts of local resisters who are striving to end the practice of FGC in their own societies. As Janne Mende argues, the conflation of "highly different societal mechanisms and the generalization of patriarchy disregards the social, cultural, political, and economic conditions" of FGC. This "not only hinders an adequate analysis and critique of FGC but also jeopardizes the possibility of cooperation [with] the women concerned, since the latter are being misrepresented and not taken seriously in their perspectives, struggles, and incentives" (25).

In a recent article entitled, "We won't eradicate FGM if we keep misunderstanding its history," scholar Sada Mire gives a similar analysis. Mire argues that a lack of knowledge about the more complex, communal roots of FGC has "hampered efforts to tackle the issue"

in a culturally meaningful way (169). An excerpt of Mire's argument, which finds support from other African scholars of genital cutting (170), is presented in Box 5.

Box 5. An account of east African origins of FGC.

> Campaigners often claim the tradition is mainly about virginity, chastity, paternity confidence or control of women's sexuality. I've found that [FGC] began instead as an act of sacrifice to the divine. In other words, the initial intention was not about relations between humans but rather between humans and the gods: an act of self-preservation related to sacred blood, existence itself, and reproduction. In many east African societies, there is a cycle of rituals that male and female children go through, from birth to childhood to adulthood and death. [FGC] is part of this indigenous cultural system. It is not an oddity against women: men have also been harmed through the rituals that take place ahead of a hunt. [FGC-related beliefs] were strong and deep-rooted enough to survive first Christianity and then Islam – religions [which] acknowledged [the practice's] "cultural" value and simply aligned it with their own concepts of chastity and virginity. Abrahamic religions still practice male circumcision. [My] ancestors were not "savage" people who just mutilated their girls to maintain patriarchal dominance … there was a much more collective existential ideology behind it.
>
> -- Sada Mire (169), based on (171)

Legal approaches

Western governments and advocacy groups opposed to non-Western forms of medically unnecessary FGC have overwhelmingly called for—and in many countries, achieved—complete criminalization of all such FGC, again regardless of severity, and in some cases, regardless of the age, desire, maturity, or consent capacity of the girl or woman (128,172,173). Although undoubtedly motivated by good intentions, this "zero-tolerance" legal situation is increasingly argued to be (a) incompatible with Western constitutional provisions ensuring equal treatment based on race, religion, sex, or gender; and (b) potentially harmful to the very people who are meant to be helped and protected. Concerns that have been raised include the following:

(1) The laws may be **unconstitutional**. Virtually all Western constitutions hold that males and females, members of different racial or ethnic groups, and adherents to different religions, must be treated equally before the law. Under current zero-tolerance laws, female ritual nicking, which does not remove tissue and—contrary to common misconceptions—is practiced for explicitly religious reasons within some sects of Islam (174–178), is regarded as a criminal act even if done with pain control and sterile equipment by a medically trained provider (27,179,180). At the same time, nonconsensual male circumcision, which removes roughly 1/3 to 1/2 of the motile skin system of the penis (111,112) including the parts of the organ that are most sensitive to light touch (109), is legally allowed (and in many countries, virtually unregulated), whether or not it is practiced for explicitly religious reasons, and even if done without pain control in an unhygienic manner by a medically untrained provider (181). Thus males and females, as well as Muslims and Jews, and—in practice—white native women and women of different ethnicities or birthplaces (see Appendix 1), are not currently being treated equally before the law (81,173,182–184).

(2) The laws may be **harmful**. In criminalizing non-Western FGC, cases must be brought to court regarding any suspected illegal cutting, no matter how slight. This has led to racial profiling and stigmatization of individuals from communities that no longer practice FGC following migration (185), fear-mongering based on unreliable, inflated statistics concerning girls presumed to be at risk (186–188), separation of vulnerable children from their parents on (suspected) grounds that do not trigger such safeguarding procedures in other ethnic or religious groups with respect to objectively comparable practices (180), exposure of young girls (but not their brothers) to humiliating and potentially traumatizing genital examinations looking for evidence of a procedure that—in the case of ritual nicking—often leaves no visible marking (35,172,189).

An emerging view is that special statutes criminalizing medically unnecessary genital cutting on the basis of sex (as opposed to provable harm or consent-status) will have to be struck down and replaced with either (a) statutes criminalizing all medically unnecessary genital cutting done without the consent of the affected individual, regardless of sex, gender, race, ethnicity, or parental religion (184,190–192), or (b) statutes *allowing* all medically unnecessary genital cutting done without the consent of the affected individual (etc.) so long as the cutting is perceived to be no more harmful than ritual male circumcision (74,193,194).

Another emerging view is that special statues "banning" all (and only) medically unnecessary FGC, apart from being unconstitutional in most Western legal regimes, are legally redundant and thus superfluous. On this view, medically unnecessary genital cutting of any non-consenting person—including children of all sexes and genders, with parental proxy consent argued to be invalid—is already illegal under common law provisions forbidding physical assault and battery (183,191,192,195–198). It has been suggested that an exemption from criminal punishment could be considered for nonconsensual genital cutting motivated by sincere religious belief, insofar as legislatures may sometimes grant "exceptional excuses" under criminal law. Such excuses might be granted, for example, for certain widespread practices that are largely performed without consciousness of their being illegal, or perhaps with the belief that they are required by a divine command (197). However, on this view, the cutting itself would remain unlawful, and all non-religious cutting would indeed be subject to criminal prosecution as soon as the grounds for a personal exemption from punishment were removed (that is, when the unlawful status of the cutting became sufficiently well known). Alternatively, groups in the United States currently lobbying for state-level anti-FGC laws insist that no exception should be made for cultural or religious reasons. However, if such laws are passed—that is, with MGC but not FGC allowed on religious grounds—the laws would almost certainly be unconstitutional and thus highly vulnerable to being struck down if challenged (182,190).

Ethical arguments

According to the WHO, non-Western FGC is morally impermissible in all cases when done for "non-medical reasons," with no regard for consent as an ethical criterion, and no clear account of what qualifies as a sufficient(ly) "medical" reason. Not only is such FGC wrong, according to the WHO, but it constitutes a human rights violation of such severity that a global campaign to eliminate all forms of the practice—wherever it may occur and irrespective of local attitudes—is wholly justified. This premise is never questioned in WHO materials (74). However, the WHO is inconsistent in its ethical analysis. Concerns about this analysis that have been raised in the literature are summarized in Table 1.

Table 1. Ethical arguments against non-Western FGC

Argument	Analysis
1. Medically unnecessary cutting of healthy genital tissue?	There is no mention of consent-status, age, or maturity in determining the moral permissibility of medically unnecessary FGC, regardless of type. This suggests that adult, consensual cosmetic labiaplasty is morally wrong and a human rights violation. However, that does not appear to be the position of the WHO, which has not sought to "eliminate" this Western form of medically unnecessary FGC. Thus, the mere cutting or removal of healthy genital tissue for non-medical reasons is evidently not sufficient to ground claims of moral impermissibility, human rights violations, and so on (37,54).
2. Lack of consent?	Perhaps it is the *nonconsensual* cutting or removal of healthy genital tissue for non-medical reasons that constitutes a human rights violation. But if that is the case, nonconsensual ritual male circumcision—which is not done "for medical reasons"—is a human rights violation, which the WHO does not seem to think. In fact, the WHO *supports* nonconsensual male circumcision (199), citing studies of adult, voluntary circumcision that appear to show certain statistical health benefits (primarily, a reduced risk of female-to-male transmission of HIV in settings with high rates of such transmission and a low prevalence of male circumcision, although real-world effectiveness outside of clinical trials remains unclear) (200–206).
3. No health benefits?	Perhaps it is the nonconsensual cutting or removal of healthy genital tissue that has *not been associated with certain statistical health benefits* that constitutes a human rights violation. If that is the argument, a clear incentive is created for medically qualified supporters of FGC to look for, or generate, evidence of such health benefits, just as has occurred with supporters of MGC (207–209). But now suppose that studies of adult, voluntary FGC (for example, labiaplasty) did indeed appear to show some statistical health benefits—such as a reduced risk of certain infections or diseases that might otherwise affect the excised tissue (210)—which could more safely and effectively be achieved non-surgically (as with MGC) (211,212). Would the WHO find such data sufficient to support *nonconsensual* FGC of minor girls? Presumably it would not (11,207,213,214).

4. Bodily integrity?	In fact the WHO *opposes* medicalization of FGC—even as a harm reduction measure (215). Even a ritual nick performed by a trained physician is considered morally impermissible by the WHO. Thus, the WHO seems to believe that girls have a human right to "bodily integrity" that is violated by all medically unnecessary FGC, no matter how superficial, *whether or not* evidence of health benefits could be found (213,216).
5. Human rights?	But if this is a *human* right, then it must apply to all humans, including intersex/DSD children and males (217,218). But the WHO does not seem to believe that intersex/DSD children or males have an absolute moral claim against nonconsensual, medically unnecessary genital cutting (199,219).

For the reasons given in Table 1, the moral basis for a zero-tolerance approach to all and only non-Western forms of female-only genital cutting, no matter how minimal, remains unsubstantiated.

Zero tolerance

Could a zero-tolerance approach nevertheless be justified in some way? According to a recent consensus statement by the Brussels Collaboration on Bodily Integrity, it can be, at least in sociolegal contexts with a strong tradition of individual rights and a concern for respecting sexual boundaries. In such contexts, it can be argued that a person is wronged by any interference with their sexual anatomy to which they do not consent, no matter how slight, unless they are incapable of consenting and the interference is medically necessary and thus cannot ethically be delayed (1). If that is correct, then medically unnecessary female, male, and intersex/DSD genital cutting would all be morally (if not necessarily legally) impermissible in the relevant contexts if done without the informed consent of the affected individual, and constitute a violation of their rights (67,135,220–223).

Against this view, it could be argued that at least some medically unnecessary procedures are allowed on minors in Western countries, despite those countries' relatively strong traditions of individual rights, including routine cosmetic orthodontia (dental braces), and infant ear-piercing (see footnote 3). If these procedures are in fact morally acceptable,

then objections to nonconsensual, medically unnecessary genital cutting might be vulnerable to accusations of special pleading. We will not take a stand on that issue here. However, one of us has argued elsewhere that there are important dis-analogies between these kinds of cases (see Box 6).

> **Box 6. Nonconsensual genital cutting vs. other interventions.** Adapted from (94).
>
> In many cultures, the genitals are widely seen as a distinctively personal part of the anatomy, often powerfully linked to one's emotions and self-esteem. This may help to explain why childhood genital modifications, compared to other modifications, are often so controversial. To illustrate, a child's vulva or penis and scrotum seem clearly different—in numerous psychosocially and morally important ways—from, e.g., the earlobes, which are sometimes pierced before an age of consent, or crooked teeth, which are sometimes straightened before an age of consent, or at least before an age of legal majority. Not only are the genitals often central to one's sexual experiences, gender identity, sexual orientation, and bodily self-image, but they are also commonly regarded as extremely private—not to be touched or even seen without one's explicit consent, which is typically granted only in intimate situations. In light of such special significance, one may coherently argue that the genitals in particular should be off limits to medically unnecessary interventions until a person has developed sufficient mental and emotional maturity to appreciate what is at stake (and thus either give or withhold their informed consent), regardless of one's position on, e.g., infant ear-piercing.

Conclusion

As it stands, the WHO appears to be engaged in highly selective condemnation of only non-Western, female-only genital cutting, irrespective of harm, consent, or the comparability of the cutting to other medically unnecessary practices. As such, it has failed to explain, for example, why girls in societies that practice both FGC and MGC for similar (e.g., religious) reasons should be categorically excluded from a type of ritual their own brothers are permitted to undergo, including by way of a less severe form of genital cutting (64,180,182,183,193,224–228). We suggest that the WHO has an obligation to take seriously the concerns of scholarly critics that its current policy on non-Western FGC is ethnocentric, culturally biased, ethically incoherent, empirically unsupported, and de facto discriminatory on the basis of sex and gender, race/ethnicity, and parental religion. For the WHO to retain its credibility on this issue, its policy must be revised to eliminate these double standards.

Conflict of interest statement. The authors declare that they have no conflicts of interest.

Appendix 1. Non-Western "FGM" as compared to Western-style "cosmetic" FGC. Adapted from (1,56).

Category	*"Female Genital Mutilation" (FGM)* as defined by the World Health Organization: namely, all medically unnecessary procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs—widely condemned as human rights violations and thought to be primarily nonconsensual	*Female Genital "Cosmetic" Surgeries (FGCS):* typically medically unnecessary procedures involving partial or total removal of the external female genitalia, or other alterations to the female genital organs for perceived cosmesis—widely practiced in Western countries and generally considered acceptable if performed with the informed consent of the individual (cf. intersex cases, which are still primarily nonconsensual)
Procedures + WHO typology	Type I: **Alterations of the clitoris or clitoral hood**, within which Type Ia is partial or total removal of the clitoral hood, and Type Ib is partial or total removal of the clitoral hood and the (external portion of the)* clitoris [i.e., glans and sometimes part of the body]	**Alterations of the clitoris or clitoral hood,** including clitoral reshaping, clitoral unhooding, and clitoroplasty (also common in "normalizing" intersex surgeries)
	Type II: **Alterations of the labia**, within which Type IIa is partial or total removal of the labia minora, Type IIb is 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"
	Type III: **Alterations of the vaginal opening** (with or without cutting of the clitoris)**,** 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** (with or without cutting of the clitoris), typified by narrowing of the vaginal opening, variously known as "vaginal tightening," "vaginal rejuvenation," or "husband stitch"
	Type IV: **Miscellaneous,** including piercing, pricking, nicking, scraping, and cauterization.	**Miscellaneous**, including piercing, tattooing, pubic liposuction, and vulval fat injections
Examples of relatively high-prevalence countries	Depending on procedure: Burkina Faso, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Indonesia, Iraqi Kurdistan, Liberia, Malaysia, Mali, Mauritania, Senegal, Sierra Leone, Somalia, Sudan, and concomitant diaspora communities	Depending on the procedure: Brazil, Colombia, France, Germany, India, Japan, Mexico, Russia, South Korea, Spain, Turkey, United States
Actor	Traditional practitioner, midwife, nurse or paramedic, surgeon.	Surgeon, tattoo artist, body piercer.
Age at which typically performed	Depending on the procedure/community: typically around puberty, but ranging from infancy to adulthood.	Typically in adulthood, but increasingly on adolescent girls or even younger minors; intersex surgeries (e.g., clitoroplasty) more common in infancy, but ranging through adolescence and adulthood.
Presumed Western legal/moral status	Unlawful and morally impermissible	Lawful and morally permissible

* The qualification in parenthesis has been added. This is because, as noted, the official WHO typology wrongly equates the external, visible portion of the clitoris with the entire clitoris, thereby diminishing the anatomical and sexual significance of the latter (44). This does not, of course, entail that sexual function or quality is unaffected by FGC, nor that the cutting does not introduce the risk of sexual harm. Rather, it is to dispel the common myth that non-Western FGC is sexually disabling *per se*—a myth that may itself cause harm to women and girls who have experienced ritual genital cutting and believe that they are (therefore) incapable of sexual enjoyment.

** In practice, the most severe instances of medically unnecessary narrowing of the vaginal opening regarded as infibulation (FGM) leave a smaller introitus and often cause greater functional difficulties than analogous procedures regarded as "vaginal rejuvenation" (FGCS). However, the WHO typology does not distinguish between more or less constrictive outcomes in its definition of Type III FGM, and both infibulation and "vaginal rejuvenation" fall on a spectrum. Thus, there is no anatomically decisive line between them, and in some cases, they may be practically indistinguishable: e.g., partial re-infibulation versus a so-called "husband stitch" (59,229).

Appendix 2. Comparative studies of genital cutting practices across sexes and cultures: selected contributions to a changing paradigm since circa 2000

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