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Gender and Genital Cutting: A New Paradigm

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Abstract

Moral and legal opposition to the non-therapeutic cutting of children's genitals has traditionally focused on female children. In recent years, however, a growing movement of scholars, activists, and individuals affected by childhood genital cutting have argued that all children, regardless of sex or gender, should be protected from such intimate violations. By drawing attention to the overlapping harms to which female, male, and intersex children may be exposed as a result of having their genitals cut, this movement posits a sex and gender neutral—that is, human—right to bodily integrity and genital autonomy. This article introduces and outlines some of the main arguments supporting this perspective.

Introduction[1]

In Western countries, the cutting of children's healthy genitals is usually discussed in three separate ethical discourses. One is for female children, where such cutting, regardless of severity, is commonly known as Female Genital Mutilation (FGM). Another is for male children, whose non-therapeutic genital alteration typically consists of the removal of part or all of their penile foreskin, termed "male circumcision." And the third is for intersex children—children with atypical sex characteristics—whose genitals may be surgically "normalized" to make them conform to a perceived gender binary.

Prevailing moral, socio-political, and legal responses to these procedures differ sharply depending upon the child's sex or gender.[2] In the female case, any form of non-therapeutic genital cutting, no matter how hygienic or minor, is seen as an intolerable violation of her right to physical integrity (Askew et al., 2016). It is also often regarded as a form of gender-based violence and child abuse (Kellner, 1993; Schroeder, 1994; WHO, 2008). When parents or community members insist that such cutting is required by their culture or religion, or is even an act of love (Momoh, 2010), their arguments are typically dismissed as being fallacious on religious grounds (see Box 1) or inadequate on moral grounds (e.g., Macklin, 2016).

In the case of intersex children, there is growing opposition to interventions that are not strictly therapeutically required, but are rather "cosmetic" in nature, aimed at creating a stereotypically male or female appearance (Carpenter, 2016; Dreger & Herndon, 2009; Ford, 2001). Debate is hampered, however, by limited public awareness of the very existence of intersex people, much less the sorts of invasive genital-altering procedures to which they are often subjected in early childhood (for an overview, see Reis, 2009; see also Ehrenreich & Barr, 2005, especially pp. 97-104). Nevertheless, attitudes appear to be shifting in favor of increased protection of intersex children from unnecessary alterations of healthy genital tissue (Ammaturo, 2016; Newbould, 2016).[3]

It is often claimed that female genital cutting is not truly a religious practice, because it is not mentioned in the Quran, the central scripture of Islam. But this view is highly simplistic and misleading. As Kavita S. Arora and Allan J. Jacobs (2016, p. 151) note, "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 [female circumcision] as 'Sunnah' or practice established by the prophet Muhammad. Though not prescribed explicitly in the Quran, the practice thus is religiously virtuous" (for further extensive discussion, see Davis, 2001; Earp, Hendry, & Thomson, in press). Indeed, as Alex Myers (2105, p. 55) explains, "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." The scriptural support for these positions "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."

Box 1. Is female genital cutting a religious practice?

Finally, in the case of male children, the most commonly encountered perspective is that boys are not significantly harmed by having their healthy foreskins removed, except in the event of so-called "botched" circumcisions (Benatar & Benatar, 2003; Mazor, 2013). Instead, proponents suggest, boys may actually benefit from such genital cutting: Not only will they enjoy greater acceptance among their peers and future sexual partners, it is alleged, but they may also experience a reduced risk of contracting certain infections or other diseases (Jacobs & Arora, 2015; see Box 2 for discussion).

Against this backdrop, a growing literature in ethics, biomedicine, anthropology, law, gender studies, and other fields, has begun to call into question these attitudes and distinctions.[4] The emerging consensus among scholars in these fields is that the ethics of nontherapeutic genital cutting (NGC) should hinge, not on the apparent sex of the subject—as judged by their external genitalia—but rather on considerations of medical necessity, informed consent, and respect for the bodily autonomy of all persons (see Svoboda, 2015).

Health benefits that have been attributed to male circumcision include a reduction in risk of acquiring a urinary tract infection (UTI) in early childhood, some sexually transmitted infections after sexual debut, and penile cancer later in life. 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 typically be cured with antibiotics as they are for girls (Frisch et al., 2013). Penile cancer is rare in developed countries, such that it would take between 909 and 322,000 circumcisions to prevent a single case (AAP, 2012). Most of the reliable evidence suggesting a reduced risk of STIs comes from studies of adult, voluntary circumcision in third world countries whose applicability to circumcision of infants in other contexts is not known (Bossio, Pukall, & Steele, 2014; Frisch & Earp, in press). Moreover, STIs are not a relevant health risk to children. In light of alternative, less invasive means of achieving the above-mentioned health benefits, including basic hygiene and the adoption of safer sex practices, relevant health authorities generally agree that the medical advantages of involuntary infant circumcision are not sufficient to offset the costs, harms, and other disadvantages associated with the surgery (Frisch et al., 2013; RACP 2010), some of which may be subjective in nature and therefore difficult to quantify (Darby, 2015; Darby & Cox, 2008; Earp & Darby, in press). Thus, none of the pediatric or other medical bodies that have issued formal policies on routine neonatal circumcision consider the health benefits of the surgery to exceed the risks, regardless of the metric used. The sole exception to this is the American Academy of Pediatrics (AAP, 2012), whose 2012 policy is due to expire this year. After considerable international criticism from experts in epidemiology and children's health, including heads and representatives of national medical societies in England, mainland Europe, and Canada (Frisch et al. 2013), a representative from the AAP Circumcision Task Force acknowledged significant problems with the AAP findings (Freedman, 2016).

Box 2. How compelling are the health benefits associated with male circumcision?[5]

The argument for this view has two main parts. The first part seeks to show that the conventional distinctions based on sex or gender do not reliably reflect the actual harms that are entailed by various forms of NGC. The second part suggests that, by contrast, distinctions based on autonomy and informed consent do provide coherent grounds for an empirically justifiable analysis of the moral permissibility of NGC. The argument proceeds roughly as follows:

Part 1. Questioning Distinctions Based on Sex or Gender

Premise 1: Physical Overlap. Female, intersex, and male forms of NGC exist on a spectrum both within and between cultures, with significant overlap in terms of physical invasiveness and adverse consequences for health and sexuality when analogous procedures are compared.

Premise 2: Symbolic Overlap. The historical causes, motivations, rationalizations, and symbolic "meanings" of childhood NGC also overlap considerably between sexes, when the full complement of such procedures across societies is taken into account.

Conclusion 1: Invalid Sex or Gender-Based Distinction. Therefore, there is no principled or coherent way to systematically distinguish childhood NGCs in terms of either physical harms or symbolic meanings, as a function of conventional sex or gender categories.

Part 2. Supporting Distinctions Based on Autonomy and Informed Consent

Premise 3: Self-Perceptions of Harm. A significant proportion of adults of all sexes and genders who have undergone a childhood NGC—of whatever degree of severity—regard the cutting as inherently and/or instrumentally harmful; as a violation of their physical integrity and sexual autonomy rights; and as an inappropriate denial of their (future) ability to make important self-affecting decisions regarding an intimate part of the body.

Premise 4: Asymmetry of Available Remedies. Those whose genitals have not been altered, but who wish they had been, can at least partially remedy their situation by choosing to undergo an NGC upon reaching an age of mental maturity. Those whose genitals were preemptively altered in childhood but who greatly resent this, by contrast, have no comparable recourse.

Conclusion 2: Valid Autonomy or Consent-Based Distinction. Because of this asymmetry, along with Conclusion 1, efforts should be made to discourage childhood NGC regardless of the sex or gender of the child. Fully informed, Gillick-competent[6] individuals (male, female, or intersex) should be allowed to choose NGC for themselves, if they wish, under conditions of valid consent.

In the following section, specific examples will be provided to elucidate the reasons and underlying empirical support for these claims. For detailed discussions and evidence, see the included references.

Discussion: Assessing Distinctions

Premise 1: Physical Overlap

Female forms of NGC fall on a wide spectrum across societies (Shell-Duncan & Hernlund, 2000). Although the most severe forms, such as infibulation (narrowing of the vaginal opening) combined with partial or complete excision of the external clitoris or clitoral glans,[7] are often emphasized in Western media accounts (Njambi, 2004; Shweder, 2000; Wade, 2009), such forms are statistically exceptional, occurring in about 10% of cases according to available estimates (Abdulcadir et al., 2012). Such cutting appears to be concentrated in parts of northeast Africa, especially the Sudan, and is not representative of female NGC overall (Abdulcadir et al., 2012; Shell-Duncan & Hernlund, 2000).

“Milder” forms of female NGC include ritual nicking of the clitoral hood, classified as FGM Type 4 according to the WHO typology (WHO, 2008). This form does not remove tissue, rarely results in serious long-term medical complications, and is, in some contexts, performed with anesthesia in a clinical setting by certified health professionals (Ainslie, 2015; Arora & Jacobs, 2016; Rashid, Patil, & Valimalar, 2010). According to the WHO (2008), such “medicalized” NGC is increasingly popular across a range of settings, and it appears to be the most common form of female NGC in parts of Malaysia, Indonesia, and in some other Muslim-majority communities (Ainslie, 2015; Coleman, 1998; Rashid et al., 2010; Taha, 2013). Despite calls for tolerance of this relatively mild procedure as a harm-reduction measure (Arora & Jacobs, 2016; Davis, 2001; Shell-Duncan, 2001), the WHO, United Nations, and other leading international organizations

do not accept any form of female NGC, regarding all as human rights violations (Askew et al., 2016; WHO, 2008; see also Earp, 2016a).

Notably, in the context of the present discussion concerning physical "overlaps" between genital cutting practices, such nicking is less invasive than almost all forms of NGC commonly performed on either male or intersex children in any society (Ainslie, 2015; Earp et al., in press; Ehrenreich & Barr, 2005). Nevertheless, along with other procedures falling under FGM WHO Type 4—including piercing, incising, scraping, and labial stretching (see Pérez, Aznar, & Bagnol, 2014)—nicking of the clitoral hood for non-medical reasons is defined as an impermissible mutilation in Western law (Davis, 2001). It is therefore as strictly forbidden as both

> (a) "intermediate" forms of female NGC, such as partial or complete excision of the labia minora (FGM WHO Type 2A), and
>
> (b) "extreme" forms of female NGC, such as partial or complete excision of the external clitoris (FGM WHO Type 1B)

The first of these, FGM WHO Type 2A, is separately known as *labiaplasty* when it is performed by a Western cosmetic surgeon (Braun, 2009; Dustin, 2010; Green, 2005; Sheldon & Wilkinson, 1998). As Moira Dustin (2010) has argued, when non-therapeutic cutting or excision of the labia minora is described as a cosmetic procedure—whether performed on an adult woman or a female minor with the permission of her parents (see Liao, Taghinejadi, & Creighton, 2012)—criminal proceedings are unlikely to be entertained. Indeed, such cutting is usually perceived as a bodily "enhancement" (Braun, 2005), and the woman or adolescent requesting it is presumed to be acting autonomously (Dustin, 2010). A telling exception to this rule occurs in practice, however, when the request comes from a female African or Middle Eastern immigrant, regardless of her age or maturity. In such cases, an anatomically identical procedure is more likely to be perceived as "culturally motivated" and hence an act of "genital mutilation" (for in-depth discussion see Dustin, 2010; see also Shahvisi, in press).

The second, "extreme" form of NGC—FGM WHO Type 1B—is separately known as *feminizing clitoroplasty* when it is performed by a Western cosmetic surgeon (Coventry, 1998; Green, 2005; Lightfoot-Klein et al., 2000; Schober, 2004). When framed in these terms, again, criminal prosecution is rarely entertained (Bennett, 2016; Sheldon &

Wilkinson, 1998; but see Bentham, 2017). Such “cosmetic” clitoroplasty—i.e., surgical reduction or removal of the external clitoris in the absence of a physical-functional indication—is one of a cluster of invasive procedures that are sometimes performed on intersex children in an effort to conform their genitals to a perceived gender binary (Ehrenreich & Barr, 2005; Schober, 2004). The result is often an unacceptable aesthetic outcome, as judged by the affected individual, a relative loss of sexual sensation or function, and feelings of shame and resentment (Beh & Diamond, 2000; Hurwitz, 2011; Karkazis, 2008; Lightfoot-Klein et al., 2000).[8]

As these examples show, the overlap between “female genital mutilation” as defined by the WHO and at least some forms of intersex “normalization” surgery can be considerable (Ehrenreich & Barr, 2005). Further overlap exists between each of these interventions and male forms of NGC.

The “mildest” form of male NGC is probably routine infant circumcision as it is customarily performed in the United States (for introductions, see Aggleton, 2007; Gollaher, 1994, 2000; Hodges, 1997). In contrast to the procedures classed as FGM WHO Type 4—most of which do not substantially alter the morphology of the external female genitalia—male circumcision as practiced in the U.S. results in an average loss of approximately 30 to 50 square centimeters of erogenous tissue in the adult organ (Cold & Taylor, 1999; Kigozi et al., 2009; Werker, Terng, & Kon, 1998), leaving a scar around the circumference of the penis (Tarhan et al., 2013).[9] Male circumcision of any kind removes the most touch-sensitive portion of the penis (Bossio, Pukall, & Steele, 2016; Earp, 2016b; Sorrells et al., 2007) along with approximately half of its motile skin system (Taylor, Lockwood, & Taylor, 1996). It also precludes any sexual acts or functions that involve manipulation of the foreskin, such as “docking”[10] among men who have sex with men (MSM) and certain styles of masturbation that are common among genitally intact men of all sexual orientations.[11]

More extreme forms of male NGC include unhygienic peripubertal circumcision, typically performed without anesthesia as part of a rite of passage—resulting in approximately 400 deaths of teenage boys in just one ethnic group in South Africa between 2008 and 2014 (Douglas & Nyembezi, 2015; Gonzalez, 2014)—and sub-incision, which involves slicing open the underside of the penis from the scrotum to the glans, as practiced by some Australian Aboriginal groups (Pounder, 1983).

In short, the degree of harmfulness of childhood NGC is a function of numerous interacting variables, such as the level of invasiveness of the intervention, the skill of the practitioner, the cutting instruments used and whether or not they have been sterilized, the type and extent of the genital tissue that is altered or removed, what the material circumstances of the procedure are, at what age the procedure is carried out, whether or not there is cooperation from the child, what the child has been led to believe about what is happening and how this affects their emotional state, how much value the child later places on having intact versus modified genitalia, how closely the child personally identifies with the NGC-practicing culture or sub-culture in which they are being raised, and, in intersex cases, how closely the child identifies with the sex category that has been surgically assigned.

Considerations of sex or gender, by contrast, are at best extremely unreliable proxies for the actual degree of harmfulness of any given instance of NGC. Anthropologist Zachary Androus (2004, p. 3) remarks that

> 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.

Following the work of Nancy Ehrenreich, among others, it should be added that what is done to some intersex children in some cultures is likewise "worse" than what is done to some girls and/or boys in other cultures, depending upon the specifics of the procedures (Ehrenreich & Barr, 2005; Karkazis, 2008; Lightfoot-Klein et al., 2000).

Premise 2: Symbolic Overlap

Some scholars who are familiar with a more traditional understanding of NGCs have recently conceded that there does not appear to be an empirically supportable, principled basis for using sex- or gender-based distinctions to categorically rank the physical harmfulness of NGCs (Mazor, 2013). But such scholars still sometimes assert that the non-physical, "expressive" harms of NGCs do differ among the sexes. Referring to male and female NGCs, for instance, the philosopher Joseph Mazor (2013, p. 428) states,

> there is an important *moral* difference that does not have to do with the physical effects of the operation[s]. Namely, in [some] 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 [physical harmfulness], the 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.

The view that female NGCs are a manifestation of patriarchal sexism, rooted in a male desire to, among other things, control female sexual desire and behavior, is widespread (but see Obiora, 1996, for a critical response). Often, this view is taken to suggest that women must have a "lower" status than men in such societies,[12] to which customary genital cutting practices either directly or indirectly contribute. There are indeed some societies in which such an interpretation is reasonably well supported (Abdulcadir et al., 2012; Shell-Duncan & Hernlund, 2000).

In parts of the Sudan, for example, the "symbolic meanings" of female NGC have in some groups become associated with longstanding cultural and religious norms that disproportionately emphasize female chastity (an asymmetry to which we have raised moral objections elsewhere; Earp, 2014). In such settings, parents or religious leaders may express that female NGC of one kind or another is required to ensure that females are more sexually passive and "pure."

At the same time, this notion that females have a special responsibility to "control" their sexual desires or limit their sexual expression is a common feature of many, if not most, patriarchal societies—including those that do not practice any form of female NGC. Thus, as recent scholarship suggests, there is no consistent relationship between the presence or degree of patriarchal oppression in some society and whether it practices a form of female NGC (Abdulcadir et al., 2012).

In other words, whatever relationship there is between these phenomena does not apply universally (Abdulcadir et al., 2012; Ahmadu, 2000; Obiora, 1996; Walley, 1997). As a committee of the foremost scholars of NGC have recently emphasized, "in almost all societies where there are customary female genital surgeries, there are also customary male genital surgeries," typically performed "at similar ages and for parallel reasons" (Abdulcadir et al., 2012, p. 23), most often in the context of an initiation

ceremony through which immature children are ritually transformed into responsible adults (Caldwell, Orubuloye, & Caldwell, 1997; Hellseten, 2004; Leonard, 2000; see also Wald, 2010).

In most such societies, the female initiations are controlled by women, who are often highly resistant to any form of interference, whether by men in their own communities or by cultural outsiders (see, e.g., Thomas, 1996). The male initiations are likewise controlled by men. In neither case, however, is the apparent purpose of the NGC to diminish the sexual experience of the initiate (Leonard, 2000). Rather, in many such contexts, the penile prepuce is believed to be a "female" appendage, whose excision is necessary to "masculinize" the boy, while the clitoral prepuce or clitoral glans is believed to be a "male" appendage, whose excision is necessary to "feminize" the girl (Ahmadu & Shweder, 2009; Earp, 2016a; see also Wald, 2010).

This desire to "shape" children's genitals into dichotomous sexes is highly reminiscent of the motivation behind intersex "normalization" surgeries that are common in Western societies (Ehrenreich & Barr, 2005; Reis, 2009). From a child's rights perspective, all such genital shaping may be equally suspect (DeLaet, 2012). But when it comes to evaluating claims of sex-based discrimination, according to which girls and women are unfairly disadvantaged compared to boys and men, it must be recognized that "there are few societies in the world, if any, in which female but not male genital surgeries are customary." Thus, "societies for whom genital surgeries are normal and routine are not singling out females as targets of punishment, sexual deprivation, or humiliation" (Abdulcadir et al., 2012, p. 23).

Historically, both male and female forms of NGC were employed—for example, in England and the United States—to discourage childhood masturbation and other expressions of juvenile sexuality, then thought to be the cause of various medical problems (Aggleton, 2007; Darby, 2005). Even today, the widely-publicized campaign to circumcise millions of African boys and men—in an effort to lower their risk of becoming infected with HIV[13]—is premised in part on the notion that such men cannot be trusted to control their own sexual behavior. Some commentators have suggested that the campaign risks reinforcing troubling colonial-era stereotypes about the "sexually promiscuous African male" (e.g., Sawires et al., 2007).

Consistent with this interpretation, one finds highly aggressive Western-funded marketing efforts aimed at "demand-creation" for male circumcision (Adams & Moyer,

2015; Katisi & Daniel, 2015). Some of these campaigns resort to explicit body-shaming of genitally intact boys, implying that their future sexual partners will be repelled unless they are circumcised (Rudrum, Oliffe, & Benoit, 2017). In short, an apparent desire to exercise "control" over individuals' sexual experiences and behavior through genital cutting can take many forms, affecting persons of different sexes and genders. But a more general empirical association between patriarchy, sex negative motives, and contemporary male or female NGC, is "not well established. 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" (Abdulcadir et al., 2012, p. 23; see also Cohen, 1997; Kimmel, 2001).[14]

Moreover, the conscious reasons parents give for authorizing childhood NGCs are often divorced from historical narratives and motives concerning sexual control. In many contemporary societies, the most common reason given for why NGC should be carried out on children is simply "it's tradition" or "the normal thing to do." When pressed for further justification, appeals to hygiene or aesthetics are also sometimes given (Brown & Brown, 1987; Shell-Duncan & Hernlund, 2000; see also generally, Waldeck, 2003). As J. Steven Svoboda (2013, p. 237) notes, "all forms of genital cutting – female genital cutting (FGC), intersex genital cutting, male genital cutting (MGC), and even cosmetic forms of FGC – are performed in a belief that they will improve the subject's life." However all can also be seen as "unnecessary alterations [of] healthy genitalia justified by questionable health benefits and bolstered by culturally, socially, or religiously defined notions of aesthetics and clearly delineated binary ideas of gender" (Gunning, 1998, p. 655–656).

Across cultures the motives for, and meanings associated with, childhood NGCs are numerous and sometimes contradictory; they exist at both conscious and unconscious levels; they differ from community to community and family to family; and they are unstable, often changing over time. With respect to sex or gender, there is too much overlap along these and other dimensions—when the full range of childhood NGCs is considered—to support a categorical distinction in terms of "symbolic meanings." As one of us has noted elsewhere, "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." Thus, if the two interventions "are meant to

be distinguishable in terms of their permissibility on account of the differing norms that they are taken to reflect … they will be very hard to distinguish indeed" (Earp 2015a, p. 98).

Premise 3: Self-Perceptions of Harm

A substantial proportion of adults of all genders who underwent childhood NGCs express resentment at having had an irreversible procedure carried out on an intimate body part before they had the capacity to decline.[15] Such resentment often develops when the adult acquires an alternative frame of reference for construing the genital alteration than the one which predominated in their childhood environment (Earp, 2016a; Earp & Darby, in press; Johnsdotter & Essén, 2016). For example, upon hearing that other societies do not modify children's genitals except out of rare medical necessity; upon engaging in a sexual interaction with someone outside their cultural or religious group who is not used to seeing "cut" genitals; or upon learning about the anatomy and functions of the tissue that was preemptively removed from their body, many adults begin to question the norms that uphold NGCs performed on children (Dreger, 1999; Johnsdotter & Essen, 2016). This then may lead to a reappraisal of their own altered genital state. Many come to feel that what had been intended as a physical or social "enhancement" by their parents, often under pressure from the surrounding community, is more appropriately described as a diminishment or mutilation (Earp, 2016a; Earp & Darby, in press).

Premise 4: Asymmetry of Available Remedies.

Those whose genitals have not been altered, but wish that they had been, can at least partially remedy their situation by choosing to undergo an NGC when they have sufficient mental maturity to understand what is at stake in the procedure. Those whose genitals were altered in childhood but who greatly resent this, by contrast, have no comparable recourse (see Earp & Darby, in press, for an extended version of this argument). This fundamental asymmetry in available remedies for an undesired situation—which applies to individuals of all sexes and genders[16]—has led several scholars to propose that childhood NGC should typically be avoided, so that the affected individual can make an informed decision about whether to undergo an elective genital surgery, in light of their own considered preferences and values and with greater understanding of the likely long-term implications (Carmack, Notini, & Earp, 2016;

DeLaet, 2012; Dustin, 2010; Mason, 2001; Svoboda, 2013; see also Maslen et al., 2014).

Conclusion: Policy Implications

What are the implications of the foregoing discussion for policy? At a recent WHO-sponsored conference on female NGC held at Geneva University Hospitals,[17] we argued that a gender-inclusive approach—based on an individual's capacity to provide informed consent to NGC—is not only better supported by the available evidence, as explained above, but also carries several practical advantages:

1. It neutralizes accusations of cultural imperialism by applying the same standards to medically unnecessary genital cutting practices primarily affecting white minors in North America, Australasia, and Europe (i.e., medicalized routine or religious male circumcision, intersex genital normalization surgery, adolescent female cosmetic genital surgery) as it does to such practices primarily affecting minors of color in Africa, the Middle East, and Southeast Asia (i.e., male and female peripubertal initiation ceremonies and other customary forms of childhood NGC);

2. It clarifies the moral confusion that is introduced by Western-led efforts to eliminate only the female "half" of childhood NGC practices in communities that practice both male and female NGC in parallel;[18]

3. It weakens accusations of sexism by recognizing that boys and intersex children are also vulnerable to non-therapeutic genital alterations that they may later come to seriously resent.

Adopting such an approach, however, does not necessarily entail "banning" all pre-consensual NGCs. History shows that the enactment of strict legal prohibitions prior to cultural readiness can backfire, creating intense resistance among those who are dedicated to the practice, often driving it underground (Bradshaw, 2012; see also Earp, 2013; Savulescu, 2013; TLRI, 2012). Prohibition of childhood female NGC, for example, has been largely unsuccessful in many countries (Arora & Jacobs, 2016; Newland, 2006) and recent attempts to criminalize childhood male NGC have either been blocked or overturned (Merkel & Putzke, 2013; Munzer, 2015). There are many "levers" society

can pull to discourage harmful practices: the law is only one among them, and not necessarily the most desirable or effective (Obiora, 1996; La Barbera, in press). Some authors have proposed step-wise regulation of childhood NGCs (e.g., Ben-Yami, 2013; Davis, 2013), along with community engagement and education (Finke, 2006), as alternatives and/or supplements to formal prohibition. Whatever specific policies are implemented, however, what is clear is that fundamentally different treatment of female, male, and intersex children—with respect to the preservation of their bodily integrity—will become increasingly difficult to justify in the coming years (Davis, 2001; Dustin, 2010; Earp et al., in press; Ehrenreich & Barr, 2005).[19]

Notes

[1] The authors thank Eduardo Zugasti, assisting MEP Teresa Giménez Barbat, for inviting us to prepare this essay. Thanks also to Professor Elizabeth Reis and Dr. Robert Darby for feedback on an earlier draft.

[2] For reasons of space, the practical and theoretical distinctions that are commonly drawn between "sex" and "gender" will largely be set aside in this essay. Thus, the terms will be used more or less interchangeably. For an introduction to the distinctions, see Muehlenhard and Peterson (2011).

[3] The Parliamentary Assembly of the Council of Europe, for example, passed a resolution in 2013 that called on member states to "undertake further research to increase knowledge about the specific situation of intersex people, ensure that no-one is subjected to unnecessary medical or surgical treatment that is cosmetic rather than vital for health during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to persons concerned, and provide families with intersex children with adequate counselling and support." Resolution 1952 (2013) Children's Right to Physical Integrity: http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-EN.asp?fileid=20174&lang=en.

[4] See, e.g., Abdulcadir et al. (2012), Abu-Sahlieh (1994), Ammaturo (2016), Androus (2004, 2013), Bell (2005, 2015), Darby (2015), Darby and Cox (2008), Darby and Svoboda (2007), Davis (2001), Earp (2015a, 2015b, 2016a, 2016b), Earp and Darby (in press), Earp, Hendry, and Thomson (in press), Dekkers (2009), Dekkers, Hoffer, and Wils (2005), DeLaet (2009, 2012), Denniston, Hodges, and Milos (1999), Dustin (2010), Ehrenreich and Barr (2005), Fox and Thomson (2006, 2009), Frisch et al. (2013), Frisch and Earp (in press), Hellsten (2004), Johnson (2010), La Barbera (in press), Lightfoot-Klein et al. (2000), Myers (2015), Shahvisi (2016, in press), Sarajlic (2013), Shweder (2013), Svoboda (2013), Svoboda et al. (2000), Van den Brink and Tigchelaar (2012), Van Howe (2013).

[5] Some phrasing in Box 1 is adapted from Frisch and Earp (in press) and Earp, Hendry, and Thomson (in press).

[6] Gillick-competence refers to an ability to give valid consent prior to an age of legal majority (Larcher & Hutchinson, 2010; see also Maslen et al., 2014). For a discussion of how one might assess such a capacity with respect to specific interventions in differing cultural contexts, see Earp (2016a, online materials at p. E9).

[7] Most of the clitoris, including the majority of its erectile tissue and sensory structures required for orgasm, is rooted underneath the outer skin layer (Puppo, 2013). Therefore, even the most invasive forms of traditional female genital cutting do not remove "the clitoris," as incorrectly stated by the World Health Organization in its influential FGM typology (Abdulcadir et al., 2016). Instead, some portion of the external clitoris or clitoral glans is typically affected, with variable implications for sexual response (Catania et al. 2007).

[8] At minimum, all sensation is eliminated that would have been experienced "in" the excised tissue itself (Earp 2016c); additional adverse effects on sensation or function in the remaining tissue can occur due to nerve damage or other complications.

[9] To be clear, the estimate given is for the fully developed foreskin, i.e., the amount of tissue that would have existed had the penis reached its mature size with its foreskin still intact. Substantially less tissue is removed if the surgery is performed in infancy or early childhood. Since there is no determinate location where the foreskin "ends" and where the rest of the penis "begins," however, "and since the organ will typically increase in size by more than 200% as the child develops, there is a considerable amount of guesswork in terms of where to cut or apply the circumcision device" if the procedure is carried out at such a young age (Earp & Darby in press). "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" (Earp & Darby, in press; see within for detailed citations).

[10] The sexual act of placing part of one man's penis inside the foreskin of another man's penis (Harrison, 2002; Frisch & Earp, 2016).

[11] These styles involve gliding the foreskin reciprocally over the glans of the penis (for a demonstration, see: http://www.circumstitions.com/completeman/sidegif.gif), or otherwise manipulating the foreskin in much the same way that the intact female genital labia can be fondled during masturbation or oral sex: for details see Ball (2006) and Earp (2016c). For related discussions, see Bell (2005), Earp (2015b), Earp and Darby (2015, in press), Fox and Thomson (2009), Harrison (2002), and Richters (2009).

[12] Anthropologists have cautioned that scholars "must be wary of imposing Western religious, 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 in a given society must of necessity have higher status (Ahmadu, 2000, p. 285). Indeed, some African societies that practice female (as well as male) NGCs, and in which women have largely been presumed by Western observers to be of lower status, may more accurately be described as having complementary gender roles that are equally valued in the local ontology (Earp, Hendry, & Thomson, in press). Christine Walley (1997, p. 420) notes that "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 … generalized assumptions about the oppression of third-world women."

[13] For an overview and critical discussion, see Bell (2015). This campaign is based on the results of three randomized control trials (RCTs) appearing to show that voluntary, adult male circumcision can lower the absolute risk of female-to-male heterosexually transmitted HIV by about 1.3% (a relative risk reduction of about 60%), in sub-Saharan African settings with high rates of such transmission and low prevalence of male circumcision. A fourth RCT examined the effects of circumcision on male-to-female transmission of HIV, but was terminated early because more female partners of circumcised men, compared to non-circumcised men, were becoming infected with HIV (Wawer et al., 2009), thus raising concerns about increased risk to women (Dushoff et al. 2011). Circumcision for HIV-prevention does not appear to benefit men who have sex with men (MSM) (e.g., Goodreau et al., 2014; Templeton et al., 2010), which is a far more common mode of transmission in most Western countries. There is no reliable evidence that neonatal or early childhood circumcision has any protective effect against HIV transmission, especially in such countries (e.g., Bossio et al., 2014; Sidler et al., 2008). For critiques of the African circumcision campaigns, see the 2015 collection of papers in *Global Public Health*, volume 10, issues 5-6.

[14] An example of the latter can be seen in traditional Jewish ritual practice, where male children, but not female children, are entitled to enter into a "divine covenant" by undergoing a neonatal NGC. Shaye D. Cohen (1997, p. 574) has argued that of all the rituals from which females are deliberately excluded in rabbinic culture, "the exclusion from circumcision is at once the most obvious and the most problematic." Throughout Jewish history, "the fundamental inferiority, marginality and Otherness of women were so self-evident that the presence of a covenantal mark on the bodies of men, and its absence from the bodies of women, seemed natural and inevitable." Cohen suggests that contemporary Jews, "especially those sensitive to gender issues … might wish to argue that male circumcision needs to be abolished or de-emphasized as a ritual marker precisely because it has functioned within history to discriminate invidiously against women" (p. 561). In a similar vein, Michael Kimmel (2001) argues that "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, according to Kimmel, is "to accept as legitimate 4000 years [of] patriarchal domination of women." For further discussion, see Wald (2010).

[15] Precise estimates are hard to come by, but in light of the common assertion that circumcised men, in particular, "don't complain" about being circumcised, we wish to highlight a few considerations. First, "a 2015 YouGov poll concluded that 10% of circumcised American men wish that they had not been circumcised. 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.' Consistent with this finding, there are many thousands of devices 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" (Earp and Darby, in press, see within for primary source citations). Second, surveys regularly show that most women in societies where female NGC is common and normative also do not "complain" about their childhood NGCs (Arora & Jacobs, 2016). But just as with men in majority (male) circumcising societies, (1) a minority do complain, often vociferously, and (2) those

who do not complain publicly or in surveys may nevertheless experience resentment in private: one may face numerous barriers to broadcasting to the world—or even to one's friends and family—that one feels harmed, sexually or otherwise, by a practice that one's surrounding community regards as normal and desirable. For evidence of these claims, further discussion, and related materials, see: Abdulcadir, Rodriguez, and Say (2015); Carpenter (2016); Dreger (1999); Earp (2016a); Earp and Darby (in press); Hammond (1999); Hammond and Carmack (2017); Hester (2004); Karkazis (2008); Lightfoot-Klein et al. (2000); and Schultheiss, et al. (1998). See also http://www.clitoraid.org, https://www.mendocomplain.com, http://www.isna.org.

[16] Indeed, even intersex children with ambiguous genitals often benefit from waiting: parents and physicians can choose the most likely gender for the child, in terms of associated norms and behaviors, but refrain from irreversible genital modification until the child is old enough to have a say.

[17] Steinfeld and Earp (2017). See https://www.meeting-com.ch/en/conferences-meetings/event-details/events/management-and-prevention-of-female-genital-mutilationcutting/.

[18] As one doctor stated in an interview with the Swiss lawyer Sami Aldeeb Abu-Salieh "female circumcision will never stop as long as male circumcision is going on. How do you expect to convince an African father to leave his daughter uncircumcised as long as you let him do it to his son?" (quoted in Abu-Salieh, 1994, p. 612).

[19] Indeed, given the numerous physical and symbolic overlaps between childhood NGCs in different societies, a question is raised as to why the cutting of male and intersex children's genitals, compared to that of female children's genitals, has failed to elicit a similar level of moral concern in the international community. One possible explanation is that the very same patriarchal norms that are often cited as the impetus for female NGC simultaneously (a) encourage the imposition of a strict gender binary on non-conforming intersexed bodies, and (b) obscure the harms to which boys and men may be exposed in having their genitals cut. With regard to the latter, while patriarchy constructs girls as weak, vulnerable, and in need of protection, it constructs boys as tough, strong, and able to withstand painful ordeals, often starting from a very young age. Since showing vulnerability and even expressing certain emotions is discouraged among boys and men in such societies, as Marie Fox and Michael Thomson (2009, p. 200) have argued, "patriarchy often allows men's experiences to remain unquestioned." The notion that patriarchy can be harmful to people of all genders, not only to females, is now a widely accepted view in feminist scholarship.

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