

The Law and Ethics of Female Genital Cutting

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Abstract

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

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

1. Introduction

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

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

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

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

2. Varieties of genital cutting

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

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

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

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

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

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

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

* Please note: the published version of this article misstates the number of hospitalizations due to an erroneous secondary source. Please refer to this version for the correct information.

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

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

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

Table 1: Comparing “FGM” and FGCS.

	<i>“FGM”</i>	<i>FGCS</i>
Procedures and typology	Type I: Alterations of the clitoris , within which type 1a is the partial or total removal of the clitoral hood, and type 1b is the partial or total removal of the clitoral hood and the (external portion of the)* clitoris.	Alterations of the clitoris , including clitoral reshaping [42], clitoral unhooding [43], and clitoridectomy or cliteroplasty [44] (also common in “intersex” surgeries) [5, 6].
	Type II: Alterations of the labia , within which type IIa is the partial or total removal of the labia minora, type IIb is the partial or total removal of the labia minora and/or the (external)* clitoris, and type IIc is the partial or total removal of the labia minora, labia majora, and (external)* clitoris.	Alterations of the labia , including trimming of the labia minora and/or majora, also known as “labiaplasty” [42, 43].
	Type III: Alterations of the vaginal opening , within which type IIIa is the partial or total removal and appositioning of the labia minora, and type IIIb is the partial or total removal and appositioning of the labia majora, both as ways of narrowing the vaginal opening.	Alterations of the vaginal opening , typified by narrowing of the vaginal opening, variously known as “vaginal tightening,” “vaginal rejuvenation” [45], or “hymen repair” [46].
	Type IV: Miscellaneous , including piercing, pricking, scraping, and cauterization.	Miscellaneous , including piercing [47], tattooing [48], and liposuction [49].
Example high-prevalence geographies	Depending on the procedure: Somalia, Sierra Leone, Guinea, Djibouti, Egypt, Mali, Sudan, Senegal, Eritrea, Ethiopia, Mauritania, Liberia, Burkina Faso, Gambia, Guinea Bissau, Kenya, Nigeria, Chad, Cote d’Ivoire, and concomitant diaspora communities [50].	North America, Australia, Europe [51].
Actor	Traditional practitioner, midwife, clinical worker or paramedic, surgeon.	Surgeon, tattoo artist, body piercer.
Age at which performed	Depending on the procedure/community: Typically around puberty, but ranging from infancy to adulthood [32].	Typically in adulthood, but increasingly on adolescent girls [3]; intersex surgeries (e.g., cliteroplasty) more common in infancy, but ranging through adolescence and adulthood [52]
Legal status in the UK and similar regimes	Unlawful	Lawful
<p>* NOTE: The WHO wrongly equates the external portion of the clitoris (i.e., the part that protrudes outside the body) with the entire clitoris, thereby diminishing the anatomical and sexual significance of the latter. Most of the clitoris, including the majority of its erectile tissues and structures necessary for orgasm, is underneath the superficial skin layer of the body—like an iceberg—and therefore cannot be removed without major surgery (which does not occur in any recognized form of “FGM”). This fact may explain why sexual pleasure and orgasm are reported at higher than expected rates in women who have experienced various forms of genital cutting [53].</p>		

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

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

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

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

3. The status of the law

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

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

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

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

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

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

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

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

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

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

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

4. Interrogating inconsistencies

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

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

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

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

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

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

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

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

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

Box 2. Double standards: a case study

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

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

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

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

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

5. Explaining the inconsistencies

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6. Conclusion

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

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

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

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

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

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