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# Zero Tolerance for Genital Mutilation: a Review of Moral Justifications

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## Abstract

**Purpose of Review** To summarize and critically evaluate the moral principles invoked in support of zero tolerance laws and policies for medically unnecessary female genital cutting (FGC).

**Recent Findings** Most of the moral reasons that are typically invoked to justify such laws and policies appear to lead to a dilemma. Either these reasons entail that several common Western practices that are widely regarded to be morally permissible and are currently treated as legal—such as intersex "normalization" surgery, female genital "cosmetic" surgery performed on adolescent girls, or infant male circumcision—are in fact morally impermissible and should be discouraged if not legally forbidden; or the reasons are being applied in a biased and prejudicial manner that is itself unethical, as well as inconsistent with Western constitutional requirements of equal treatment of individuals before the law.

**Summary** In the recent literature, only one principle has been defended that appears capable of justifying a zero tolerance stance toward medically unnecessary FGC without relying on, exhibiting, or perpetuating unjust cultural or moral double standards. This principle holds that, in countries whose ethicolegal traditions are shaped by a foundational concern for individual rights, respect for bodily integrity, and personal autonomy over sexual boundaries, all non-consenting persons have an inviolable moral right against any medically unnecessary (or medically deferrable) interference with their genitals or other private anatomy. In such countries, therefore, all non-consenting persons, regardless of age, race, ethnicity, parental religion, assigned sex, gender identity, or other individual or group-based features, should be protected from medically unnecessary genital cutting, regardless of the severity of the cutting or the expected level of benefit or harm.

**Keywords** Female genital cutting · Female genital mutilation · Intersex normalization surgery · Male circumcision · Zero tolerance · Bodily integrity · Genital autonomy · Sexual rights

## Introduction

In Australia at the time of writing, a person may be imprisoned for up to 7 years who either "excises, infibulates or otherwise mutilates the whole or any part of the labia majora or labia minora or clitoris of another person," or "aids, abets, counsels, or procures a person to perform" any of those acts, collectively defined as "female genital mutilation" or "FGM" for legal purposes. The only exception to this prohibition is for procedures that are necessary to the health of the person and which are performed by a qualified medical practitioner on that basis; otherwise, even the real or apparent consent of the affected individual does not count as a valid defense against a charge of "FGM" [1]. Similar legislation exists in most other Western countries—and countries sufficiently under Western influence [2]—although in some cases, it is clarified that the crime in

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question concerns medically unnecessary[1] female genital cutting (FGC) done to persons who are under the age of 18, specifically [5]. Because of the seriousness of the crime and of the penalties that may be applied to anyone convicted of committing it, a precise understanding of key terms and definitions in the law is necessary. In particular, the meanings of "clitoris" and "otherwise mutilates" turn out to be vital for determining which acts are in fact "FGM," as the first case addressing this crime in Australia has recently revealed.

The defendants in this case were members of the Dawoodi Bohra community, a sect within the Musta'li Isma'ili Shi'a branch of Islam. The Dawoodi Bohras practice both female and male genital cutting for religious reasons, basing the rituals on a secondary source of Islamic jurisprudence known as the *da'a'im al-Islam* [6]. Although many facts of the case were in dispute, it was agreed by all that some kind of procedure involving the genitals of two girls had occurred and that, at minimum, a metal object or tool had been applied to their vulvas. Whether cutting of any kind took place was a matter of contestation, but if it did, it was likely to have been what is sometimes called a ritual "prick" or "nick" to the clitoral prepuce (foreskin or hood), without removal of tissue [7]. At least, there was no physical evidence of scarring, discoloration, altered morphology, or any other visible sign of cutting, which is consistent with at least two possibilities: (a) no cutting occurred, or (b) cutting did occur, but was sufficiently slight or superficial so as to allow complete healing, resulting in no discernable difference between the genitals of the alleged victims of "FGM" and developmentally normal, unaltered female genitalia [8–10]. By contrast, when boys within the Dawoodi Bohra community have their genitals altered for religious reasons, there is no doubt as to whether cutting has occurred: the male version of the ritual, assuming a typical circumcision, removes a third or more of the functioning skin system of the penis, often leaving a scar [11–13].

The grounds for conviction, then, came down to this: Does an act of pricking or nicking the clitoral prepuce, except for cases of medical necessity, count as "otherwise mutilating" the "clitoris" even if there is no cutting of the clitoral glans, no removal of genital tissue, no lasting injury beyond the period of healing, no loss of sexual sensation, no functional impairment, and no permanent change to the appearance of the vulva? According to the original trial judge, whose decision was later affirmed by the Australian High Court after a series of appeals, the answer to this question is yes: (a) for legal purposes, the clitoral prepuce is part of the clitoris (or else continuous with the labia minora, also covered by the law), and (b) any medically unnecessary cutting of this tissue, no matter how slight or by what means, whether performed for religious reasons or otherwise, and regardless of anatomical or health-related outcomes, falls under "otherwise mutilates" and is thus illegal and subject to harsh criminal sanction.

## The Problem of Double Standards

As might have been expected, this ruling was celebrated by supporters of so-called "zero tolerance" laws and policies regarding non-Western-associated forms of FGC (see Table 1 for more on this distinction), such as those that have been championed by the World Health Organization (WHO) and various other agencies of the United Nations (UN) [16]. However, some scholarly commentators expressed concern that the court's conclusion was both legally erroneous and morally suspect. One of these scholars was the trauma specialist and criminology professor Juliet Rogers, whose work often focuses on disparate treatment of marginalized communities. Rogers made the following observations, comparing the (apparent) form of cutting at stake in the Australian case to two other forms of genital cutting that are more familiar to Western culture, one of which has already been mentioned:

(1) Male genital cutting or circumcision (MGC). According to Rogers [10] (p. 236): "anything which happened to the girls was far less of an invasion into the flesh than the practice of male circumcision." Although ritual MGC of boys is practiced within the same Bohra families as the less invasive, but illegal, rite for girls, the former is not defined as mutilation and is currently regarded as legal to perform on non-consenting minors in all "states and territories of Australia and in most Western countries." Notably, such non-consensual MGC is permitted whether or not it is done for religious reasons and irrespective of medical rationale.
(2) Female genital "cosmetic" surgery (FGCS). According to Rogers [10] (p. 236): "labiaplasty is [also] alive and flourishing" in Australia, including among adolescent girls with the permission of their parents. So are such purportedly cosmetic procedures as "vaginal tightening" and even "clitoral piercing" (the latter of which is routinely performed in Western countries by medically unqualified "body artists" in commercial studios and other non-clinical environments).

[1] According to a recent consensus statement by the Brussels Collaboration on Bodily Integrity, "an intervention to alter a bodily state is medically necessary when (1) the bodily state poses a serious, time-sensitive threat to the person's well-being, typically due to a functional impairment in an associated somatic process, and (2) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat. 'Medically necessary' is therefore different from 'medically beneficial'—a weaker standard—which requires only that the expected health-related benefits outweigh the expected health-related harms. The latter ratio is often contested as it depends on the specific weights assigned to the potential outcomes of the intervention, given, among other things, (a) the subjective value to the individual of the body parts that may be affected, (b) the individual's tolerance for different kinds or degrees of risk to which those body parts may be exposed, and (c) any preferences the individual may have for alternative (e.g., less invasive or risky) means of pursuing the intended health-related benefits" [3••] (p. 18). Definition based on [4].

Rogers explained that because the legislation on "FGM" in Australia has no age limit, it should logically find these latter acts (i.e., of FGCS) to be criminal as well, even if performed consensually [10] (p. 236). However, as with male circumcision, Western-style FGCS is not currently treated as illegal, even when performed on minors, despite sharing multiple morally salient features with the practices that have been criminalized in Australia as "FGM" (Table 1) [14, 17–19]. Complicating matters further, the legal scholars Nancy Ehrenreich and Mark Barr, among many other writers [20–27], have raised an additional comparison in this context, namely to:

(3) Intersex genital cutting (IGC) (i.e., gender "normalization" surgery). Every year, in Western countries, thousands of intersex genital surgeries are performed on children and infants to make their genitals appear more stereotypically masculine or feminine. According to Ehrenreich and Barr, "These surgeries are medically unnecessary, are far more complicated than African genital cutting, and often have equally, if not more, serious physical and psychological consequences for their recipients" [28] (p. 74).

Among the IGC practices mentioned by Ehrenreich and Barr is the surgical reduction of the clitoris, also known as "feminizing" clitoroplasty. This surgery is often performed on children with certain natural variations in sex characteristics (or differences of sex development) who are assigned female at birth [29–32]. Such cutting is far more invasive than any pricking or nicking of the clitoral hood, affects the same organ, is almost always performed on minors who are incapable of consenting, and is arguably no more "necessary to the health of the person on whom it is performed"—to quote the Australian statute—than are those practices which the law considers to be "FGM" (see Box 1 for further discussion). As such, the existence of a double standard seems apparent. Indeed, if one "applies the arguments usually marshaled against FGC to intersex cutting," as Ehrenreich and Barr point out, one will find that those same arguments have "equal force in the intersex context" [28] (p. 75). And yet non-consensual IGC remains legal in the vast majority of Western countries that have forbidden non-Western-associated FGC, in some cases irrespective of consent and typically irrespective of intent or severity [20, 21, 33].

How can this situation be explained? According to Ehrenreich and Barr, it can be explained by the influence of cultural bias stemming from, among other things, "a racially privileged" Western exceptionalism, wherein "the posture of white privilege [that is] subtly revealed in the arguments against female circumcision prevents FGC opponents from acknowledging that similar unnecessary and harmful genital cutting occurs in their own backyards." Ehrenreich and Barr go on to argue that "recognition of that similarity has policy implications: the condemnation directed at FGC practitioners is inappropriate unless we are equally willing to condemn physicians performing intersex operations" [28] (p. 75). This implication falls out of what might be called the *principle of policy parity*, to be discussed in the following section.

**Box 1. On defining "health" in the context of genital cutting.** Adapted from [34]

It is sometimes claimed, albeit without strong evidence, that children with visibly atypical genitalia (such as a larger than average but healthy clitoris) would be embarrassed or otherwise psychosocially disadvantaged by virtue of their bodily difference. Accordingly, it might be argued that early surgery to "normalize" their genitals (i.e., before they are capable of providing their own informed consent) could be justified on grounds of mental health, notwithstanding the risks to physical, or indeed mental, health entailed by the surgery [35]. At the same time, following the WHO, it is often claimed that "FGM" has no health benefits, and only causes harm. Taken together, these two claims might seem to ground a principled distinction between the two forms of genital cutting, helping to explain why the former is considered permissible in Western countries while the latter is not.

But even supposing, despite the lack of strong evidence, that intersex genital cutting did promote mental health by mitigating purported social harms associated with being perceived as "different," this would not categorically distinguish it from so-called "FGM." This is for the simple reason that, in societies where genital modification of children is culturally normative, any child who has not undergone the prescribed modification would be left with "atypical" genitalia vis-a-vis local standards and, presumably, be just as liable to teasing or other forms of social disadvantage claimed to adversely affect a person's mental health [5, 36–38]. If that is right, then "FGM" may well have health benefits in certain contexts according to the WHO's own broad definition [39].

Given such a broad definition, it is problematic to assume that the mere attribution of "health benefits" (of some kind or another) to non-consensual genital cutting is sufficient to make it morally permissible, especially if there are other, less risky, more autonomy-respecting ways of achieving the same or substantively similar health benefits [40, 41]. Such an assumption can only incentivize supporters of non-consensual genital cutting to medicalize the practice and look for evidence of "health benefits" [42–45], however questionable or readily achievable by other means [46–49]. In any event, the "mental and social well-being" allegedly afforded to children through ritual genital cutting in societies where such cutting is culturally normative—e.g., acceptance by one's peers and elders, avoidance of teasing, initiation into a religious community, elevation to adult status in the case of a rite of passage, greater perceived attractiveness, and so on [2, 37, 50–52]—should be given no less moral weight (all else being equal) than what is alleged to follow from intersex "normalization" surgeries.

Yet in the case of "FGM" it is widely argued that, instead of surgically shaping children's genitals to make them conform to apparently unjust or harmfully constrictive societal expectations, it is the societal expectations themselves that should be changed, for example, through education and consciousness-raising. If surgically unmodified genitalia thereby became more culturally normative, a "lack of genital cutting" could no longer reasonably be construed as prejudicial to a child's mental health or social well-being [53].

**Table 1** Non-Western-associated FGC ("FGM") vs. Western-style "cosmetic" surgeries

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|---|---|---|
| Category | Non-Western-associated FGC or "female genital mutilation" as it is defined by the WHO: namely, all medically unnecessary procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs—widely condemned as human rights violations and thought to be primarily non-consensual | Western-style FGC or "female genital cosmetic surgeries" (FGCS): typically medically unnecessary procedures involving partial or total removal of the external female genitalia, or other alterations to the female genital organs for perceived cosmesis—widely practiced in Western countries and generally considered acceptable if performed with the informed consent of the individual |
| Procedures + WHO typology | Type I: Alterations of the clitoris or clitoral hood, within which type Ia is partial or total removal of the clitoral hood, and type Ib is partial or total removal of the clitoral hood and the clitoral glans | Alterations of the clitoris or clitoral hood, including clitoral reshaping, clitoral unhooding, and feminizing clitoroplasty |
| | Type II: Alterations of the labia, within which type IIa is partial or total removal of the labia minora, type IIb is partial or total removal of the labia minora and/or the clitoral glans, and type IIc is the partial or total removal of the labia minora, labia majora, and clitoral glans | Alterations of the labia, including trimming of the labia minora and/or majora, also known as "labiaplasty" |
| | Type III: Alterations of the vaginal opening (with or without cutting of the clitoris), within which type IIIa is the partial or total removal and appositioning of the labia minora, and type IIIb is the partial or total removal and appositioning of the labia majora, both as ways of narrowing the vaginal opening** | Alterations of the vaginal opening (with or without cutting of the clitoris), typified by narrowing of the vaginal opening, variously known as "vaginal tightening," "vaginal rejuvenation," or "husband stitch" |
| | Type IV: Miscellaneous, including piercing, pricking, nicking, scraping, and cauterization. | Miscellaneous, including piercing, tattooing, pubic liposuction, and vulval fat injections |
| Examples of relatively high-prevalence countries | Depending on procedure: Burkina Faso, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Indonesia, Iraqi Kurdistan, Liberia, Malaysia, Mali, Mauritania, Senegal, Sierra Leone, Somalia, Sudan, and concomitant diaspora communities | Depending on the procedure: Brazil, Colombia, France, Germany, India, Japan, Mexico, Russia, South Korea, Spain, Turkey, USA |
| Actor | Traditional practitioner, midwife, nurse or paramedic, surgeon | Surgeon, tattoo artist, body piercer |
| Age at which typically performed | Depending on the procedure/community: typically around puberty, but ranging from infancy to adulthood. | Typically in adulthood, but increasingly on adolescent girls or even younger minors; intersex surgeries (e.g., clitoroplasty) more common in infancy, but ranging through adolescence and adulthood. |
| Presumed Western status | Unlawful and morally impermissible | Lawful and morally permissible |
| Analysis | Given that there is overlap (or a close anatomical parallel) between each form of WHO-defined "mutilation" and Western-style "cosmetic" FGC, neither of which is medically necessary, one must ask what the widely perceived *categorical* moral difference is between these two sets of procedures. Controlling for clinical context—which varies across the two sets and is often functionally similar—the most promising candidate for such a difference appears to be the typical age, and hence presumed or likely consent-status, of the subject. But if that is correct, it is not ultimately the degree of invasiveness (which ranges widely across both sets of practices), specific tissues affected, or the precise medical or nonmedical benefit-to-risk profile of medically unnecessary (female) genital cutting that is most central to determining its perceived moral acceptability. Rather, it is the extent to which the affected individual desires the genital cutting and is capable of consenting to it. This suggests that the core of the putative rights violation is the lack of consent regarding a medically unnecessary interference with one's sexual anatomy, a consideration that applies regardless of the sex or gender of the non-consenting person | |

Adapted from [3, 5]

**In practice, the most severe instances of medically unnecessary narrowing of the vaginal opening regarded as infibulation (FGM) leave a smaller introitus and often cause greater functional difficulties than analogous procedures regarded as "vaginal rejuvenation" (FGCS). However, the WHO typology does not distinguish between more or less constrictive outcomes in its definition of type III FGM, and both infibulation and "vaginal rejuvenation" fall on a spectrum. Thus, there is no anatomically decisive line between them, and in some cases, they may be practically indistinguishable: e.g., partial re-infibulation versus a so-called husband stitch [14, 15]

## The Principle of Policy Parity

The principle of policy parity (PPP) holds that, for any given policy or policy proposal, relevantly like cases within the policy remit should be treated alike. The PPP applies generally. Indeed, in most ethical systems, invidious treatment of relevantly similar persons or social groups is forbidden. Moreover, such treatment is expressly forbidden in virtually all Western legal regimes. So, for example, as the anthropologist Fuambai Ahmadu has argued, "if there is to be an age of consent for nonmedical genital procedures, then this needs to be applied across all categories of groups and individuals." However, "if we allow that, among some groups or for some individual cases, exceptions can be made, we also must allow similar exceptions in parallel cases within other groups or among other individuals under similar circumstances" [54] (p. 233). Of course, what reasonably constitutes a "parallel" case or a sufficiently "similar" circumstance is a difficult question, to be addressed later on.

With respect to the specific comparison between non-Western-associated FGC (Table 1) and male circumcision (partial or total removal of the penile prepuce; Box 2), Ingvild Bergom Lunde and colleagues have echoed Ahmadu's perspective. In a recent paper, they describe a growing awareness among scholars of genital cutting of an apparently "unresolvable dilemma." Given the physical and symbolic overlap between male and female genital cutting (when the full range of each kind of practice across cultural contexts is taken into consideration and like cases compared), in order to avoid violating the PPP, it seems that parents and policymakers must decide whether (1) "girls should have the same access to cultural identity-promoting genital rituals as boys by allowing a minor cutting or 'pricking' of their genitalia" or (2) "boys should be granted the same human rights as girls with the ritual cutting of their genitalia being regarded as a breach of the right to bodily integrity" [55•] (internal citations omitted). This dilemma, rarely expressed so directly but raised in one form or another by scholars and activists alike for decades, has come to the fore of bioethical debates in recent years.

**Box 2. The human prepuce**. Adapted from [56]. Quotes from [57]. See also [58–60]

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The prepuce is a "common anatomical structure of the male and female external genitalia of all human and non-human primates." In humans, the penile and clitoral prepuces are identical in early fetal development and remain indistinguishable in some intersex individuals. The prepuce is an "integral, normal part of the external genitalia that forms the anatomical covering of the glans penis and clitoris," thereby internalizing each and "decreasing external irritation and contamination." In the case of the penile prepuce, an additional function is to protect the urinary opening from abrasion, as this runs through the penile, but not through the clitoral, glans. In both cases, the prepuce is "a specialized, junctional mucocutaneous tissue which marks the boundary between mucosa and skin ... similar to the eyelids, labia minora, anus, and lips." The "unique innervation of the prepuce establishes its function as an erogenous tissue."

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In contributing to these debates, some ethicists and others, including the present author, have argued against the first proposed solution to the dilemma (i.e., removing or weakening existing protections for girls in order to allow medically unnecessary genital cutting of male and intersex children to continue unrestricted) [61–88]. Those who support such a solution, by contrast, typically begin with the assumption that non-consensual genital cutting of healthy male children is morally acceptable and should be allowed and argue from this that relatively more "minor" forms of non-consensual FGC should also be allowed (with no need to prove medical necessity) [89–95]. An advantage of this solution is that it would indeed respect the PPP and avoid the apparent problem of unjust double standards. However, it may also be regarded as undesirable for several reasons. As argued elsewhere [68] (p. 161), if Western societies were to change their laws and policies to allow for medically unnecessary, non-consensual cutting of female genitalia, this would likely result in:

(1) Disturbances and inconsistencies throughout their legal systems, possibly requiring new definitions of bodily assault and opening the door for inadvertent legal protection of a wide range of potentially harmful practices (typically carried out on children, who cannot adequately defend themselves)
(2) Removal of an important tool that reformers from within the affected communities rely on to solve the "collective action" problem introduced by FGC (i.e., the problem of taking unilateral action to protect one's child from genital cutting in the face of countervailing social pressures)
(3) Regulatory challenges in tracking and monitoring FGC sessions to ensure that they were not being used as opportunities for more invasive procedures
(4) Exposure of young girls to an unknown amount of surgical risk in the absence of medical need, thereby placing doctors in an untenable position with respect to their professional duties
(5) Widespread outrage among women who consider themselves victims and/or survivors of FGC (including relatively minor forms of such cutting) as well as their allies, and other forms of political backlash

For these and other reasons, it may be worthwhile to consider an alternative solution to the dilemma: namely,

introducing at least some measure of protection against nonconsensual, medically unnecessary genital cutting of children who do not have characteristically female genitalia (i.e., vulvas) [96]. In addition to intersex children and cisgender boys (i.e., non-transgender males), this would include children born with penises who later experience or exhibit a gender identity other than male: for example, some transgender, especially transfeminine, persons, as well as those who identify as genderqueer or (otherwise) non-binary [97–99].[2] In short, according to this solution, all non-consenting persons, regardless of sex, gender, or gender identity, should be acknowledged as having a basic moral right to bodily integrity and to genital autonomy.

In this context, genital autonomy refers to "a person's being left to make their own informed decision about whether or not to have [their] genitals modified for non-therapeutic reasons (that is, modified in the absence of a physical disease or functional problem requiring immediate surgical intervention)" [72] (p. 7). In Western societies, all adults of sound mind are currently assumed to have an absolute right to genital autonomy in this sense, no matter how slight the intended modification, as are all children in these societies who have vulvas. The notion that children in the same societies who do not have vulvas should also be afforded this right has historically been seen as controversial. However, it was recently defended by a large group of scholars in law, medicine, ethics, sociology, anthropology, and other areas. This group argued that, at least in places with a strong tradition of individual rights—including the right to set and maintain one's own sexual boundaries—"cutting any person's genitals without their informed consent is a serious violation of their right to bodily integrity." As such, it is "morally impermissible unless the person is nonautonomous (incapable of consent) and the cutting is medically necessary" [3••] (p. 17).

To summarize, there are at least two main ways to resolve the above-stated dilemma regarding the PPP, given the overlapping features of (at least some forms) of female, male, and intersex genital cutting. These two approaches are currently represented by different sets of contributors to the bioethical literature, who might broadly be characterized as follows:

(1) Equal opportunity advocates of parental and religious rights: Those who maintain that *both* male and female (and presumably also intersex) medically unnecessary, non-consensual genital cutting are morally permissible and should be tolerated in Western societies for any reason so long as the cutting is no more harmful on average or in expectation than ritual male circumcision (especially as it is performed on newborns within Judaism).

(2) Equal opportunity advocates of children's rights: Those who maintain that *neither* male nor female (nor intersex) medically unnecessary, nonconsensual genital cutting are morally permissible, regardless of parental intent or the expected (average) level of benefit or harm.

A third position, which stands in contrast to both (1) and (2), can be inferred from the relevant policy materials of the WHO [104–107] and is still sometimes defended in the bioethical literature [108]. This position is reflected in the views of those individuals or organizations that—like the WHO—are dedicated to "zero tolerance for FGM" while at the same time being neutral toward or even supportive of other forms of medically unnecessary genital cutting, including some that affect non-consenting persons. These individuals and organizations could be called:

(3) Selective advocates of zero tolerance for genital cutting: Those who maintain, in effect, at least one of the first three propositions below (a–c) along with the fourth (d).

 (a) Medically unnecessary male genital cutting should be allowed for any reason, including when performed by individuals who do not have a medical license on children who cannot consent, so long as what is attempted is a penile circumcision and the child's parents give their permission.

 (b) Medically unnecessary intersex genital cutting should be allowed for social and cosmetic reasons, including when performed on children who cannot consent, but only by individuals who do have a medical license, so long as the child's parents give their permission.

 (c) Western-style "cosmetic" female genital cutting should be allowed, including some forms performed by individuals who do not have a medical license (e.g., genital piercing by a "body artist"), unless the person requesting the procedure is from an African, Middle Eastern, or Southeast Asian culture in which female (as well as male) genital cutting is traditionally practiced and the request is interpreted as being

[2] Transgender women and girls can be harmed in particular ways by the preemptive removal of their penile foreskins through circumcision [56]. For example, the penile foreskin, which amounts to between 30 and 50 square centimeters of highly sensitive, erogenous tissue in the fully developed organ [11, 57, 100–102], can be used in the construction of a neovagina if the individual decides to pursue certain gender-affirming procedures, thereby reducing the need for extensive skin grafts from other parts of the body, such as the thigh [103].

culturally motivated;[3] and the affected individual (or her proxy, if she is a legal minor) consents or gives permission.

(d) Medically unnecessary female genital cutting as performed in a non-Western context or by a non-Western actor (see Table 1) should be criminally prohibited in all cases, regardless of severity, whether or not it is performed by someone with a medical license, and irrespective of the intentions of the parents (even if religious in nature), especially, but not necessarily only, if the affected individual is under the age of 18, even if her parents give permission.

This position has been criticized by various scholars for being logically inconsistent, morally incoherent, and culturally biased.[4] Can it nevertheless be defended?

## Defending Selective Zero Tolerance

In a 2008 joint report with other UN agencies, the WHO asserts that "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs" are morally impermissible if done for "non-medical reasons" [105] (p. 1). Although the WHO acknowledges, in passing, that "a variety of social and religious reasons" are reported by the families and communities that value ritual FGC, it does not seem to assign much weight to these reasons. Instead, it claims that all instances of FGC that are not done for "medical reasons," including forms that are less invasive than male circumcision and various forms of intersex genital cutting, violate the human rights of women and girls, including the right to physical integrity. How can this claim be morally justified in a way that supports the third position outlined above, that is, the selective condemnation of non-Western-associated FGC? Potential hurdles for adequately grounding such a justification include the following [adapted from [114•]]:

(1) There is no mention in the WHO materials of consent-status, age, or maturity in determining what constitutes impermissible "mutilation" regardless of type. This suggests that adult, consensual FGCS (not done for "medical reasons") is definitionally "FGM" (Table 1) and thus morally wrong and a human rights violation. However, that does not appear to be the position of the WHO, which has not sought to "eliminate" this Western form of medically unnecessary female genital cutting. Thus, the mere cutting or removal of healthy genital tissue for non-medical reasons is evidently not sufficient to ground claims of moral impermissibility, human rights violations, and so on [115, 116].[5]

(2) Perhaps it is the *non-consensual* cutting or removal of healthy genital tissue for non-medical reasons that constitutes a human rights violation. But if that is the case, non-consensual ritual male circumcision—which is not done "for medical reasons"—is a human rights violation, which the WHO does not seem to think. In fact, the WHO *supports* non-consensual male circumcision, citing studies of adult, voluntary circumcision that appear to show certain health benefits (primarily, a reduced risk of female-to-male transmission of HIV in settings with high rates of such transmission and a low prevalence of male circumcision) [104, 119].

(3) Perhaps, then, it is the non-consensual cutting or removal of healthy genital tissue that has *not been associated with potential health benefits* that constitutes a human rights violation. If so, as noted in Box 1, this creates an incentive for medically qualified supporters of non-Western-associated FGC to look for, or generate, evidence of such health benefits, just as medically qualified supporters of non-consensual MGC have done [46, 120]. But now suppose that studies of adult, voluntary female genital cutting appeared to show certain health benefits, such as a reduced risk of various infections or diseases, most of which could be more safely and effectively managed non-surgically (as with MGC). Would the WHO find such data sufficient to support non-consensual genital cutting of minor girls? Presumably it would not [120–122].

(4) In fact the WHO *opposes* medicalization of FGC—even as a harm reduction measure (see footnote 5) [117]. Even

[3] Referring to the current UK anti-FGM law, which is similar to the one in Australia, Arianne Shahvisi has recently argued that the law "codifies the idea that women of particular cultures are not as capable of making their own decisions as are other women, let alone as capable as men. For, if a woman requests a labiaplasty (say) from a private cosmetic surgeon in the UK, her ethnicity will likely be used to determine her consent status, and in turn whether or not the procedure can occur legally. The current law enforces differential access to [genital cutting] procedures on the basis of race" [109] (p. 105).

[4] For a selection of arguments in this vein, see these references: [5, 36, 61, 67, 70, 82, 85, 86, 109–113].

[5] Ironically, advocates of "selective zero tolerance" do not criticize the performance of medically unnecessary female genital cutting when it is done for ostensibly "cosmetic" reasons by medical professionals in a clinical environment ("FGCS"), while at the same time, they categorically oppose the performance of medically unnecessary female genital cutting when it is done for "cultural" reasons ("FGM") *even when* it is done by medical professionals in a clinical environment (that is, they oppose the so-called "medicalization" of non-Western-associated FGC, arguing instead that it must be stopped altogether) [16, 117]. However, it is hard to see why Western-style "cosmetic" practices should not be regarded as just as "cultural" as non-Western-associated FGC practices. For as Alice 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" [118] (p. 27). As such, "highly restrictive esthetic 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 [play] a role in motivating requests" for FGCS in Western countries [4] (p. 62). In short, "the rationale [for cutting] cannot be separated from cultural associations" irrespective of the culture in which it occurs [118] (p. 27).

a ritual nick performed with pain control by a trained physician is considered to be morally impermissible by the WHO. Thus, the WHO seems to believe that girls have a human right to "bodily integrity" that is violated by *all* medically unnecessary FGC, no matter how superficial, whether or not evidence of health benefits could be found [121].

(5) But if this is a *human* right, then it must apply to all humans, including intersex children and males [84, 123, 124]. But the WHO does not seem to believe that male children, at least, have an absolute moral claim against non-consensual, medically unnecessary genital cutting (its position with respect to intersex children is unclear) [104, 107, 125].

Thus, the ethical basis for selective zero tolerance of non-Western-associated FGC remains uncertain [114•].

As a final possibility, seemingly different symbolic meanings or parental intentions are sometimes invoked to explain why non-Western-associated FGC, but no other form of medically unnecessary genital cutting (as such) should be categorically prohibited as a rights violation, irrespective of the level of harm. For example, it is often said that FGC, unlike at least some forms of MGC, is "not a religious practice" [126], with the apparent implication being that religious practices deserve greater respect, whether morally or legally, than otherwise comparable practices that are not religious in nature (i.e., "merely cultural" practices) [127]. However, this argument is questionable along several dimensions [128–130], as summarized in Table 2.

A second claim that is often raised is that non-Western-associated FGC is a sexist practice that either involves or amounts to gender-based violence [131]. As the WHO states in its 2008 report, such FGC "reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women" [105] (p. 1). This is not typically thought to be the case for other forms of genital cutting, which might suggest that there is still a principled basis for the "selective zero tolerance" position outlined above. This possibility is discussed in the following section.

## Sex Discrimination

What about the view that non-Western-associated FGC is a form of sex discrimination or gender-based violence? The claim that all such FGC, other than that performed for medical reasons, reflects inequality between the sexes and discriminates against women is doubtful.[6] Most notably, there are virtually no societies that practice ritual FGC that do not also practice ritual MGC, usually in a parallel rite of passage with similar social functions [50, 51, 132, 133]. As the anthropologist Sara Johnsdotter has recently noted, "Rationales for circumcision of boys and girls vary with local context, but the genital modifications are often performed with similar motives irrespective of gender: to prepare the child for a life in religious community, to accentuate gender difference and to perfect gendered bodies, for beautification, for cleanliness, to improve the social status of the child through ritual, and so on" [50•] (p. 32).

In short, there are numerous, overlapping motives behind male and female genital cutting and considerable cross-cultural variation. But one thing is a cross-cultural constant: *if* a group practices ritual FGC, it almost certainly *also* practices ritual MGC (but not vice versa; there are numerous groups that cut the genitals only of boys). Moreover, depending on the group in question, either the male or female version of the ritual may be more invasive, risky, or damaging to health or sexuality [134–144]. For further discussion, see Box 3.

**Box 3. Sexual control as a motive for child genital cutting**

Following the WHO, it is a common belief that—wherever it may happen—non-Western-associated FGC is primarily intended to "control" the sexuality of women and girls. But this belief, if it is meant to apply universally, and especially if it is thought to ground a categorical distinction with MGC, is not supported by the anthropological record. Certainly, there are many societies in which women and girls are expected to be sexually chaste or submissive in a way, or to an extent, that differs greatly from the corresponding expectation for boys and men. Some of these (highly sexually unequal) societies practice FGC—as well as MGC—but most such societies practice neither form of genital cutting, or practice MGC only [132]. In other words, there does not seem to be a strongly predictive relationship between the extent of sexual inequality in a society and whether it practices a form of FGC (and thus also MGC). As a panel of scholarly experts has recently noted, "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" [132] (p. 23).

Moreover, some societies that do practice FGC—as well as MGC—are not especially concerned with female chastity and virginity. Among the Kono of Sierra Leone, for instance, it has been argued that "there is no cultural obsession with feminine chastity, virginity, or women's sexual fidelity, perhaps because the role of the biological father is considered marginal and peripheral to the central matricentric unit" [145] (p. 285). And to the extent that there is an explicit link between genital cutting and attempted "control" of sexuality in some cases, this association is not limited to FGC but applies to MGC in certain contexts as well [146, 147]. Male circumcision among the Nso people of Cameroon, for example, is said to tame, moderate, and temper the sexual instinct, "thereby helping a man to act responsibly" [85] (p. 186).

Finally, Western countries have their own histories of attempted control of sexuality; and in the United States this history is directly linked to genital cutting. According to historians, male circumcision was adopted in New England in the late 1800s as part of a cultural crusade to combat childhood masturbation, alongside proposals to mass-circumcise "Negro" men to supposedly quiet their sexual appetite and prevent them from raping white women [46, 119, 148, 149].

[6] For an extensive recent discussion, see Earp and Johnsdotter [114•]. Only a brief outline can be given here.

**Table 2** Problems with claiming "religious" vs. "cultural" motivations for genital cutting

| | |
|---|---|
| It is often claimed that at least some forms of MGC, unlike any form of FGC, are religious in nature. This claim appears to be based on the observation that FGC is nowhere mentioned in the Quran, the central scripture of Islam, whereas MGC is not only mentioned in but is positively endorsed by the Torah, the central scripture of Judaism. The implication then is that MGC is at least sometimes done for religious reasons, whereas FGC, though perhaps incidentally associated with Islam or other religions in many contexts, is ultimately done for "merely cultural" reasons, which are assumed to be less worthy of respect. There are several problems with this line of reasoning, as follows: | |
| Basis in the Quran | It is true that FGC is not mentioned in the Quran, but neither is MGC nor the injunction to pray five times per day facing Mecca. Nevertheless, both MGC—viz., male circumcision—and the daily prayer ritual are still widely recognized as Muslim religious practices, both by insiders and outsiders to Islam, and few would contest this interpretation. Clearly, then, it is possible for a practice to have a meaningful religious standing within Islam despite not being mentioned in the Quran |
| Basis in the Hadith | Though neither practice is mentioned in the Quran, both MGC and FGC are mentioned in the Hadith—sayings and deeds attributed to Muhammed—as well as other secondary sources of Islamic scripture. Based upon such scripture, some Muslim communities, including the Dawoodi Bohra, regard both MGC and FGC as religiously required |
| Cultural reasons | Though MGC is sometimes performed for unambiguously religious reasons, for example among devout Orthodox Jews, in the USA, at least, it is overwhelmingly performed for "merely cultural" reasons and yet is still accepted in those cases by defenders of "selective zero tolerance." From their perspective, then, medically unnecessary childhood genital cutting clearly does not need to be performed for explicitly religious reasons to be regarded as both morally and legally permissible |
| Respect | Finally, even if a given practice were only "cultural" as opposed to religious, this would not entail that it was any less valuable or worthy of respect. For example, a practice might be central to the way of life of a community despite not being formally listed in a book of scripture, and thus be at least prima facie worthy of respect; and a practice might be clearly religious in nature, but nevertheless highly objectionable and ultimately unworthy of being respected on moral or legal grounds. Thus, the religious or cultural nature of a practice does not determine the level of respect it is owed |

## Ethical Implications

What these observations suggest is that appealing to sex discrimination to justify "selective zero tolerance" is unlikely to succeed on empirical grounds. But let us suppose, for the sake of argument, that all non-Western-associated FGC did indeed reflect patriarchal social structures: for example, by symbolically assigning a lower status to girls and women compared to boys and men. If that were true, could it explain why all and only non-Western-associated medically unnecessary FGC was an unambiguous human rights violation, while the same could not be said of medically unnecessary MGC or IGC or even Western-style FGCS?

The legal theorist Kai Möller has recently argued against this proposition [81••]. According to Möller, there must be something intrinsically objectionable about medically unnecessary genital cutting, especially when it is done without consent, that makes it a human rights violation in the first place, for questions about gender (in)equality in this context to arise: "the near-consensus against female genital cutting in the Western world, to be defensible," he writes, "must be more than just a proxy for a commitment to gender equality … it must also reflect the conviction that there is something wrong with the genital cutting of girls *independently* of the patriarchal structures within which it occurs" [81••] (p. 18, emphasis added). In other words, if there was nothing at all wrong with cutting a girl's healthy genitals without her consent, it would not be sufficient—for it to become a uniquely egregious human rights abuse—to point out that the cutting (also) reflected patriarchal social structures. After all, *many* practices in society reflect such structures to some degree, but not all of them are serious human rights violations. As Möller argues, "the existence of patriarchal power structures may be relevant in so far as such structures [can] make a violation of rights *even worse than it would otherwise be*; but there still needs to be a violation of rights in the first place" [81••] (p. 17).

If that is correct, what is the nature of the rights violation in question? In other words, what is it about cutting a girl's healthy genitals without her consent that wrongs her, irrespective of the patriarchal context? Möller proposes that it is the non-consensual nature of the cutting, its being medically unnecessary, and its targeting of the sexual anatomy (a part of the body that is widely considered to be private or intimate). But these features apply to medically unnecessary genital cutting of all types, that is, regardless of the sex or gender of the child [150]. Möller thus concludes that "the wrong of genital cutting flows *not* (in the first instance) from contingent empirical factors relating, for example, to harm or social structures, but from the child's right to have his or her physical integrity respected and protected" [81••] (p. 24).

## Conclusion

Three main positions regarding the relative permissibility of female, male, and intersex genital cutting have been evaluated in this review. According to equal opportunity advocates of

parental and religious rights, no child, regardless of sex or gender, has an absolute moral right to be free from non-consensual, medically unnecessary cutting of their genitals. According to the WHO, UN, and other advocates of "selective zero tolerance for FGM," children with characteristically female genitalia have such a right, but intersex children and children with characteristically male genitalia do not have such a right. Finally, according to equal opportunity advocates of children's rights, all non-consenting persons have an absolute moral right against any medically unnecessary (or medically deferrable) interference with their genital anatomy, at least in Western societies with a strong tradition of individual rights, which includes a concern for respecting sexual boundaries. Only the last of these perspectives, it seems, can explain why ritual nicking of the clitoral hood of the kind described at the beginning of this essay is categorically impermissible even when it causes no lasting physical harm, without relying on unjust double standards pertaining to race, ethnicity, parental religion, assigned sex, gender identity, or other individual or group-based features.

## Compliance with Ethical Standards

**Conflict of Interest** The author has no conflict of interest to report.

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