Male or Female Genital Cutting: Why 'Health Benefits' Are Morally Irrelevant

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Male or female genital cutting: why 'health benefits' are morally irrelevant

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ABSTRACT

The WHO, American Academy of Pediatrics and other Western medical bodies currently maintain that all medically unnecessary female genital cutting of minors is categorically a human rights violation, while either tolerating or actively endorsing medically unnecessary male genital cutting of minors, especially in the form of penile circumcision. Given that some forms of female genital cutting, such as ritual pricking or nicking of the clitoral hood, are less severe than penile circumcision, yet are often performed within the same families for similar (eg, religious) reasons, it may seem that there is an unjust double standard. Against this view, it is sometimes claimed that while female genital cutting has 'no health benefits', male genital cutting has at least some. Is that really the case? And if it is the case, can it justify the disparate treatment of children with different sex characteristics when it comes to protecting their genital integrity? I argue that, even if one accepts the health claims that are sometimes raised in this context, they cannot justify such disparate treatment. Rather, children of all sexes and genders have an equal right to (future) bodily autonomy. This includes the right to decide whether their own 'private' anatomy should be exposed to surgical risk, much less permanently altered, for reasons they themselves endorse when they are sufficiently mature.

INTRODUCTION

There has been an explosion of research, in recent years, on the ethics of medically unnecessary child genital cutting practices.[1–41] These practices include such things as ritual 'nicking' or 'pricking' of the clitoral hood (common in parts of Southeast Asia, for example),[42–45] 'cosmetic' labiaplasty of peripubertal girls (a growing phenomenon in various Western countries),[46–49] routine or religious male circumcision,[50–52] 'normalising' surgeries on children with certain intersex traits or diverse sex development,[53–55] hymenoplasty for so-called 'virginity restoration'[56–58] and more invasive forms of female genital cutting defined as 'mutilations' by the WHO (table 1).[i]

Although these practices have most often been treated separately, a growing number of scholars of genital cutting have begun to synthesise research across societies—and across conventional boundaries of sex and gender. In doing so, some have noted certain inconsistencies and even apparent double standards in the way that children from different cultural backgrounds, or with different sets of sex characteristics, are treated when it comes to the protection of their genital integrity. For example, the human rights scholar Melinda Jones has recently drawn a comparison between non-Western-associated forms of female genital cutting (NWFGC; see table 1 for an explanation of this terminology) and Western forms of intersex genital cutting. According to Jones, the former sort of cutting is almost universally condemned outside of practicing communities 'as an abhorrent social practice for which there should be zero tolerance,' while at the same time, 'intersex children in the West are subjected to equivalent treatment, and [yet] their plight has been ignored or endorsed'[59] (p396).

Other authors have compared NWFGC with non-therapeutic penile circumcision, a form of medically unnecessary male genital cutting (see box 1 for other examples). Debra DeLaet, for instance, has noted that the international human rights community has not framed any form of male genital cutting as a human rights violation[ii] while taking an unambiguous stand against every form of NWFGC. DeLaet acknowledges that there are 'sharp differences between the most extreme forms' of NWFGC and male circumcision 'as it is most widely practised.' But she argues that the most common forms of male and female genital cutting as they are actually performed across societies 'are not sufficiently divergent practices to warrant a differential response from the international community … there are more similarities between the two practices than is typically acknowledged'[60] (p405).

[i]Another, albeit theoretical example might be elective gender affirmation surgery involving the genitals, for example, penile inversion vaginoplasty for transgender females. However, in contrast to the administration of certain hormones—for example, to delay puberty or facilitate cross-sex development—genital surgeries for gender affirmation are rare in minors, especially in those who would be considered pre-autonomous.[120] On the ethics of body modification for gender expression in adolescence, see[121].

[ii]For a fascinating sociological discussion of why this might be the case, see the work of Charli Carpenter.[122] In brief, Carpenter argues that male genital cutting, in the form of routine or religious penile circumcision—common within US American and Muslim and Jewish families, respectively—is a relatively popular practice among many of the most influential 'gatekeepers' of the global human rights agenda: 'the practice is prevalent in their own social networks' (p138). Indeed: 'unlike many other practices human rights professionals condemn but do not participate in, the practice of circumcision was widespread' among her interview subjects. 'Confronting it evoked defensiveness from those who had circumcised their own [male] children and were loath to think of themselves as human rights abusers' (p139). It seems it is less difficult for these Western arbiters of human rights to imagine proverbial 'Others'—for example, Africans who practise female alongside male genital cutting—as abusers of human rights.[65]

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Table 1 Non-Western female genital 'mutilation' versus Western-style 'cosmetic' female genital cutting; adapted from[1 69]

Category	*Non-Western-associated female genital cutting (NWFGC) 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 'cosmetic' female genital cutting*: 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 practised 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 feminising 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 cauterisation.	**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 (eg, clitoroplasty) more common in infancy, but ranging through adolescence and adulthood.
Presumed Western status	Unlawful and morally impermissible.	Lawful and morally permissible.
Ethical analysis	Given that there is overlap (or a close anatomical parallel) between each form of WHO-defined 'mutilation' and Western-style 'cosmetic' female genital cutting, 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 non-medical 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 intervention into one's sexual anatomy, a consideration that applies regardless of the sex or gender of the non-consenting person.	

How convincing are these comparisons? For example, are medically unnecessary female and intersex forms of genital cutting really 'equivalent', as Jones suggests?[iii] And while there might be certain 'similarities' between male and female forms of genital cutting—as DeLaet argues—are there not also some rather important *differences*?

How one answers these questions will depend on several factors: which form of female genital cutting (table 1) is being compared with which form of intersex or male genital cutting (Box 1); the dimension(s) along which the comparison is drawn; the level of abstraction at which the relevant argument is pitched, and what one hopes to show with the argument. Nevertheless, there is now a substantial body of literature arguing that female, male, and intersex child genital cutting have much more in common than is usually supposed.[17] I will be referring to this literature throughout what follows, and I will touch on some of the main similarities between practices—both empirical and ethical—that have been unearthed by recent scholarship.

[iii]There are in fact many different forms of both female and intersex genital cutting. But some forms, including clitorectomy (partial or total removal of the external clitoris) are anatomically quite similar and may sometimes be effectively the same. Yet even in those cases, they may be treated as morally different. In support of this claim, consider the results of a recent experimental philosophical bioethics study[123] by Annette Smith and Peter Hegarty.[124] These authors presented participants, between conditions, with a nearly identical description of a clitorectomy performed on an infant who was described as either female or intersex. They found that one and the same operation was perceived as violating human rights more so when the infant was described as female than as intersex, holding everything else the same. For further discussion of the role of such experimental studies in developing normative conclusions within bioethics, see[125].

Focus of the paper

To streamline the discussion, I will focus on one particular claim that is often advanced by those who regard NWFGC as categorically different from other forms of genital cutting.[61] I am referring to the claim of the WHO that all cutting of the external female genitalia, apart from that done for ill-defined 'medical reasons', has 'no health benefits, only harm.'[62] When it comes to intersex and especially male genital cutting, by contrast, claims of health benefit are not infrequently raised. For example, at a recent international experts meeting on NWFGC at which I presented (https://igvm-activiteiten.be/eng/event/30/8105), the representative from the WHO was asked, by a different presenter, whether the WHO was sending mixed messages about human rights to African communities. The questioner noted, as I recall, that almost all African communities that practise ritual female genital cutting also practise ritual male genital cutting, typically in a parallel rite of passage serving analagous social functions.[63] Given this, the questioner proposed that it might be confusing or inconsistent for the WHO to simultaneously assert the following propositions: (1) that all ritual forms of female genital cutting, no matter how slight and irrespective of consent, are unambiguous human rights violations that must be eliminated from society and must under no circumstances be medicalised, even as a harm reduction measure, while (2) ritual male genital cutting of non-consenting minors within the same communities is not a human rights violation, no matter how severe; and it should not only be medicalised, but in fact expanded to groups that do not currently practise it.[64] The official replied that the cases were different:

Box 1 Medically unnecessary male genital cutting across societies; adapted from[69 126]

Medically unnecessary male genital cutting ranges from ritual pricking (eg, *hatafat dam brit*), to piercing, scraping the inside of the urethra, bloodletting, shaft scarring, and/or foreskin slitting (among, eg, various ethnic groups in Papua New Guinea), to circumcision as it is traditionally performed on male newborns in Judaism and more generally in the United States (separation of the membrane that fuses the immature foreskin to the head of the penis followed by clamping and excising the majority of the foreskin), to *metzitzah b'peh* (the same followed by direct oral suction of the wound, an unhygeinic practice risking herpes infection still common among some ultra-Orthodox Jews), to non-sterilised, un-anaesthetised circumcisions performed in the bush during rites of passage in Eastern and Southern Africa, to mass circumcision of pre-teen boys carried out on school tables in the Philippines (*tuli*), to forced genital cutting of men following political conflict in various countries, to subincision (slicing open the underside of the penis lengthwise, often through to the urethra) among some Indigenous peoples of Australia, to full 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 (eg, 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 (eg, sometimes medicalized, often not), depending on the group in question.

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

'whereas male circumcision has proven health benefits, female genital mutilation has none.'

As we shall see, matters are not so simple. But suppose we grant the official's claim for now. It might seem that this apparent distinction in health consequences could serve to explain or justify the putatively unique status of NWFGC as a human rights violation, irrespective of any other features it may share with male or intersex child genital cutting.

In a recent paper, my coauthors and I analysed this 'health benefits' argument as it relates to the comparison between female and intersex forms of genital cutting.[65] In contrast to the orthodox view about NWFGC (ie, that it has no health benefits), proponents of medically elective or 'cosmetic' intersex operations have sometimes argued that these operations may indeed improve the health of the child. In this, they seem to conceive of health in something like the wider psychosocial sense adopted by the WHO.[66] Specifically, proponents suggest that by cosmetically 'normalising' the genitals of children who have certain differences of sex development (that is, by cutting and reshaping their genitals to fit a more stereotypically masculine or feminine appearance), the child will have a better self-image, avoid teasing or stigma, or otherwise benefit in terms of mental health.[67] Without rehearsing our whole argument here, we suggested that this line of reasoning has certain flaws:

1. There is very little good evidence to support the claim that non-consensual intersex 'normalisation' surgeries do in fact reliably tend to promote mental health.
2. There is growing evidence that many individuals who were subjected to medically unnecessary genital cutting when they were pre-autonomous regard themselves as seriously harmed by it, both physically and psychologically.
3. Even if there were strong evidence that non-consensual intersex genital cutting promoted mental health (for example, by reducing the chances of being teased for having genitals that are not visually typical for one's assigned sex), this would not make the surgeries medically necessary (as defined below).
4. Even if intersex genital cutting could be shown to promote mental health by mitigating purported social harms associated with being perceived as 'different', this would not serve to categorically distinguish it from NWFGC.[iv 65]

The aim of the present paper is to build on these arguments by making a different comparison. Rather than comparing female and intersex genital cutting, I will compare female and male genital cutting, as this raises some distinct issues. For example, while intersex operations are relatively uncommon, affecting a very small subset of children, male genital cutting—in the form of penile circumcision—is one of the most common surgical operations in the world. Moreover, the health benefits that are often cited in support of male circumcision, primarily a reduced risk of contracting certain infections, could be seen as more straightforwardly 'medical' than the mainly psychological health benefits cited in support of (elective) intersex genital cutting. In other words, it might seem relatively easier to justify male genital cutting on strictly medical grounds.

Finally, as alluded to above, anthropological research suggests that virtually all communities that practise female genital cutting also practise male genital cutting—but not vice versa—usually under similar conditions.[68] Depending on the context, either the male or female version of the ritual may be more risky or severe[69] and the underlying motives often overlap as well.[70] As Sara Johnsdotter has argued: '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, [and] to improve the social status of the child through ritual'[71] (p32).[v] This observation provides an

[iv]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. Because of this, the child would presumably be just as liable to teasing or other forms of social disadvantage claimed to adversely affect a person's mental health.'[65] See the preceding reference for relevant citations.

[v]For more on the significance of these and related facts for the oft-repeated, yet highly misleading claim of the WHO that female genital cutting is fundamentally a form of sex discrimination or gender-based violence, see[126].

additional reason to evaluate male and female genital cutting together. Given all this, I ask the following question:

> When, if ever, do 'health benefits' justify cutting the vulva or penis of a child?

I am particularly interested in what I have been calling 'medically unnecessary' genital cutting.[72] Accordingly, I will start the next section by clarifying what I mean by medical necessity, using a novel definition from a recent international consensus statement on bodily integrity. I will then explain why the authors of this statement (myself included) have identified medical necessity as the threshold criterion for permissibly cutting the genitals of a pre-autonomous and (*ipso facto*) non-consenting child.

Next, I consider whether the existence of health benefits can over-ride this threshold criterion given that male, but not female, genital cutting has been associated with certain health benefits, including by such influential organisations as the American Academy of Pediatrics (AAP) and the WHO. Finally, I explore whether other purported differences between male and female genital cutting (such as their respective statuses in certain religions) can justify treating the practices fundamentally differently as a matter of human rights. I argue that neither these differences, nor the supposed distinction in terms of health benefits, can justify such differential treatment. I suggest, therefore, that Western societies exhibit an unjust double standard in their unequal protection of children's genital integrity, based on whether the child has characteristically male or female sexual anatomy.

Note: some individuals born with characteristically male genitalia come to occupy a feminized social gender role and/or identify as (trans) girls or women, while some born with characteristically female genitalia come to occupy a masculinized social gender role and/or identify as (trans) boys or men. Thus, both male and female child genital cutting can have lifelong ramifications for persons of a different sex or gender category, depending on how those categories are defined. [73 74][vi] I will try to use inclusive language in what follows to reflect this.

MEDICAL NECESSITY AS A THRESHOLD CRITERION

According to the authors of a recent international consensus statement, the ethics of female, male, and intersex genital cutting 'must be considered together'[1] (p21). In support of this view, the authors note that, despite various differences between them, the practices still share certain morally relevant features. These include: (a) being medically unnecessary acts of (b) genital cutting (ie, cutting of a part of the body that is widely considered to be especially personal or private) that are (c) predominately performed on small children (ie, persons who are particularly vulnerable) (d) on behalf of 'norms, beliefs, or values that may not be the child's own and which the child may not adopt when of age'[1] (p21).

The authors define 'medical necessity' as follows:

> … an intervention to alter a bodily state is medically necessary when (a) the bodily state poses a serious, time-sensitive threat to the person's well-being, typically due to a functional impairment in an associated somatic process, and (b) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat[1] (p18).

Such interventions, the authors claim, are almost universally valued, that is, 'valued irrespective of local epistemologies, individual bodily preferences, religious commitments, or cultural backgrounds'[1] (p21), which explains why they are usually permissible even in pre-autonomous persons.[75]

In other words, even though a pre-autonomous person's bodily integrity might be radically infringed by an intervention, for example by an open heart surgery, if the infringement were medically necessary in the above sense, one could safely assume—that is, with a high degree of warranted certainty—that the person *would* consent to the infringement if they were able.[75–77] Moreover, one could safely assume this against the widest plausible range of beliefs or values the person might have or come to adopt when they are autonomous.

By contrast, the norms, beliefs and values which uphold medically unnecessary genital cutting practices (for example, particular metaphysical or religious beliefs, subjective aesthetic preferences, contested gender norms, or the endorsement of surgery as prophylaxis), 'are often controversial in the wider society and hence [more] prone to reevaluation upon later reflection or exposure to other points of view'[1] (p21). In other words, assuming a multicultural context with sufficient access to contrary perspectives, there will typically be greater opportunity for someone who was pre-autonomously exposed to a medically *unnecessary* genital operation to (re)construe the operation as having been harmful or inappropriate, than for someone who was exposed to a medically *necessary* genital operation, all else being equal.[75 78–81][vii]

So, the authors concluded, cutting any person's genitals without their own informed consent should be considered a violation of their right to bodily integrity, unless they are temporarily non-autonomous and the cutting is medically necessary (and so cannot ethically be delayed).

THE 'HEALTH BENEFITS' DEFENCE

In response to such an argument, defenders of child genital cutting practices might think to cite the existence of potential *health benefits* associated with their custom: excised genital tissue cannot, after all, become infected or cancerous, injured during sexual activity, or serve as an entry point for

[vi] For example, transgender women and girls 'can be harmed in particular ways by the pre-emptive removal of their penile foreskins through circumcision.' The foreskin 'amounts to between 30 and 50 cm^2 of highly sensitive … tissue in the fully developed organ (and) 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'[61] (internal references omitted).

[vii] As the authors of the consensus statement noted, 'One exception to the general prohibition on adults [so much as] touching children's genitals pertains to necessary parental (or equivalent) care: for example, changing diapers or help with washing. But this exception applies only insofar as the child requires such help; a parent or caregiver who continued to wash a child's genitals when the child was capable of such washing on their own would likely be acting inappropriately'[1] (p21). Similarly, they continue, 'a doctor or other health care professional who handled—much less cut into or removed tissue from—a child's genitals beyond what was strictly necessary for diagnosis or treatment would almost certainly be crossing an ethical line' (*ibid*).

Box 2 Reasons for international scepticism about the 2012 American Academy of Pediatrics (AAP) policy and technical report on newborn male circumcision.[88 142] Adapted from[107] (internal references omitted). Please note that no other comparable national-level medical society outside the United States has endorsed the main conclusion of the AAP that the health benefits of newborn male circumcision outweigh the risks. For additional criticisms, see[143–156]

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

various diseases which may then affect other parts of the body. Since health is, itself, on some conceptions, among the set of things that is 'almost universally valued', perhaps the existence of such health benefits could convert what would otherwise count as a violation of a non-consenting person's right to bodily integrity into a non-violation (and so something that is an appropriate matter for parental discretion). Indeed, this seems to be the position of the AAP, as evidenced by its influential, if widely criticised (see box 2 for details), 2012 policy on newborn male circumcision.

'The right to physical integrity,' the authors of that policy wrote, 'is easier to defend in the context of a procedure that offers no potential [health] benefit'[82] (p803). The allusion is to NWFGC (table 1), which the AAP categorically condemns.[83] The point was to explain why medically unnecessary, non-consensual male genital cutting, a popular US custom, should not be seen as a rights violation, whereas medically unnecessary, non-consensual female genital cutting—more common in parts of Africa, the Middle East and Southeast Asia—should be seen as an egregious human rights violation even in its most superficial forms. These forms include practices, such as ritual nicking or pricking of the clitoral hood, which are less severe than male circumcision yet are often performed for similar reasons under similar conditions in the very same families (for example, among some Muslim communities in Malaysia, Indonesia, Sri Lanka, parts of India, and elsewhere).[42–45 84–86]

Of course, one worry is that, if this argument were taken seriously, it might seem to suggest that as soon as some potential health benefit or another could be credibly linked to female genital cutting, it would suddenly lose its status as a rights violation even when medically unnecessary and performed on non-consenting girls. But that is presumably not the position of the AAP or the WHO.[83 87] As Kai Möller notes, 'The whole judicial and societal discourse about [NWFGC] makes it clear that it is *inherently* wrong, that is, its wrongness does not depend on certain contingent empirical claims about, for example, minor health benefits'[27] (p11, emphasis in original). So, we may need to explore the argument further in order to see what is going on.

EXPLORING THE 'HEALTH BENEFITS' ARGUMENT

The reasoning of the AAP authors goes something like this: since non-consensual male genital cutting, unlike non-consensual female genital cutting, has been statistically associated with at least some potential health benefits that apply before an age of consent[viii]—primarily, a reduced risk of acquiring a urinary tract infection (UTI)—the former, but not the latter, is morally permissible and (as such) does not violate the child's right to bodily integrity. Now, according to the AAP, it would take approximately 100 penile circumcisions to prevent one, likely treatable, UTI.[88] This estimate may in fact be conservative, because there is evidence that UTIs are more frequently misdiagnosed in genitally intact (non-circumcised) males,[ix] resulting in a likely overestimation of the risk of UTIs in this group.[x] Nevertheless, let us

[viii]This is an important caveat. Insofar as a health benefit 'kicks in' after an age of consent, as is true of most of the other health benefits that have been attributed to male circumcision (such as a reduced risk of sexually transmitted infections) it is harder to argue that the decision about whether to pursue the benefit via genital surgery as opposed to some other means should not be left to the individual when autonomous. For extensive discussion of this point, including a response to the argument that some pre-autonomous children may nevertheless engage in unprotected sexual activity, see[41]. Note: most of the experimental data suggesting a partially protective effect of male circumcision against sexually transmitted infections such as HIV come from studies of adult, voluntary circumcision in sub-Saharan Africa, not routine or religious circumcision performed in infancy or childhood in so-called developed countries.[127–129]

[ix]This is because 'urines obtained via a midstream or catheter specimen from an uncircumcised male are commonly contaminated [leading to false positive diagnoses]. Evidence for this is that 9% of uncircumcised and 0.5% of circumcised asymptomatic males had bacteriuria later verified by suprapubic urine collection to be falsely positive'[130] (p8684), referring to[131]; see also[132 133].

[x]In addition, most US physicians are not trained in proper care of the intact penis, leading many of them to incorrectly recommend (or engage in) forcible and premature retraction of the foreskin (eg, during examinations), which can cause tearing and thus potentially increase the risk of a UTI iatrogenically. For example, in a survey sent to all US members of the Society for Pediatric Urology, the majority of respondents (with a 78% response rate among those who opened the invitation and a 40% overall response rate) gave incorrect age-based recommendations to retract the child's foreskin.[134]

just assume that infants with intact penises really do have a greater relative risk of acquiring a UTI compared with their circumcised counterparts (notwithstanding the low absolute risk: roughly 1% according to the AAP). Is non-consensual surgery on a person's healthy sexual anatomy an appropriate means of reducing such a risk?

To answer this question, let us try an analogy. Suppose that removing healthy tissue from an infant's vulva, perhaps the labia so as to avoid cutting the clitoris, similarly reduced the risk of acquiring a UTI, which girls are about four to eight times more likely to acquire than are boys by the age of 5.[89] If 100 'infant labiaplasties',[xi] or even far fewer such labiaplasties, were needed to prevent one, likely treatable, UTI, would the AAP, WHO, or any other Western organisation concede that girls did *not* have a right to bodily integrity according to which such genital cutting would morally wrong them?

Again, presumably not. Instead, they would argue that healthy, nerve-laden genital tissue (a description that applies equally to the penile foreskin as it does to the labia) is valuable in its own right, so that removing it without urgent medical need is itself a harm; they would stress that all more conservative means of addressing potential infection should be exhausted before sugery is employed; and they would insist that girls have an i nviolable moral right against *any* medically unnecessary interference with their private, sexual anatomy to which they themselves do not consent when of age. By contrast, if the 'health benefits' argument were accepted in such a context, the supposed 'right to bodily integrity' on which the AAP and WHO explicitly rely to justify their categorical condemnation of NWFGC would be a flimsy right indeed. It would, in essence, be vulnerable to empirical refutation.

THE CULTURAL CONTEXT OF SCIENCE

This is not a hypothetical or abstract concern. Rather, claims of health benefit are already regularly raised by defenders of female 'circumcision' in cultures that practise both male and female genital cutting together.[90–99] In Egypt, Muslim doctors have reportedly claimed that 'health benefits of female circumcision include reduced sexual desire, lower risk of vaginal cancer and AIDS, less nervous anxiety, fewer infections "from microbes gathering under the head of the clitoris" [and] protection against herpes and genital ulcers'[91] (p258, quoting[51]). A Kono woman from Sierra Leone has asked, 'Why [would] any reasonable mother want to burden her daughter with excess clitoral and labial tissue that is unhygienic, unsightly and interferes with sexual penetration … especially if the same mother would choose circumcision to ensure healthy and aesthetically appealing genitalia for her son?'[99] (p17). Or consider the perspective of a leader within the Sri Lankan Center for Islamic Studies: 'Our religion requires [female circumcision] and it actually helps keep the area clean and hygienic and prevents infections.'[98]

Of course, one possible response to such claims would be to try to refute them. That is, one could fire up PubMed or Google Scholar and search for scientific articles which seem to undermine the empirical basis for the alleged health benefits of female 'circumcision'. But this will only get one so far, and it remains an unstable solution. For one thing, there is the cultural context of the science itself to consider, which undoubtedly shapes the sorts of studies one will find. Just imagine that researchers from Egypt, Sri Lanka, or Sierra Leone—who value female as well as male genital cutting—had as much sway over the scientific literature, global health policy, and research funding, as do circumcised men and their partners in the USA.[xii] It is not implausible, under such circumstances, that the proportion of studies appearing to show 'health benefits' for female genital cutting would be greater than it currently is.[100] Commenting on this possibility, the historian of medicine Robert Darby has noted:

> Official bodies working against FGC [such as the WHO] have condemned medicalization of the procedure and funded massive research programs into the harm of the surgery. The irony [is] that WHO also frames male circumcision as a public health issue—but from the opposite starting point. Instead of a research program to study the possible harms of circumcision, it funds research into the benefits and advantages of the operation. In neither case, however, is the research open-ended: in relation to women the search is for damage, in relation to men it is for benefit; and since the initial assumptions influence the outcomes, these results are duly found.[101] (p157)

In other words, if the implied 'health benefits' argument of the AAP and the WHO is accepted in the case of non-consenting children with penises, the risk of an empirical refutation of the right to bodily integrity as applied to non-consenting children with vulvas remains in play (depending on who is doing the research and what they hope to find). So, it may be fruitful to step back from particular empirical claims and think more broadly about the conceptual and ethical relevance of health benefits as these apply to the genital cutting of children.

THE MORAL IRRELEVANCE OF HEALTH BENEFITS

How should we think about the relevance of potential health benefits to a moral analysis of child genital cutting? According to the ethicist Eike-Henner Kluge, in order to answer this question we first must ask ourselves whether it is morally appropriate to perform such cutting 'because there is some statistical evidence that a potentially curable disease with a low incidence rate may be prevented by surgery, even though the disease also occurs in people who have undergone the surgery and the incidence rate of the disease in countries where the surgery is not routinely performed is similar to [or less than] that in countries where it is?' If the answer is 'yes', Kluge continues, 'then the same underlying principle should be applied to all similar cases.' But if one actually did this, 'all sorts of medical conditions would be implicated [and] I suspect that we would be operating nonstop on just about every part of the human body'[102] (p1542).

The upshot of Kluge's analysis seems to be this: surgery, and perhaps especially surgery that concentrates risk on a psychosexually significant[xiii] part of a non-consenting person's undiseased

[xi] For more in-depth discussion of this hypothetical example, see[65].

[xii] The USA is the only Western country that practises routine circumcision on a majority of male newborns for non-religious reasons.[107 135 136] It also has an outsized influence on global research and policy, including with respect to genital cutting.[137] See footnote ii for further discussion. Please note that some of the examples and quotations in this section are similar to ones I have used elsewhere.

[xiii] As Rebecca Steinfeld and I have argued elsewhere, 'a child's vulva or penis and scrotum are clearly different—in numerous psychosocially and morally important ways—from, for example, the earlobes, which are

body, should not be undertaken in pursuit of merely potential future health benefits.[103] Unless, that is, those benefits are central to the person's well-being and they cannot feasibly be achieved in a less harmful, risky, or invasive way—or by waiting until the person can consent.[65]

In that case, however, they would fall under the rubric of medical necessity as defined in the international consensus statement mentioned above. According to the authors of that statement, 'medically necessary' is importantly different from 'medically beneficial'. For an intervention to fall into the latter category, it needs only to be the case that its associated health-related benefits outweigh its health-related harms.[10] But whether such benefits actually do outweigh such harms is often highly controversial: '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 (eg, less invasive or risky) means of pursuing the intended health-related benefits'[1] (p18). Given the special significance of the genitals to most people, the authors argue:

> … although the weaker, 'medically beneficial' standard may well be appropriate for certain interventions into the body, it is not appropriate for cutting or removing healthy tissue from the genitals of a nonconsenting person. If someone is capable of consenting to genital cutting but declines to do so, no type or degree of expected benefit, health-related or otherwise, can ethically justify the imposition of such cutting. If, by contrast, a person is not even capable of consenting due to a temporary lack of sufficient autonomy (eg, an intoxicated adult or a young child), there are strong moral reasons in the absence of a relevant medical emergency to wait until the person acquires the capacity to make their own decision. (*ibid*)

Seen in this light, it might seem that appeals to statistical or potential/future health benefits as a way of justifying non-consensual genital cutting fall short of the mark. In fact, it is not entirely clear to what extent such appeals are really sincere. After all, defenders of cultural or religious male circumcision, at least, have long supposed that the practice was morally (and ought to be legally) permissible, even before any meaningful evidence of health benefits was available.[52] In other words, the existence or otherwise of such benefits does not seem to be at the heart of their moral position. As Andrew Freedman, one of the main authors of the AAP circumcision policy statement, has written: 'In the West, although parents may use the conflicting medical literature to buttress their own beliefs and desires, for the most part parents choose what they want for a wide variety of nonmedical reasons'[104] (p1).

For example, 'religion, culture, aesthetic preference, familial identity, and personal experience all factor into their decision. Few parents when really questioned are doing it solely to lower the risk of urinary tract infections or ulcerative sexually transmitted infections'[104] (p1). Indeed, citing his own case in a separate interview, Freedman said: 'I circumcised [my son] myself on my parents' kitchen table on the eight day of his life. But I did it for religious, not medical reasons. I did it because I had 3000 years of ancestors looking over my shoulder.'[105]

RELIGION AND MOTIVATED COGNITION

According to Yale psychologist Dan Kahan, when one's standing within a religious or cultural group depends in part on certain beliefs one may hold, this can generate what he calls 'motivated cognitions' relating to 'policy-relevant facts'[106] (p408). Experimental studies suggest that such motivated cognitions need not be conscious or intentional:

> If a proposition about some policy-relevant fact comes to be commonly associated with membership in [an affinity] group, the prospect that one might form a contrary position can threaten one's standing within it. Thus, as a form of 'identity self-defense', individuals are unconsciously motivated to resist empirical assertions … if those assertions run contrary to the dominant belief within their groups. (*ibid*)

Of course, motivated cognitions concerning policy-relevant facts can also sometimes be explicit. As AAP author Andrew Freedman revealed in a recent editorial, 'protecting' the right of parents, such as himself, to choose medically unnecessary male genital cutting for cultural or religious reasons was not an 'idle concern' for him and the other AAP circumcision task force members 'at a time when there are serious efforts in both the United States and Europe to ban the procedure outright'[104] (p1).

Whether such an openly political consideration should in fact have been an idle concern for the task force—given its remit to dispassionately review the scientific literature on the health benefits and risks of newborn male circumcision—is a complicated question (one that David Shaw and I have examined elsewhere).[107] For present purposes, we should simply remember that those families who practise what they call female 'circumcision' have ancestors looking over their shoulders, too. They, too, have religious, cultural, aesthetic, familial, and personal reasons for wanting to circumcise their daughters alongside their sons. And although they may have less clout than Dr Freedman and his colleagues in shaping US healthcare policy, they are not any less concerned with carrying on their traditions. If 'health benefits' are seen as sufficient to ward off moral or legal condemnation of religiously motivated, medically unnecessary child genital cutting, this creates a strong incentive to actively seek them out.[90]

Against this view, it might be argued that female 'circumcision' is not *really* a religious practice, as male circumcision is at least within Judaism, but is rather 'merely a cultural practice'. Accordingly, it might be thought that, health benefits or no health benefits, it is less deserving of respect or consideration. This argument has been addressed in considerable detail elsewhere,[108–110] so I will not dwell on the matter here. For a short summary of some of the main problems with the argument, however, see table 2.

CONCLUSION

As Kai Möller has recently forcefully argued, Western societies cannot coherently continue to maintain that non-Western forms of female genital cutting are 'categorically unacceptable while endorsing a balancing approach to male cutting'[27] (p25). Rather, he insists, medically unnecessary genital cutting is 'intrinsically wrong because it violates the right to physical integrity of the

sometimes pierced before an age of consent, or crooked teeth, which are sometimes straightened before an age of consent, or at least before an age of legal majority. Not only are the genitals often central to one's sexual experiences, gender identity, sexual orientation, and bodily self-image, but they are also commonly regarded as extremely private—not to be touched or even seen without one's explicit consent, which is typically granted only in intimate situations'[116] (p7). Please note that both the clitoral hood and penile prepuce or foreskin are highly innervated components of the human genitalia, whose tactile manipulation or other stimulation are typically experienced as sexually pleasurable.[138–141]

Table 2 Problems with claiming 'religious' versus 'cultural' motivations for genital cutting; adapted from[61]

Standard Claim	It is often claimed that at least some forms of male genital cutting, unlike any form of female genital cutting, are religious in nature. This claim appears to be based on the observation that female 'circumcision' is nowhere mentioned in the Quran, the central scripture of Islam, whereas male circumcision is not only mentioned in but is positively endorsed by the Torah, the central scripture of Judaism. The implication then is that male genital cutting is at least sometimes done for religious reasons, whereas female genital cutting, 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.
Basis in the Quran	It is true that female 'circumcision' is not mentioned in the Quran, but neither is male circumcision nor the injunction to pray five times per day facing Mecca. Nevertheless, both male circumcision and the daily prayer ritual are still widely recognised 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 explicitly mentioned in the Quran.
Basis in the Hadith	Though neither practice is mentioned in the Quran, both male and female 'circumcision' are mentioned in the Hadith—sayings and deeds attributed to Muhammed—as well as other secondary sources of Islamic scripture. Based on such scripture, some Muslim communities regard both practices as religiously required. This includes, for example, the Dawoodi Bohra, a sect within the Musta'li Isma'ili Shi'a branch of Islam.[84 157]
Cultural reasons	Though male circumcision 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 such organizations as the AAP and WHO. 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.

child; thus, the conclusion that genital cutting is wrong as a matter of principle applies equally to boys and girls' (*ibid*).

In light of such arguments, which are gaining steam among bioethicists and legal experts,[1 38 111–115] it seems that individuals, groups and organisations—including the AAP and WHO—that categorically condemn all medically unnecessary genital cutting of non-consenting female minors, while simultaneously approving of such cutting of male minors, will need to make up their minds. If they see the former as violating a child's right to bodily integrity, no matter how slight the cutting and irrespective of parental motivations, religious or otherwise, then they ought to extend this principle across the spectrum of sex and gender and stand up for the bodily integrity rights of children who have intersex traits, as well as those who have male-typical genitalia (including both cisgender boys and transgender girls).[116–118] That is my own position and I have defended it at length in other publications.

If, on the other hand, they see it as permissible for parents to authorise medically unnecessary genital cutting for children who have a penis, regardless of the reason and whether or not meaningful health benefits are expected to accrue, then they ought to extend this principle back across the spectrum to children who have a vulva, while deciding on the precise type or extent of genital cutting they are willing to tolerate in this regard.[4 108 119]

Finally, if they believe that the sheer existence of statistical health benefits is what makes it morally permissible to cut the genitals of male children—even if those benefits are contested, lacking in urgency, peripheral to the child's well-being, or achievable by less harmful means—then they should be prepared to concede the permissibility of cutting the genitals of female children on this basis, just as soon as such health benefits may be found.

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