

Appendix to: “In defence of genital autonomy for children”

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Introduction

This is an Appendix to the article, “In Defence of Genital Autonomy for Children”(1) which is itself a response to “Female Genital Alteration—A Compromise Solution” by Arora and Jacobs.(2)

The Appendix is divided into two parts. In the first part (Part I), I present an overview of various “overlaps,” both physical and symbolic, between male and female forms of non-therapeutic genital alteration (MGA, FGA). This is to show why the conditional argument by Arora and Jacobs—namely that *if* it is the case that MGA should be widely tolerated, then so should some forms of FGA—is valid even if it is not, as I argue in my response piece, sound. In the second part (Part II), I provide a point-by-point response to various specific claims by Arora and Jacobs that are misleading, inaccurate, or otherwise problematic, but which I did not have the space to cover in the main article.

PART I. A brief overview of the morally-relevant “overlaps” between FGA and MGA

In this section, I provide a brief sketch of the “overlaps” between non-therapeutic male and female genital altering procedures. I recognize that many of the claims in this section will seem counterintuitive to those who are new to this area given the prevailing popular and academic discourses; I can only hope that the reader will take the time to follow up on the references I cite in support of them. For a much more sustained defense of the view presented in this section, please see my essay, “Female Genital Mutilation and Male Circumcision: Toward an Autonomy-Based Ethical Framework.”(3)

Area of overlap #1: harm

Both male and female forms of non-therapeutic genital alteration fall on a wide spectrum. The physical and sexual harms that they may cause substantially overlap, depending upon the type of procedure, how much tissue (and of what kind) is removed, which instruments are used and how

sterile they are, what level of training the practitioner has, and so on. In particular, several forms of WHO-recognized FGM procedures, such as cutting and/or removing part(s) of the clitoral hood (such as is common in Malaysia), as well as some interventions into the labia, are uncontroversially less physically harmful than the most widespread forms of male circumcision. Conversely, several forms of male genital cutting/alteration, such as subincision in parts of aboriginal Australia, or tribal circumcision as it is carried out among the Xhosa of South Africa, can be at least as physically harmful as the most widespread forms of FGM, and are frequently much more harmful as a matter of practice.(3)

Area of overlap #2: benefits

The benefits of both male and female forms of non-therapeutic genital alteration overlap as well. As I have argued elsewhere,(3,4) the health benefits that have been attributed to male circumcision, at least in a Western context, are relatively minor (in terms of absolute risk reduction for various diseases, many of which can be prevented and/or treated non-surgically); they apply mostly after an age of sexual debut (i.e., when meaningful consent could at least in principle be obtained); they can be achieved in much less harmful ways (such as by the practice of basic hygiene and the adoption of safe sex practices); and, according to the balance of medical opinion on a global scale, they do not very likely outweigh the risk of immediate complications plus delayed complications and longer-term harms(5) (contrary to the insinuations of Arora and Jacobs; see the discussion in Part II of this Appendix).

On the other side of the coin, we do not actually know that certain minor forms of FGA—such as neonatal labiaplasty, or perhaps other interventions—would not confer the same degree of prophylaxis against disease as male circumcision purportedly does, in virtue of removing healthy tissue from the vulva that could later host an infection, cancer, or other malady. Indeed, it is illegal, in Western countries, to conduct a trial to find this out.(4) That said, there is in fact some observational evidence that FGA may be associated with certain health benefits, including reduced transmission of HIV.(3)

With respect to purported socio-cultural and/or religious (or spiritual) benefits, both male and female forms of non-therapeutic genital alteration are defended in largely similar terms by those who endorse them.(3,6–13) Speaking generally, as Gunning notes, “Both can be seen as unnecessary alterations of normal, healthy genitalia justified by questionable health benefits and

bolstered by culturally, socially, or religiously defined notions of aesthetics and clearly delineated binary ideas of gender.”(14)[p. 655-656]

Area of overlap #3: symbolic meanings

Contrary to common wisdom, FGA “is not always associated with, nor a reflection of, sexist and patriarchal norms; nor are the norms associated with male genital cutting always as morally innocent as is typically assumed.”(3) For example, among the Kono of Sierra Leone, “there is no cultural obsession with feminine chastity, virginity, or women’s sexual fidelity ... because the role of the biological father is considered marginal and peripheral to the central ‘matricentric unit.’”(15) In this context (as in many other African contexts) “male and female genital alterations are performed in parallel ceremonies, are not primarily intended to reduce sexual pleasure, and the operations are seen as mirror images of each other.”(3)

At the same time, as Fox and Thomson show, certain other forms of male genital cutting (as well as female genital cutting) can in fact be understood as gendering practices tied to patriarchal notions of masculinity, as well as to cultural systems based on male privilege and the ritual exclusion of women.(16) For example, as Kimmel argues, male circumcision “means [the] reproduction of patriarchy.” In the Jewish tradition, “Abraham cements his relationship to God by a symbolic genital mutilation of his son. It is on the body of his son that Abraham writes his own beliefs. In a religion marked by the ritual exclusion of women, such a marking not only enables Isaac to be included within the community of men [but] he can also lay claim to all the privileges to which being a Jewish male now entitles him.” To circumcise one’s son, therefore, is “to accept as legitimate 4000 years [of] patriarchal domination of women.”(17)

Finally, as Arora and Jacobs themselves point out (and as many others have argued), the supposed distinction between “religion” and “culture” as a means of distinguishing male vs. female forms of ritual genital cutting is logically untenable, historically inaccurate, and anthropologically ill-informed.(6,18,19)

Implication

Taken together, these overlaps imply that “a stark moral distinction between male and female forms of non-therapeutic, non-consensual genital alteration may be impossible to maintain on principled grounds.”(3) As a consequence of this fact, liberal societies face a choice if they wish

to be consistent.(20) Roughly speaking, they can either allow both types of genital alteration to be carried out on similar terms, or they can disallow (or at least discourage) both types of genital alteration on similar terms.

Arora and Jacobs prefer the former option; I prefer the latter. In the next section, I take a closer look at the arguments and evidence presented by Arora and Jacobs in support of their position, which I argue is ultimately untenable. Here I go beyond what I was able to cover in my original response piece.

Part II. A closer look at the various claims advanced by Arora and Jacobs

In this section I address specific weaknesses in Arora and Jacobs's (A&J's) argument, by giving a point-by-point response. I will move sequentially through their paper, and the format will be to give a quote from A&J, followed by a discussion of any problems contained therein.

“The World Health Organization (WHO), American Academy of Pediatrics (AAP), and the American Congress of Obstetricians and Gynecologists (ACOG) have policies in place to support circumcision.”

There are several problems with this statement. First, the WHO has a policy in place to support so-called Voluntary Medical Male Circumcision (VMMC), not in “Western” countries (which is the main subject of A&J's proposal), but rather in sub-Saharan Africa as a form of partial prophylaxis against heterosexually transmitted HIV (female-to-male only) in areas with high base-rates of such transmission, and low base rates of male circumcision.(21) Crucially, the “Voluntary” part of VMMC implies (or should imply) that the circumcision should be undertaken by an individual who can provide his own consent, not an infant or young child (who cannot). Nobody objects to truly informed, consensual adult circumcision; it is the circumcision of infants and children that is ethically contentious. Moreover, the data that the WHO appeals to in support of its policy were derived from Randomized Control Trials (RCTs) performed with adult male participants (in Africa), not infants or young children (in Western countries). Since “the spread of disease, including sexually transmitted infections, is determined much more by socio-behavioral and situational factors than by strictly anatomical-biological factors, such as the presence or absence of a foreskin ... the apparent findings from these studies cannot be simply mapped on to non-analogous public health environments, nor to circumcisions performed earlier in life, i.e., before an age of sexual debut.”(4)

Second, A&J do not mention that the policy by the AAP they cite (which does not recommend circumcision, but rather leaves the decision up to parents) was roundly criticized by international pediatric and sexual health experts,(22) and is in fact inconsistent with comparable policies from many other pediatric societies in peer nations, including the recently-released statement by the Canadian Paediatric Society.(23,24) As Wolfram Hartmann, President of the German Pediatric Society, explained, “The statement from the AAP ... has been graded by almost all other paediatric societies and associations worldwide as being scientifically untenable.”(25) For an incomplete sample of published critiques of the 2012 AAP policy statement and technical report—none of which were cited by Arora and Jacobs in their paper—see the references collected here.(4) For an incomplete sample of medical bodies which, in their current policies, either fail to conclude that the benefits of involuntary male circumcision outweigh the risks, or state that the risks in fact outweigh the benefits, see statements from: the Canadian Paediatric Society;(23) the Royal Australasian College of Physicians;(26) the Royal Dutch Medical Association;(27) the German Academy for Pediatrics and Adolescent Medicine;(25) the Swedish, Norwegian, and Icelandic Pediatrics Societies;(28) and the National Health Service of England.(29) Why Arora and Jacobs decided to emphasize the position of a minority of medical bodies—from the single developed country in the world that practices routine circumcision for non-religious reasons—whose policies could be interpreted as supporting their views on health benefits for male circumcision is unclear.

Finally, please note that the ACOG does not have its own policy “supporting” male circumcision, but rather signed on to the AAP policy as a formal gesture. The document available from the ACOG’s own website actually states: “At the present time, there is not enough information to recommend routine newborn circumcision for health reasons.”(30)

“While years of advocacy and legislation aimed at eliminating non-therapeutic procedures on female external genitalia has resulted in a decline in the prevalence of the practice, the magnitude of this decline has been soberingly small. ... In a study in Somalia, the country in the world with the highest prevalence of these procedures, 81% of subjects underwent infibulation and only 3% did not have FGA. Eighty-five percent had an intention to subject their daughters to an extensive FGA procedure, and 90% supported the continuation of the practice.

This citation is misleading. The study involved a sample of 215 persons from one county in one town in Somalia; there is no way of knowing whether the reported estimates are nationally

representative.(31) Moreover, the statement that “Eighty-five percent” of participants “had an intention to subject their daughters to an extensive FGA procedure” is false: as the authors of the report themselves stated, of this 85%, fully “154 (71.6%) were planning to use the *Sunna* form [i.e., the least extensive form], with the reason behind their decision either being because they considered the *Sunna* form to be harmless or because it was seen as a religious requirement.”(31)[p. 4]. Similarly, with respect to the statement (from A&J) that “90% supported the continuation of the practice,” it should be noted that the authors of the report actually wrote: “Of this, 164 (76.3%) persons supported the continuation of the Sunna form only, while [only] 10.7% supported the continuation of all forms” of the practice.(31)[p. 4] The broader point, however, is that there has, in fact, been significant progress in many African countries in reducing the rate of non-therapeutic FGA procedures (as A&J themselves concede later on in the paragraph).

Even more importantly, however, what A&J appear to be advocating (although their language is ambiguous on this point) is a change in laws in Western countries, not Africa. So the only data that are relevant to their argument is the prevalence of FGA in Western countries (among immigrant populations), and the effect of laws that prohibit FGA on its prevalence in those countries. In other words, it is a non-sequitur to argue that, since the effects of anti-FGA advocacy in African countries have been “soberingly small” (whether or not that really is the case), we should therefore “relax” the laws concerning FGA in countries like the United States!

On this point, A&J provide no compelling estimates of FGA prevalence in Western societies, but instead state that: “Immigrants to Western nations may continue to subject their daughters to genital alteration, though the frequency is difficult to assess.” By contrast, in a recent review of the evidence, Johnsdotter and Essén report that: “Exploratory studies show trends of radical change of this harmful practice, especially the most extensive form of its kind. The widespread interpretation that Islam would require circumcision of girls becomes questioned when, e.g., Somalis meet other migrants, such as Arab Muslims, who do not circumcise their daughters. The few criminal court cases for circumcision of girls that have taken place in Western countries corroborate the conclusion that substantial change of the practice has occurred among migrants.”(32) Insofar as A&J’s policy proposal really is motivated by a concern about “widespread” FGA being carried out on an “underground” basis in Western countries, due to their restrictive laws concerning the practice, it is not clear that there is enough of a problem that

changes to these laws should in fact be seriously entertained.

“While laws enacted in [Western] societies make procedures that alter a female’s external genitalia illegal, they may in some instances worsen health outcomes by driving the practice underground, by sending female children to Africa, or by inviting circumcisers to the West.”

They may have this effect, or they may not. Unfortunately, the authors do not provide any evidence that prohibitions on FGA in Western countries lead to worse health outcomes overall by, e.g., “driving the practice underground.” Instead, they cite a paper by Leye et al., which in turn cites another paper by Leye (and a colleague) in which those authors state: “The true magnitude of the problem of FGM in [the studied countries] could not be assessed, and this lack of accurate FGM prevalence data make it hard to substantiate the claim for services, legislation and funds for prevention work.”(33)[p. 47] It is easy to speculate. But on a harm-reduction analysis, prohibition would only be an imprudent strategy if the amount of harm that was added through the postulated “underground” FGA procedures (including overseas trips, etc.) as a consequence of the law were greater than the amount of harm that was reduced by an overall drop in prevalence of FGA (due to its being illegal).

In short, we do not know how many girls are at risk of FGA in Western countries, and we have no evidence that the law (as it stands) is not an effective harm-reduction measure compared to alternatives (including A&J’s proposal), particularly when it comes to “health outcomes.”(32) In Africa and the Middle East, by contrast, where many communities see the prohibitions in their countries as being effectively forced on them by cultural outsiders/ former colonial powers, the laws may indeed lead to resentment and backlash and may therefore be much less effective. But this would suggest that cultural imperialism is a problem,(34) not (necessarily) that the laws in Western countries should be changed to accommodate the practices of immigrants who come to their shores (just as we would not expect, e.g., China to change its laws to accommodate the controversial practices of Westerners who might immigrate there). As Chapin (quoted in Belluck)(35) stated in response to an earlier U.S. policy proposal (by the AAP) similar to the one advanced by A&J: “There are countries in the world that allow wife beating, slavery and child abuse, but we don’t allow people to practice those customs in this country. We don’t let people have slavery ‘a little bit’ because they’re going to do it anyway, or beat their wives ‘a little bit’ because they’re going to do it anyway.” More generally, when certain acts in a host country are considered morally impermissible, such as sexual assault—yet nevertheless persist for whatever

reason (whether in immigrant communities or in the majority population)—this does not normally cause us to consider “relaxing” the laws against sexual assault (to repeat that example), including its “minor” forms.

Now, one could certainly argue that the law should not be the only tool for reducing harm associated with FGA, especially if it is being applied in a “sensationalized, ethnocentrist, racist, culturally insensitive, and simplistic” manner as A&J worry. But rather than “relaxing” the law, the law could instead be complemented with, e.g., sensitivity training, and could be applied in a nonracist, non-ethnocentric way by being expanded to cover similar practices that happen to be more popular in the host country.(34)

“To accommodate cultural beliefs while protecting the physical health of girls, we propose a compromise solution in which liberal states would legally permit ‘de minimis’ FGA in recognition of its fulfillment of cultural and religious obligations, but would proscribe those forms of FGA that are dangerous or that produce significant sexual or reproductive dysfunction.”

First, there is a question of whether it is the role of liberal state to “accommodate cultural beliefs,” and a further question about what a “cultural belief” is in the first place, but those are minor points. More important is the suggestion that FGA should be tolerated if it is not “dangerous” or does not “produce significant sexual or reproductive dysfunction.” Language can be slippery. What do A&J mean by “significant” sexual dysfunction? Is there (by contrast) “insignificant” or “mild” sexual dysfunction that would still be permitted on this analysis? And who gets to decide what degree of sexual dysfunction is “significant” (and in what sense), or what degree of risk of such dysfunction is tolerable? One plausible argument is that it is the individual herself (whose possible sexual dysfunction is at stake) who should be able to decide the degree of risk she is willing to take on—as well as what she considers to be “significant” in this very personal area—when she reaches an age of mental competence. This is as opposed to the individual’s parents before such an age.

“Grouping all forms of FGA in discourse and condemnation assumes that all FGA procedures carry the same risks, which is medically inaccurate.”

This is not true. It is not in fact necessary to assume that all FGA procedures carry the same medical risks in order to object to them without discrimination, since “medical risk” is not necessarily the only morally relevant feature that they share. Indeed, most people who argue

against all forms of FGA acknowledge that there is more or less risk of certain kinds of physical or psychological harms depending upon the type of the procedure and the context in which it is carried out. What they suggest does not vary between type, however, and which may therefore justify their being “grouped together,” is that all forms are in conflict with (what they see as) (a) the child’s right to bodily integrity, and (b) her interest in making an informed decision about irreversible genital surgery when she understands what is at stake in such an intervention and is competent to weigh alternatives.(36)

“Authors arguing against all forms of FGA ... argue that physical well-being trumps social and cultural well-being.”

A&J do not cite any authors specifically, so it is hard to know whose work they are referring to. However, speaking generally, those who argue against all forms of FGA do not necessarily suggest that physical well-being trumps social and cultural well-being; rather, they include in “social and cultural well-being” a child’s interest in having her future autonomy preserved when it comes to making controversial and irreversible bodily alterations that she (or he, in the case of MGA) may later come to resent. Moreover, they question why a child’s social and cultural well-being should hinge on having a non-therapeutic genital surgery performed before an age of meaningful consent. As an alternative, they suggest that cultural groups should reconsider holding a child’s social well-being hostage to such a surgery, and should instead love and care for the child unconditionally until the child herself can make an informed decision about so “private” a part of her own body.(37–39)

“We believe that all procedures should be performed with adequate analgesia.”

What do A&J consider “adequate” in this regard? In the case of male circumcision, where pain control has been better studied, Bellieni et al. argue that “no procedure has been found to definitively eliminate pain; the gold standard procedure to make MC totally pain free has not yet been established.”(40) Just as with their vague phrasing about “significant sexual dysfunction,” then, one could reasonably wonder how much pain, exactly, A&J think is acceptable to inflict on a young girl for non-therapeutic reasons.

“Given that the more extensive forms of FGA are physically harmful and may constitute oppression towards women, these practices should be actively discouraged by means such as education, social pressure, regulation, and prohibition. [However, since] ‘de minimis’ alternate

procedures are not associated with the same risks of long-term harm, these should be encouraged as a compromise solution that upholds cultural and religious practices without sacrificing the health and well-being of female children.

A&J change their standard of analysis halfway through this paragraph. They begin by arguing that the “more extensive” forms of FGA should be prohibited because, in addition to being “physically harmful” they also “may constitute oppression towards women.” But then when it comes to the more “minor” forms that they believe should be “encouraged” (note that this is a stronger claim than that they should merely be “tolerated”), they suddenly forget the issue of oppression towards women. But these “minor” forms, too, may also constitute oppression towards women (and therefore be objectionable), even if they are not as “physically harmful” as the more extensive forms.(41)

“We use the term ‘procedure’ in the context of FGA rather than ‘surgery’ to emphasize that there is no medical benefit established by well-designed trials, and that the primary purpose is not health-related.”

A&J are indirectly alluding to male circumcision here, which is presumed to have medical benefits “established by well-designed trials,” but there are a couple of things wrong with this (implied) contrast. First, in the case of *ritual* male circumcision, which is the relevant comparison, the “primary purpose” is not “health-related” either. Health benefits are often referred to when secular critics question the practice, but that is also the case for FGA.(7,13,42) Second, there is no “medical benefit established by well-designed trials” (for FGA) because it is illegal to conduct such trials in the first place. There is in fact research showing a “significant and perplexing inverse association between reported female circumcision and HIV seropositivity,”(43) but as the medical anthropologist Kirsten Bell has noted (personal communication, January 16, 2015): “These findings, which were presented at an International AIDS Society conference in 2005, have never been published in a peer-reviewed journal and it is difficult to imagine any agency willing to entertain [the authors’] call for further research. Indeed, the topic is self-evidently a non-starter. Regardless of any evidence that might suggest an association, it is impossible to imagine a parallel research agenda [to the one on male circumcision] solidifying around the procedure, irrespective of whether the surgery was conducted in a medical context and [irrespective of] the extent of cutting involved.”

“Category 1 includes procedures that should almost never have a lasting effect on morphology or function if performed properly. A small nick to the vulvar skin fits into this category. Category 2 consists of procedures that create morphologic changes, but are not expected to have an adverse effect on reproduction or on the sexual satisfaction of the woman or her partner. Examples include surgical retraction of the clitoral hood or procedures resembling labiaplasty as performed in Western nations.”

Several points here. To count for Category 1 (on A&J’s proposed typology), the procedure must “almost never” have a lasting effect on morphology or function if performed properly. This raises the regulatory issue of how individuals will be trained (and by whom), and how “proper” performance will be monitored and assessed. In this context, we should ask: How many girls should we be willing to subject to “improperly performed” Category 1 procedures (which would in fact risk changing morphology and/or damaging function), as we sort out the issues of training and regulation? Here it should be remembered that even the slightest nick to the vulvar skin carries risk: the knife can slip; the equipment may not have been properly sterilized, introducing the risk of infection, and so on.

With respect to male circumcision, which has been performed in a Western context for centuries, and primarily by medical professionals, there is—even so—little guarantee of a “proper performance.” A recent study in the *Canadian Urological Association Journal*, for example, found: “Most physicians performing neonatal circumcisions in our community have received informal and unstructured training, [leading to] unsatisfactory results [being] witnessed in our pediatric urology practice. Many practitioners are not aware of the contraindications to neonatal circumcision and most non-surgeons perform the procedure without being able to handle common post-surgical complications.”(44) How much worse might the situation be with FGA procedures performed on a diminutive genital organ, given that comparable MGA procedures have had a much longer time period to become stabilized and thus “properly” performed?

For Category 2, A&J give the examples of surgical retraction of the clitoral hood and procedures akin to labiaplasty, arguing that these would “create morphological changes, but are not expected to have an adverse effect on reproduction or the sexual satisfaction of the woman or her partner.” It must first be noted that it is likely to be difficult to retract “just” the clitoral hood, since, in a young girl, the external clitoral organ (including its prepuce) is typically very small. Thus there would be a substantial risk of damaging (or over-exposing) the glans clitoridis, which is extremely

sensitive and which can be excruciating to touch directly (i.e., without the covering of the clitoral prepuce, which typically only retracts in a state of high arousal).(45) Why this is not seen as posing a meaningful risk of an “adverse effect on ... the sexual satisfaction of the woman” is unclear.

With respect to labiaplasty, it might be helpful to keep in mind what sort of tissue is at stake in this procedure, so that we can assess the likely effects of its removal on sexual sensation, function, etc.(46) As Schober et al. state: “Labia minora is highly innervated along its entire edge. Related vascular compartment tissue involved in engorgement during sexual arousal makes this tissue important for sexual response. Labiaplasty risks removal of tissue with an important contribution to sensory sexual arousal.”(47) Brzyski and Knudtson state: “The labia majora [are] relatively large, fleshy folds of tissue that enclose and protect the other external genital organs. They are comparable to the scrotum in males. The labia majora contain sweat and sebaceous glands, which produce lubricating secretions [while] the labia minora are lined with a mucous membrane, whose surface is kept moist by fluid secreted by specialized cells.”(48) Of course, if an adult female would like to sacrifice any of this tissue—with its concomitant sensory and protective functions, lubricating secretions, and so on—for “cosmetic” (or other) reasons, one could argue that that is her business. But to suggest that removing this tissue from a minor, who might very well grow up to wish that she still had her labia intact, is only a “*de minimis*” intervention, strikes me as somewhat harder to defend than the authors seem to think it is.

Indeed, it is worrying that A&J would include labiaplasty in a category that is “not expected to have an adverse effect on [the] sexual satisfaction of the woman or her partner” while providing no evidence whatsoever in support of this assertion. What is relevant to this debate is the likely (future) sexual effects of labiaplasty (or similar) as performed on a young girl. But since performing labiaplasty on young girls is illegal in Western societies, it is impossible to collect the relevant data. So, there is no way to know whether such an intervention would in fact fall into Category 2 unless it were first permitted, but A&J argue that it should be permitted on account of falling into Category 2. That seems somewhat circular.

But at least A&J are consistent. In a previous paper,(49)[p. 32] they argued that ritual infant male circumcision should have “little negative effect on sexual health and functioning,” based on data collected from trials of medicalized adult circumcision that involved only limited follow-up and which did not use validated questionnaires.(24) In a reply piece,(50) I pointed out that these data,

quite apart from being of poor quality, were not actually applicable (along several dimensions) to the form of circumcision A&J were defending. Moreover, I stressed that the foreskin itself consists of a substantial amount of touch-sensitive tissue that is both manually and orally manipulable, and that its removal necessarily eliminates any concomitant motions and sensations. To this, they replied: “Sexually sensitive skin unquestionably is removed during circumcision. It does not follow that this causes a loss of function or of satisfaction, or that remaining skin cannot compensate.”(51)[p. W1]

But it depends on how you define function, how you measure satisfaction—and who you ask. Any sexual functions (including masturbatory gestures) that require manipulation of the foreskin are, in fact, lost to circumcision. Similarly, any sexual functions involving manipulation of the labia (including some possible aspects of oral sex) are, in fact, lost to labial excision. Whether the inability to have one’s foreskin or labia manually or orally manipulated counts against one’s sexual satisfaction will depend upon one’s sexual preferences. Some men who have sex with men (MSM) use their foreskins in a sexual act known as “docking”(52) – an act that is impossible if the foreskin has been removed. In fact, in a recent study, “men indicated a strong preference toward intact penises for all sexual activities assessed and held more positive beliefs about intact penises.”(53) Similarly, the labia can be tugged, stretched, sucked on, and otherwise fondled during sexual interaction, and for those for whom such activities are an important part of their sexual experience, the loss of labia would indeed be a problem.

“Surgical resection of the clitoral hood is the vulvar procedure that most closely resembles male circumcision.”

The two interventions are similar in that they both involve resection of the genital prepuce. However, the highest concentration of sensitive nerve endings for the female is in the glans clitoris, not the clitoral prepuce; whereas, according to some researchers, in males the inverse is true: the glans penis is relatively lacking in fine-touch neuro-receptors, whereas the penile prepuce has a greater concentration of such receptors.(45) Moreover, the clitoral prepuce is very small, whereas the penile prepuce is very large, constituting between 30 and 50 square centimeters, on average, of sexually sensitive tissue according to available estimates.(54,55) That said, both the clitoral and penile prepuces serve similar functions in protecting the soft, sensitive, and moist glans tissue, preventing abrasion and drying out. In that specific regard, then, there would be a comparable effect of removing them.

“Category 3 contains those procedures that are likely to impair the ability of the recipient to engage in or enjoy sexual relations. Clitoridectomy, whether partial or complete, falls into this category.”

It is unclear whether excision of the external clitoris is “likely to impair the ability of the recipient to engage in or enjoy sexual relations,” and thus whether clitoridectomy is an apt illustration for the proposed Category 3. This is because the clitoris is a “multiplanar” organ that is nearly as long as the vagina is deep, that is, about 5-7.5 cm, with approximately 80% of its length and most of its erectile tissue being subcutaneous.(56,57) This tissue may be able to be stimulated through the vagina; it can also be stimulated externally even if the external glans has been resected, by applying pressure to the remaining tissue. There is certainly a *risk* of diminished sexual experience with clitoral excision, but as Catania et al. state: “our results suggest that FGM/C [including clitoridectomy] does not necessarily have a negative impact on psychosexual life (fantasies, desire, pleasure, ability to experience orgasm). [Even] in infibulated women, some fundamental structures for the orgasm have not been excised.”(58)

What this suggests is that it is possible to remove even a great deal of tissue from the external female genitalia and yet “leave enough behind” that there is nevertheless a decent chance that the person will be able to “enjoy sex” (as measured broadly by these kinds of studies), “experience pleasure during sexual intercourse,” and even orgasm. However, that those should be the benchmarks for acceptability is doubtful: even if it is physiologically possible to have an orgasm after one’s external clitoral glans has been excised (or to experience at least some degree of pleasure during sex due to the stimulation of other parts of the vulva/vagina that have not been removed), this does not mean that sex would be no different if one still had one’s glans. Some women who have had parts of their genitals removed in childhood—even if they can still “enjoy sex”—feel upset, angry, violated, and mutilated, simply because of the fact that part of their genitals were removed without their permission.(34) Other women who have undergone such procedures do not feel this way.(59,60) However, there is a crucial difference between these two cases. Anyone who would like to have her clitoral glans, clitoral hood, or labia removed or altered (but hasn’t yet had this done) can always undertake the surgery later; whereas, someone who did have those things done to her—but wishes they hadn’t been—has no recourse.(61) Similarly with respect to male circumcision/MGA: many men—precise numbers are hard to come by, but a recent YouGov survey concluded that fully 10% of American men wish that they

had not been circumcised(62)—have impaired sexual lives either because their surgery was “botched,” or because they feel angry, violated, mutilated, etc., in virtue of having had a large sleeve of functional, erogenous tissue removed from their genitals before they could object.(63,64)

“Critics of FGA have pointed out that there is no medical benefit to factor in the risk versus benefit calculus so often used in medicine and when compared to male circumcision. However, up to recently, the medical benefits of male circumcision were also thought to be tenuous, contested, or so minor that circumcision was classified as an elective, cosmetic procedure.”

Again, A&J are conflating adult (and hence voluntary), medicalized circumcision and infant (and hence involuntary), ritual circumcision. There is little in the way of robust data on “health benefits” as concerns the latter, and most of the data that do exist are in fact extremely “tenuous” and “contested.” In fact, the only medical bodies that have suggested that the known benefits of circumcision outweigh the known risks (though note that these bodies, too, conflate adult and infant circumcision in their assessments of the available data) are the ones mentioned by A&J in their paper. But they are in the minority on a global scale (see earlier discussion).

“The Jacobs’s three-pronged test has been previously proposed that, if satisfied, would morally preclude a government or regulatory agency from reversing a parental decision to involve a child in a minority group practice. First, the practice in question must not significantly burden either society or its members outside the group. Second, the practice must not (a) create burdens that a reasonable person outside the group would not accept for himself, or that a reasonable parent would not accept for her child (such as child marriage or slavery); or (b) carry a substantial chance of death or of major disruption of a physiological function. Third, the burden on society or individuals must be actual and substantial, not hypothetical or unlikely. ... Categories 1 and 2 of FGA ... fulfill these criteria and thus, a government or regulatory agency does not have a medical basis for interfering with a parental decision to practice a cultural or religious belief.”

First, the “Jacobs’s three-pronged test” was proposed by the same Jacobs who now advocates, with Arora, for “minor” forms of FGA, in a paper in the *Israeli Medical Association Journal* whose overriding purpose was to mount a defense of ritual male circumcision. There is no evidence that ethicists, moral philosophers, or political theorists accept this test as having any

validity, and what attention it has received has not necessarily been favorable.(65) But let us just take it for granted. Criterion #2 is that “the practice in question must not ... create burdens that a reasonable parent [outside the group] would not accept for her child.” So one can ask: Would a reasonable parent in a Western country, that is not a member of an immigrant group that practices FGA, accept for their daughter a non-therapeutic cutting procedure to the child’s vulva that carries the risk (however slight) of damaging erogenous tissue? My guess is “no,” but this is admittedly an empirical question. Finally, please note that A&J once again shift the terms of their analysis halfway through the paragraph. They begin by stating that the three-pronged test, if satisfied, would “morally preclude” a government from reversing a parental decision. But they finish by stating that a government “does not have a medical basis” for interfering with a parental decision. This careering back and forth between medical and moral arguments does not give the impression of a principled stand on the issue, but rather a desire to defend the permissibility of culturally-motivated cutting of children’s genitals (of whatever sex) by whatever argumentative means.

“Procedures that compromise sexual function, sexual enjoyment and reproductive capacity clearly violate the best interest of the child. ‘De minimis’ procedures such as removal of the clitoral hood or a ritual nick on the external female genitalia .. cause little or no functional harm.”

It seems clear that removal of the clitoral hood would cause functional harm: specifically, it would eliminate all the functions performed by the clitoral hood itself, including protection of the clitoral glans (much as the penile prepuce serves to protect the penile glans). Notice also the phrasing “little or no” harm – is a “little” harm acceptable then? And who gets to decide how much harm is only “a little”? Harm is a subjective matter. Given that A&J cannot imagine how removing something as large, sensitive, and functional as the labia minora could have a meaningfully adverse effect on a woman’s sexuality (see above discussion), it seems unlikely that their subjective judgments about sexual harm would be particularly widely shared by others. An alternative proposal is that it is the individual herself (who will be affected by the genital procedure) who should be able to decide how much value she places on having an intact vulva, and how “harmful” it would be to her sexual experience to have parts of it surgically altered or removed.

“The best interests of a child encompass not only physical well-being, but social, economic,

psychological and spiritual well-being.”

If the best interests of the child encompass not just physical well-being (which is clearly the case) but also social, economic, psychological, and spiritual well-being, then preservation of the child’s future autonomy (i.e., the freedom to make an important decision about a private part of one’s body later on) should arguably be counted among those non-physical interests that need to be factored into the equation.(66)

“The tolerant attitude in the United States to male circumcision is in stark contrast to its treatment of FGA. Yet, ‘both are likely voluntary choices influenced by cultural conditioning.’”

If either male circumcision or FGA is performed on a child before that child can understand what is at stake in the procedure, then the procedure cannot meaningfully be described as “voluntary.” It is true, however, that parents who perform (or authorize) such procedures are typically influenced by cultural conditioning.

“Neonatal boys are certainly just as vulnerable as girls. In fact, one could argue that the pubescent or adolescent girl undergoing FGA is more capable of assenting to the procedure and claiming the culture/religion as her own, than the neonatal boy. We do not condone the forcible practice of FGA if a child developmentally capable of providing assent declines to do so.”

One cannot help but agree. Neonatal boys (and girls) are uniquely vulnerable: they cannot effectively resist having a non-therapeutic procedure carried out on their genitals. But if A&J do not think that a child who is capable of declining to assent to FGA (and presumably MGA) should have the procedure forced on her (or him), then why do they approve of forcing the same procedure on an infant who is not yet *capable* of declining to assent (at least not articulately, using words)? Presumably, they would respond: “because the vulnerable infant is entirely in the parents’ care, and must depend on them to make decisions that they judge to be in its best interest.” But one could equally recommend that irreversible surgeries whose very status as being in the child’s best interest is contentious should be deferred until such a time as the individual who will actually be affected by them is in a position to weigh the pros and cons in light of her (or his) own values.(34,67)

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