Between Moral Relativism and Moral Hypocrisy: Reframing the Debate on "FGM"

Brian D. Earp

Kennedy Institute of Ethics Journal, Volume 26, Number 2, June 2016, pp. 105-144 (Article)

Published by Johns Hopkins University Press

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ABSTRACT. The spectrum of practices termed "Female Genital Mutilation" (or FGM) by the World Health Organization is sometimes held up as a counterexample to moral relativism. Those who advance this line of thought suggest the practices are so harmful in terms of their physical and emotional consequences, as well as so problematic in terms of their sexist or oppressive implications, that they provide sufficient, rational grounds for the assertion of a universal moral claim—namely, that all forms of FGM are wrong, regardless of the cultural context. However, others point to cultural bias and moral double standards on the part of those who espouse this argument, and have begun to question the received interpretation of the relevant empirical data on FGM as well. In this article I assess the merits of these competing perspectives. I argue that each of them involves valid moral concerns that should be taken seriously in order to move the discussion forward. In doing so, I draw on the biomedical "enhancement" literature in order to develop a novel ethical framework for evaluating FGM (and related interventions—such as female genital "cosmetic" surgery and nontherapeutic male circumcision) that takes into account the genuine harms that are at stake in these procedures, but which does not suffer from being based on cultural or moral double standards.

INTRODUCTION

"Female Genital Mutilation" or FGM—the terminology is extremely contentious[1]—is sometimes held up as a counterexample to moral relativism (see, e.g., Hernlund and Shell-Duncan 2007; Kopelman 1994; Lane and Rubenstein 1996; Shweder 2002).[2] Those who advance this line of thought suggest that such mutilation is so harmful in terms of its physical and emotional consequences, as well as so problematic in terms of its sexist or oppressive implications, that it provides sufficient, rational grounds for the assertion of a universal moral claim—namely, that all forms of FGM are wrong, regardless of the cultural

Kennedy Institute of Ethics Journal Vol. 26, No. 2, 105–144 © 2016 by The Johns Hopkins University Press

context. Prominent philosophers who have argued for this position, or one reasonably close to it, include Martha Nussbaum[3] (1996, 1999), Ruth Macklin (1998), Amy Gutmann (1993), and many others, and it has been adopted as official policy by such influential bodies as the World Health Organization (WHO) and the United Nations (UN). In 2008, for example, the WHO/UN published a joint statement calling for the "eradication" of FGM (WHO/UN 2008); four years later, the UN passed a unanimous resolution effectively "banning" the practice all around the world (see UN Women 2012).

In both cases, the policies were justified, at least in part, by an appeal to objective or universal moral principles, typically expressed in the language of human rights (for further discussion, see Askew et al. 2016).[4] According to the 2008 joint statement, for example, FGM "violates the right [to] physical integrity of the person" (WHO/UN 2008, 1). According to the 2012 UN resolution, FGM is an "irreparable, irreversible abuse" that violates "human rights" (United Nations General Assembly 2012, 2).

Many people have celebrated these (and other similar) developments and have hailed them as advances in the cause of social justice. Certainly, this appears to be the prevailing view among Western[5] bioethicists and moral philosophers, who are inclined to see the reasoning of the anti-FGM universalists as being both dispassionate and empirically well-informed. However, others suggest that cultural bias may be corrupting the conventional analysis—and have raised serious questions about the standard interpretation of the relevant "facts" about FGM as well (e.g., Abdulcadir et al. 2012; Ahmadu 2000, 2007, 2016; Ahmadu and Shweder 2009; Androus 2004, 2009, 2013; Arora and Jacobs 2016; Bell 2005; Benatar and Benatar 2003; Bishop 2004; Boddy 1991; van den Brink and Tigchelaar 2012; Chase 2005; Coleman 1998; Darby 2015; Davis 2001, 2002, 2013; DeLaet 2009, 2012; Fox and Thomson 2005, 2009; Frissa 2011; Galeotti 2007; Gruenbaum 2001; Gunning 1991; Hellsten 2004; Hernlund and Shell-Duncan 2007; Hodžić 2013; James and Robertson 2005; Johnsdotter and Essén 2010, 2016; Johnson 2010, 2014; Johnson and O'Branski 2013; Kirby 1987; Lane and Rubenstein 1996; Lightfoot-Klein 1997; Lightfoot-Klein et al. 2000; Lyons 2007; Manderson 2004; Mason 2001; Njambi 2004; Oba 2008; Obermeyer 1999, 2003, 2005; Sanchez 2014; Shell-Duncan and Hernlund 2000; Shweder 2002, 2005, 2013; Smith 2011; Svoboda 2013; Svoboda and Darby 2008; Toubia 1999; Wade 2009, 2012a, 2012b; Wisdom 2012; Wong 2006).

Although these emerging critics do not speak in one voice, it is worth noting that they include a number of academics who have described themselves as being personally opposed to FGM or even strongly in favor of its discontinuance (e.g., Androus 2004, 2009; Boddy 1991; James and Robertson 2005), as well as some scholar-activists and feminists who have been at the very forefront of the anti-FGM movement (e.g., Lightfoot-Klein 1997; Lightfoot-Klein et al. 2000; Toubia 1999). According to these critics, the prevailing moral discourse surrounding FGM has not been entirely objective, but has instead been compromised by what they see as Western ethnocentrism and cultural imperialism (see Gunning 1991, 191; see also Oba 2008). Some of these critics have gone even further and raised a charge of outright moral hypocrisy (e.g., Baker 1998; DeLaet 2009; Dustin 2010; Ehrenreich and Barr 2005; Ford 2001; Johnson 2010).

What would such hypocrisy mean in this case? In simplest terms, it would mean that the specific moral principles that are currently being used to justify a "zero-tolerance" stance on FGM (both philosophically and in terms of actual global policy; see Topping 2015) are not being applied consistently to analogous practices that happen to be more popular in Western countries.[6] Examples that have been raised in the literature of such potentially analogous practices include: female "cosmetic" surgeries such as breast implantation, along with female "cosmetic" genital surgeries in particular (see, e.g., Chambers 2004, 2008; Davis 2002; Johnsdotter and Essén 2010; Kelly and Foster 2012; Sheldon and Wilkinson 1998; Svoboda 2013), intersex genital "normalization" surgeries (see, e.g., Chase 2005; Ehrenreich and Barr 2005; Ford 2001; Lightfoot-Klein et al. 2000; Svoboda 2013), and nontherapeutic infant male circumcision (see, e.g., Bell 2005; Chambers 2008; Davis 2001; Earp 2015a; Hellsten 2004; Johnson 2010; Svoboda and Darby 2008; Toubia 1999). These practices, perhaps because they are more familiar to a Western mindset, might be presumed to be morally unproblematic—or at least, on the whole, permissible—even if a more careful analysis would reveal that they share a number of features with FGM that should qualify them as being comparably morally suspicious. In other words, these critics argue, it might be the case that what appears to be a universal moral standard concerning FGM will turn out to be, upon closer inspection, a "relativistic double standard that masquerades as universalism" (DeLaet 2009, 422).

In this article, I assess the merits of these competing perspectives. I argue that each of them involves valid moral concerns that should be taken seriously in order to move the discussion forward. Accordingly, my aim

will be to develop an ethical framework concerning FGM (and related interventions) that acknowledges the genuine harms that are at stake, but which does not suffer from being based on cultural double standards. In order to develop this framework, I will begin by presenting the orthodox position on FGM as represented by the WHO/UN, and then I will turn to the analysis of the critics of this position who have raised the concerns about cultural bias.

WHAT IS THE POSITION OF THE WHO/UN?

According to the WHO/UN (2008), the term "Female Genital Mutilation" refers to "all procedures involving partial or total removal of the external female genitalia [i.e., the external clitoris, clitoral prepuce, and labia] or other injury to the female genital organs for non-medical reasons" (1). The most invasive form of FGM is called "infibulation," which is defined as the "narrowing of the vaginal orifice with [the] creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris" (24). Other, more "minor" forms of FGM will be discussed in detail later on.

Such "mutilation" has "no known health benefits," according to the WHO/UN (2008), but instead is "known to be harmful to girls and women in many ways" (1). For example: "it is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences" (1). Such consequences may include "chronic pain, infections, decreased sexual enjoyment, and psychological consequences, such as post-traumatic stress disorder" (11).

Although the WHO/UN acknowledge that "communities that practise female genital mutilation report a variety of social and religious reasons for continuing with it," they suggest that these reasons are not sufficient to justify the practice on moral grounds. Instead, "from a human rights perspective," FGM reflects "deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women." Moreover, since "female genital mutilation is nearly always carried out on minors it is therefore a violation of the rights of the child" (2008, 1).

As we can see, the WHO/UN position rests on a number of specific moral as well as empirical considerations. Taken together, these considerations are believed to justify a concerted effort on their part to "eradicate" all forms of FGM, including from the countries and cultures in which it has long been performed and continues to be widely endorsed. As noted earlier,

however, this position is not unique to the WHO/UN. Instead, it is typical of—and indeed, very heavily informed by—the broader Western discourse on the subject. Therefore it is important to try to understand why some people have raised concerns about this broader discourse, so that we can see how those concerns might apply to the specific claims that have been advanced by the WHO/UN.

WHAT ARE THE CONCERNS OF THE CRITICS?

That the WHO/UN position on FGM might be controversial is likely to come as a surprise to many people. As Richard Shweder (2002) has noted, the apparent Western consensus about FGM is that it is so clearly beyond the pale—even barbaric, as it is often said—that "the mere query, 'What about FGM?' is [now] presumed to function in and of itself as a knockdown argument against both cultural pluralism and any inclination toward tolerance" (226). But a perception of consensus can also breed complacency. In particular, it can lead to an echo chamber of mutual agreement that might make it hard to be properly self-critical, much less open to the possibility of dissent. Consistent with this view, as Lori Leonard (2000) has argued, the Western literature on FGM has become "remarkably constrained and predictable, bearing signs of an almost standardized discourse" (159).

A standardized discourse might still be—for the most part—an accurate discourse, or a discourse that is accurate enough. In this case, however, the emerging critical view is that it is neither. Instead, these critics suggest, it is characterized by such problems as oversimplification, unjustified conflation of disparate phenomena, exaggeration, and often extremely emotive rhetoric[7] that is not supported by dispassionate research (James and Robertson 2005). As Andrew Delaney (2013) has argued, "research and activism [have been largely] conflated . . . and data on FGM that [are not] actually investigated taken as true" (see also Hodžić 2013; Johnsdotter 2013; Johnsdotter and Essén 2010; Obermeyer 1999; Shweder 2002). We will look at some examples of this phenomenon a little bit later on.

In light of these sorts of considerations, some scholars who work on FGM have expressed concern about the degree of insularity that is present in the Western discourse on the subject (see, e.g., Abdulcadir et al. 2012). Since FGM is a foreign practice with respect to this discourse, they argue, it might be hard for some people—including not only members of the general public, but also government officials, journalists, policymakers, medical researchers, moral philosophers, and even some Western feminists and

anthropologists—to take seriously the perspective of cultural "insiders" who regard FGM as something "normal" (see, e.g., Berggren et al. 2007; Ahmadu 2000; Kirby 1987).[8] As a result, they might fail to understand the complexity of the actual contexts associated with FGM, including not only the abstract interpretive standards by which the practice is locally evaluated, but also the range of purely physical consequences it can have for health and sexuality. As Carla Obermeyer (1999) has written:

> It is rarely pointed out that the frequency and severity of complications are a function of the extent and circumstances of the operation and it is not usually recognized that much of [our] information comes from studies of the Sudan, where [in contrast to the majority of settings] most women are infibulated. The ill-health and death that these practices are thought to cause are difficult to reconcile with the reality of their persistence in so many societies, and raises the question of a possible discrepancy between our "knowledge" of their harmful effects and the behavior of millions of women and their families. (91)

What might explain this discrepancy, should we find that it exists (as I will argue that it does in the course of what follows)? Part of the explanation, as the Sierra Leonean–American anthropologist Fuambai Ahmadu (2007) has put it, has to do with the tendency of Western observers to direct their gaze "between the legs" of women who are affected by FGM, rather than on the wider circumstances of their lived experiences. This has the effect, she argues, of negating their beliefs and feelings about the practice, "rendering them 'invisible' as individuals with their own dynamic histories, cultures, and traditions" (279).

What might Westerners notice if they were to lift up their gaze? One thing they might notice is that "coming-of-age and gender-identity [rites] involving genital alterations are embraced by, and deeply embedded in the lives of many African women" (Shweder 2002, 218).[8] Such rites are also common, in one form or another, in some parts of Southeast Asia and the Arabian peninsula, as well as in a number of immigrant communities derived from these populations. Moreover, the women who participate in (and perpetuate) these rites come from a range of different ethnic and religious backgrounds, as well as social and economic classes; and they run the gamut of educational attainment (see Abdulcadir et al. 2012; Shweder 2002). In these groups, what is usually referred to (in English) as "female circumcision"—rather than "mutilation"—is typically regarded as a cause for celebration: it is often accompanied by ceremonies intended to

honor the girls and welcome them into the adult community (Kopelman 1994, 55).

Of course, the mere popularity of a given practice in a given context does not necessarily tell us very much about its underlying moral character. As I have argued elsewhere, it is quite possible that those women who approve of female circumcision in their societies "possess a comparatively narrow degree of awareness of the key issues, such as the relevant genital anatomy, the ethical controversies surrounding the practice, the way it is perceived in other societies, and so on" (Earp 2015a, 96; see also Dalal, Lawoko, and Jansson 2010). Nevertheless, critics of what I have been calling the orthodox view have noted that these women—that is, those who are supportive of female circumcision, and who have actually gone through a version of it themselves—are not typically given standing in the international debate.[9] Instead, their voices have been for the most part ignored, or, if acknowledged, explained away, often by appeals to "patriarchy" or "false consciousness"[10] that are based largely upon untested assumptions rather than carefully collected evidence (Ahmadu 2000, 2007; Engle 1992; Haddon 1998; Lewis 1995; Lyons 2007; Obiora 1997; Shweder 2002). For example, it is often asserted that female circumcision is done at the behest of men (whether directly or indirectly) as a way to "control the sexuality" of women. On this interpretation, women who endorse or even manage such rituals themselves—as they do in the vast majority of cases (Abdulcadir et al. 2012; Shweder 2002)—are unwittingly participating in their own subordination.

The Question of Patriarchy

Researchers who have looked more closely at the question of patriarchy—here defined as "a system of social structures and practices in which men dominate, oppress, and exploit women" (Walby 1989, 214)—emphasize that there is a wide "diversity of female genital cutting practices" across cultures (Johnson and O'Branski 2013, 211), and that these are carried out by different groups, under different circumstances, for a multiplicity of reasons (Lyons 2007). In some cases, the motivation for the cutting has little to do with curbing sexuality (see, e.g., Shell-Duncan and Hernlund 2000); and the relationship to patriarchy across these various settings is at best unclear.[11] For example, while some groups that practice female genital cutting appear to be characterized by power imbalances that favor males, others are more egalitarian (see later discussion). More importantly,

however, there does not seem to be any consistent relationship between the respective status of men versus women in some society and whether it practices a form of FGM. This point has recently been underlined by the Public Policy Advisory Network on Female Genital Surgeries in Africa, a nonpartisan, interdisciplinary coalition of some of the foremost scholars of genital cutting. As these authors state: "The vast majority of the world's societies can be described as patriarchal, and most either do not modify the genitals of either sex or modify the genitals of males only. There are almost no patriarchal societies with customary genital surgeries for females only" (Abdulcadir et al. 2012, 23). We will return to this point in a moment.

As for the act of cutting itself, as Mackie (2000) has stated, "a group may perform it at infancy, before puberty, at puberty, with or without initiation rites, upon contracting marriage, in the seventh month of the first pregnancy, [or] after the birth of the first child" (270). In some cases, FGM has been done (by women) over the objections of the majority of men (see Thomas 1996); in other cases it has been adopted by teenage girls over the objections of the entire adult community (see Leonard 2000). More often, however, it is done around puberty as part of a rite of passage, with men, women, and teenagers typically supporting the initiation. As Lisa Wade (2012a) has argued, attributing the persistence of female genital altering rituals to patriarchy "grossly over-simplifies their social, cultural, and economic functions" in the diverse societies in which they are performed (28; see also Obiora 1997).

Male Circumcision

Another point to consider when analyzing the role of patriarchy in upholding genital cutting practices is that it isn't only the girls who are initiated. The boys are circumcised as well. As alluded to in the previous section, there are few or no human societies on record that practice female genital cutting without also practicing male genital cutting—often in parallel, under the same conditions, and for very similar reasons (see, e.g., Ahmadu and Shweder 2009; Androus 2013; Caldwell, Orubuloye, Caldwell 1997; DeLaet 2009; Leonard 2000; Manderson 2004). As J. Steven Svoboda (2013) notes, across societies, analogous justifications are given for both male and female genital reshaping customs: "these include claimed health benefits, absence of 'bad' genital odors, enhancement of physical beauty, greater attractiveness and acceptability of the sex organs, [spurious] medical reasons, minimization of damage and pain, hygiene,

preventing future problems . . . looking like other children or like the child's parents, fear of promiscuity, and acceptance of altered genitalia as more [appealing] to the opposite sex" (244). Providing an additional perspective, Lori Leonard (2000) has written:

> When practiced as part of a rite of passage, [male and female] genital cutting simultaneously separates initiates from the asexual world of childhood and incorporates them into [the] world of adulthood. In such contexts, genital cutting is construed as having little to do with sex, per se. Rather, its function is to prepare young men and women to occupy [their adult roles] within the community. (162)

Nelson Mandela's (2008) account in *The Long Walk to Freedom* of his own ritual circumcision among the Xhosa is consistent with this view:

> When I was sixteen, the regent decided that it was time that I became a man. In Xhosa tradition, this is achieved through one means only: circumcision. In my tradition, an uncircumcised male [cannot] marry or officiate in tribal rituals. An uncircumcised Xhosa man is a contradiction in terms, for he is not considered a man at all, but a boy. (30–36)

As Mandela goes on to say, "It was a sacred time; I felt happy and fulfilled taking part in my people's customs and ready to make the transition from boyhood to manhood." At the same time, however, "I was also tense and anxious, uncertain of how I would react when the critical moment came." For, among the Xhosa, as in many other African ethnic groups, "circumcision is a trial of bravery and stoicism; no anaesthetic is used; a man must suffer in silence" (*ibid.*).[12]

In some societies where male and female circumcisions are performed, the operations are seen as mirror images of each other. That is, male circumcision is regarded as removing the "female" part of the penis (namely, the foreskin, which encloses, like a womb or vagina), whereas female circumcision is regarded as removing the "male" part of the vulva (namely, the external clitoris, which sticks out like a miniature phallus). In this way, "androgynous" children are transformed into fully sexualized adults with distinct sex-based characteristics (see Ahmadu and Shweder 2009; Shell-Duncan and Hernlund 2000). Lest this way of thinking seem too alien, it may be useful to raise an analogy here with the Western practice of surgically "normalizing" the genitals of so-called intersex children—i.e., children who are born with what *their* community regards as insufficiently differentiated genitalia (for further discussion, see, e.g., Dreger 1998,

1999; Ehrenreich and Barr 2005; Ford 2001; Karkazis 2008). In any case, as Zachary Androus (2004) has noted, it is important to recognize that female and male genital altering rituals are often "closely related in the practitioners' minds" (6).

John Caldwell and his colleagues offer a similar perspective. "The failure to relate the two types of circumcision," they write, "is curious . . . because they have probably been regarded by most Africans as being related for aeons" (Caldwell, Orubuloye, and Caldwell 1997, 1181). In consequence, many African women and men are genuinely perplexed by what they see as Western efforts to eliminate only the female half of their initiation rites. Recognizing this, one scholar of genital cutting has suggested that: "Female circumcision will never stop as long as male circumcision is going on . . . [for how] do you expect to convince an African father to leave his daughter uncircumcised as long as you let him do it to his son?" (quoted in Abu-Sahlieh 1993, 612; see also Steinfeld and Lyssarides 2015).

Against this view, some might wish to argue that a clear distinction can nevertheless be drawn between the two types of genital cutting. This would be based on the assumption that female forms of circumcision are more invasive, more medically risky, and more physically harmful than their male counterparts. But it is hard to see on what empirical grounds such a categorical perspective could successfully be advanced. To pick just one example, in South Africa in 2013, nearly 80 teenage boys died from their traditional circumcision initiations, very much like the one described by Mandela (Maseko 2013); between 2008 and 2014 the total figure for circumcision-related deaths in South Africa was conservatively 400 in just two of the nine provinces, with several thousands of boys being hospitalized due to seriously botched operations (Gonzalez 2014; Douglas and Nyembezi 2015). Most of these procedures were carried out in the bush, with nonsterilized tools such as spearheads and dirty knives, by ritual practitioners with little or no medical training (see, e.g., Malan 2013). Among those who did not die, several lost their penises or suffered partial amputations, and dozens more suffered from such conditions as necrosis and severe infections (for extensive photographic evidence, see the website http://ulwaluko.co.za). In this same time period, however, there were no known deaths from female circumcision in South Africa, probably because the Xhosa ritual for girls is much shorter than the one for boys and does not involve the actual removal of tissue (South African History Online 2014); otherwise, female genital cutting in South Africa

appears to be limited to a handful of immigrant groups, with no reliable prevalence statistics available (see Interparliamentary Union 2002).

The situation varies from group to group. To be certain, as Debra DeLaet (2009) points out, "there are sharp differences between infibulation, the most extreme form . . . of female genital mutilation, and the less invasive form of male circumcision that is most widely practiced." However: "that comparison is not necessarily the most appropriate comparison that can be made. There are extremely invasive forms of male circumcision that are as harsh as infibulation" (406), such as subincision, traditionally practiced by some Australian Aboriginal groups, in which the underside of the penis is sliced open from the scrotum to the corona of the glans (see, e.g., Cawte, Djagamara, and Barrett 1966; Pounder 1983; Rowanchilde 1996); and while "it is true that these extreme forms of male circumcision are rare . . . it is also the case that infibulation" is rare, occurring in approximately 10% of cases according to available estimates (see Abdulcadir et al. 2012; Yoder and Kahn 2008). "Indeed, female circumcision as it is commonly practiced can be as limited in terms of the procedures that are performed and their effects as the most widespread type of male circumcision" (DeLaet 2009, 407).

The Clitoris and Sexual Function and Satisfaction

The final sentence of DeLaet's analysis may strike a Western reader as dubious. Is it not the case, this reader may be thinking, that female circumcision at the very least involves the removal of the clitoris? And is it not the case that—setting aside certain extremes such as subincision in Aboriginal Australia or septic circumcisions among the Xhosa of South Africa—male circumcision involves "only" the removal of the foreskin, thereby leaving the rest of the organ intact? And does not this basic anatomical difference suggest that, holding everything else to one side, female circumcision is likely to be much more sexually damaging?

This appears to be a very common view. As David Johnson (1994) has argued, "The circumcision of women is qualitatively different from the circumcision of men. [It] takes from women an essential part of their humanness, preventing them from ever becoming full participants in sexual relations. In this sense, the male equivalent of female circumcision is not circumcision but castration" (440). Nan Burke (1994) has expressed a similar perspective: "the comparison to male circumcision is not apt and belittles the seriousness of the debate. Unlike male circumcision, female

circumcision is mutilation. The organ is destroyed and, along with it, any pleasure the woman may experience during intercourse" (440).

Although both of these statements appear in a leading British healthcare ethics journal, it is interesting to note that no citations were given for any of the assertions made. Indeed, the authors may have thought that no citations were necessary: perhaps they believed that they were simply stating the obvious. However, recent research suggests that "the obvious" may not be quite as obvious as has typically been presumed.

First, it is not the case that female circumcision necessarily involves removal of the clitoris. Indeed, it is not the case that *any* form of female circumcision removes the clitoris, because most of the clitoris is underneath the skin. Anatomical studies show that the clitoris is a "multiplanar" organ (O'Connell, Sanjeevan, and Hutson 2005) whose visible portion varies considerably in size between individuals (roughly 1–3 centimeters in the flaccid state), with the preponderance of its true length, including the majority of its erectile tissue, being subcutaneous (Puppo 2013). There is disagreement about whether internal clitoral structures can be stimulated through the vagina—thereby allowing for a "vaginal orgasm" in some women without recourse to external tissue (Fenner 2013; see also Ahmadu and Shweder 2009; Paterson, Davis, and Binik 2012)—but it appears likely that at least some of these structures can be activated even if the "outside" part of the clitoris has been resected, by applying pressure to the tissue that remains.

As Lucrezia Catania and her colleagues report, "[even in] infibulated women, some fundamental structures for the orgasm have not been excised." Many infibulated women, therefore, "achieve orgasm by stimulating the vagina and consider the clitoris as something extra" (2007, 1673). However, Catania et al. note that the term "clitoris" in this context refers only to the visible, external part of the clitoris, which they describe as the "tip of the iceberg" of the entire structure. Putting these observations together, Shweder (2013) remarks that: "a massive amount of . . . tissue and . . . nerve endings enabling the experience of sexual pleasure and the capacity for orgasm reside beneath the surface of the vulva [and thus] beyond the scope of any customary African circumcision procedure" (361; see also Johnsdotter and Essén 2010; Lyons 2007).

None of this is to deny that the excision of sensitive genital tissue, damage to or elimination of nerve endings, and the formation of scar tissue—all of which occur in most forms of both female and male circumcision, as well as

most forms of intersex genital "normalization" surgery—can *increase the risk* of adverse sexual outcomes (for evidence concerning the female case, see, e.g., Berg and Denison 2012; Paterson, Davis, and Binik 2012). For one thing, as I have noted elsewhere, any sensation that would have been experienced "in" the excised tissue itself is inevitably precluded by these kinds of procedures (Earp 2016a, 2016b, 2016c); for another thing, any associated feelings of loss or resentment—which are far from uncommon in adults of all genders who were subjected to involuntary genital surgeries in early childhood—can interfere with one's sexual enjoyment quite apart from any "purely physical" effects that may or may not ensue from the act of cutting (Abdulcadir et al. 2010). But it is important to clarify that the almost universal Western assumption regarding female genital cutting in particular (at least its more invasive forms)—namely, that it eliminates the capacity for orgasm as a matter of anatomical necessity—is simply untrue.[13] To the contrary, it appears that many, if not most, circumcised women are capable of achieving orgasm, experiencing feelings of desire and arousal, and enjoying their sexual experiences overall (Catania et al. 2007; Okonofua et al. 2002; Paterson, Davis, and Binik 2012; see also Shweder 2013 for an overview and critical discussion). As Catania and her co-authors point out:

> Human sexuality depends on a complex interaction of cognitive processes, relational dynamics, and neurophysiological and biochemical mechanisms. It is influenced and modulated by many factors (biological, psychosexual, and social/contextual dependence) which act in [such] a way that one factor can improve or inhibit the other and vice versa. (2007, 1673)

In other words, the role of the clitoris in sexual function and satisfaction is not biochemically determined (although it is certainly biochemically influenced); instead, its role depends in large part upon "relational dynamics" and "psychosexual" factors, including how a woman feels about her own body in the context of her romantic partnerships and in light of the prevailing sexual and aesthetic norms of her community.

For example, many African women see the external clitoris as an undesirable "masculine" appendage, and prefer what they consider to be a "smoother" and "neater" look, unencumbered by any fleshy protrusions (Manderson 2004, 295; see also Ahmadu and Shweder 2009). This perspective is captured by the blunt remark of one Somali woman, who, after seeing surgically unmodified vulvae for the first time, stated:

"I thought, they've got a lot of cow pussy. That's what it looked like to me. That part of a Somali woman is covered and closed—it looks better" (quoted in Manderson 2004, 293). By removing parts of the vulva that "stick out," therefore, many of these women feel more beautiful, and more confident in their own bodies, which can have a positive effect, all else being equal, on their subjective sexual experience and satisfaction. In this respect, they are not altogether unlike their Anglo–American counterparts—increasingly teenage girls (see Braun 2010; BSPAG 2013)—who opt for so-called "cosmetic" surgeries to achieve largely similar effects. These surgeries, which I hasten to add are by no means unproblematic, go variously by the names of "clitoral reshaping," "clitoral unhooding," "labial trimming," "vaginal rejuvenation," "vaginal tightening," "hymen repair," and other labels for "designer vaginas" (Green 2005; Liao, Taghinejadi, and Creighton 2012; McColgan 2011; Rodriguez 2014). As Ronán Conroy noted in a 2006 editorial in the *BMJ*, the practice of nontherapeutic female genital alteration "is on the increase nowhere in the world except in our so-called developed societies" (Conroy 2006, 106).

An Aside About Consent and Double Standards

That many of these Anglo–American females are teenagers is important. This is because some people might think that the "African" customs involving genital cutting are done exclusively to young girls (who cannot provide their own informed consent), whereas the Western analogs are done exclusively to adult women (who have requested them for "cosmetic" reasons). But this is not accurate. In the first place, the large majority of "African" genital cutting rites (whether done to females or males) are performed around the time of puberty, and are in fact the very ritual by which adult status is conferred within the community. In other words, by the end of the ceremony, the initiate is in fact formally an adult—so the question of whether she or he was competent to "consent" to the operation is perhaps more complicated than these discussions typically allow. In the Western context, by contrast, while it is true that *most* nontherapeutic female (but not male) genital alterations are done to individuals over the age of 18, evidence suggests that increasing numbers of those who undergo such operations are aged 14 or even younger, having received permission for the surgery from their parents (Liao, Taghinejadi, and Creighton 2012).

In my own view—for which I argue elsewhere (Carmack, Notini, and Earp 2015; Earp 2012a, 2012b, 2013a, 2013b, 2014a, 2014b, 2014c,

2015a, 2015b, 2015c, 2015d, 2015e, 2016a, 2016b, 2016c; Earp and Darby 2015; Frisch and Earp 2016)—it is the case that *all* nontherapeutic genital alterations, whether of females, males, or intersex people, and regardless of their cultural background, should be performed (in Western societies) only under conditions of informed consent as given by the individual to be affected by the surgery. Here, however, I am merely pointing out that the issue of childhood versus adulthood as a proxy for the question of consent cannot be used as a bright-line means of distinguishing so-called Western forms of nontherapeutic female genital cutting from so-called African forms, in terms of actual contemporary practice.

Nor can supposed anatomical differences be used for this purpose. Consider the following admission from the British government during its deliberations over the "Prohibition of Female Circumcision Act" of 1985:

> The problem is that while the distinction between this legitimate surgery [i.e., Western female cosmetic genital surgery] and the traditional practice of female circumcision is quite clear in commonsense terms, there is no precise anatomical definition which would admit one and not the other. (quoted in Dustin 2010, 15)

Notwithstanding this definitional problem, the British medical lobby were apparently concerned[14] that the government not make illegal a number of quite popular and lucrative genital surgeries for British girls and women who—as Moira Dustin (2010) puts it—were "under the misapprehension that they had deformed genitalia" (15). The government's solution was as follows. First, they added a "mental health" exception for British girls, who, as judged by their cosmetic surgeons, might be deemed to have such "anxiety" about the shape or size of their external genitalia that it could lead to "mental illness" (14). Second, they simultaneously blocked the application of the mental illness clause to African immigrants who might be distressed about (not) fitting in with the aesthetic norms of their own communities:

> In determining for the purposes of this section whether an action is necessary for the mental health of a person, no account shall be taken of the effect on that person of any belief on the part of that or any other person that the operation is required as a matter of custom or ritual. (Quoted in Dustin 2010, 15; note that more recent 2003 legislation carries forward this distinction.)

In effect, the Act said that "if you are a British girl who believes her genitals are abnormal, it is permissible to have surgery to fit in with the ideals of

the majority society. However, if you are from a minority [community], your mental health is culturally determined—you have a group delusion rather than an individual one—and you do not have the same rights as members of the majority society to alter your body" (Dustin 2010, 16; see also McColgan 2011).[15]

African women have picked up on the double standard. As Nahid Toubia—a Sudanese surgeon and longtime campaigner against FGM—has cautioned: "The people of the countries where female genital mutilation is practised resent references to 'barbaric practices imposed on women by male-dominated primitive societies,' especially when they look at the Western world and see women undergoing their own feminization rites intended to increase sexual desirability: medically dangerous forms of cosmetic plastic surgery, for instance" (Toubia 1995, as quoted in Sheldon and Wilkinson 1998, 263–64). Indeed, as Isabel Gunning (1991) states, "How bizarre and barbaric must a practice like implanting polyurethane covered silicone into one's breasts [i.e., breast augmentation surgery] be perceived by one not accustomed to the practice" (213). As she goes on to suggest, Westerners need to take seriously the fact that their "articulations of concern over the contemporary practice of genital surgery in third world nations are often perceived as only thinly disguised expressions of racial and cultural superiority" (213)—calling to mind what Gayatri Spivak (1988) once famously referred to as "white [people] seeking to save brown women from brown men" (101).

Non-Clitoral Genital Cutting

Let us return to our discussion of the clitoris. One major lesson from this discussion has been that the "symbolic meanings" of the clitoris are different in different cultures. To many Western feminists, the clitoris symbolizes both the liberation and embodiment of female sexuality: such a view may have its origins in a particular discourse from the 1960s in England and America concerning whether or not sex was equivalent to penile penetration (see, e.g., Lyons 2007). To many African women, by contrast, the external clitoris has a different significance: it is a vestige of childhood androgyny—a "male" part whose removal is both feminizing and an affirmation of "matriarchal power" (Ahmadu and Shweder 2009, 14; see also Shell-Duncan and Hernlund 2000, 21). There are many other interpretations as well. Associations can be both conscious and unconscious; they can (and do) overlap and change over time; and there

is also significant variability in terms of how the clitoris is conceptualized by different women even "within" a certain group or society (Shell-Duncan and Hernlund 2000). The "meaning" of the clitoris, therefore, is not strictly determined by its anatomical properties; women's sexual experiences cannot be meaningfully reduced to a tally of nerve endings (Althof et al. 2005; Paterson, Davis, and Binik 2012).

Moreover, there are several kinds of female circumcision that do not involve modification of the clitoris at all. Just as with the kinds that do, however, these have been banned in many Western countries, as well as defined as "mutilations" by the WHO/UN. For example, there is cutting or removal of the clitoral hood, which is the skin that covers and protects the head of the clitoris (much as the foreskin covers and protects the head of the penis, see Cold and Taylor 1999). This is classified as FGM Type 1-a, and it is anatomically identical to the Western "cosmetic" practice of clitoral unhooding that I mentioned earlier. There is also cutting or removal of the labia minora, which are the inner "lips" that frame the vaginal opening. This is classified as FGM Type 2-a, and it is anatomically identical to the Western "cosmetic" practice of labial trimming that I mentioned earlier.

For FGM Type 3, which is the narrowing or stitching of the vaginal opening (infibulation), the WHO/UN note that this can be done with or without the excision of the external clitoris. According to the available empirical research on the question, it is frequently done without (see, e.g., Nour, Michels, and Bryant 2006). Although this is generally considered to be the most "extreme" type of FGM, even here there are some apparent Western parallels. For example, when a Western woman requests a "vaginal tightening" procedure, perhaps after giving birth, this is *not* generally considered to be a kind of FGM, even though it formally meets the definition of infibulation. Instead, the procedure is referred to as "vaginal rejuvenation" (see, e.g., Goodman 2009; see also Manderson 2004, 297). When an African immigrant, by contrast, asks to be re-infibulated after she has given birth—in order to "restore" her genitals to what she considers to be their "normal" state—in England and Australia, at least, she will be denied the procedure.[16]

Finally, FGM Type 4 is a catch-all category that refers to "all other harmful procedures to the female genitalia for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization" (WHO/UN 2008, 24). Note that none of these involve the removal of the external clitoris. Moreover, specific procedures like piercing—for example, of the

labia or the clitoral hood—are also common in some Western countries, but are considered in those contexts to be a form of cosmetic "enhancement" (see, e.g., Armstrong, Caliendo, and Roberts 2006; Miller and Edenholm 1999).

Abstract Definitions, or Reality?

It is sometimes argued that the WHO classification scheme is somewhat artificial. In other words, while it might describe interventions that are *anatomically possible*, not all such interventions are reflective of "actual" female circumcision as it is practiced "in the real world." For example, consider this email from a Norwegian medical anthropologist who worked on the WHO/UN policy on FGM (personal correspondence, June 5th, 2014):

> Type I, as you [point out], has a subtype of removal of [the] clitoral prepuce, however, this is an anatomical definition. That is, if somebody were to remove the foreskin of the clitoris, this would fall under Type I. However, there is no traditional form of FGM that remove[s] the prepuce only, as such a surgery would have to be carried out by a specialist surgeon under full sedation.

Note that my correspondent refers to "traditional" circumcision in this email, by which she apparently means circumcision that is not carried out by a "specialist surgeon under full sedation." However, as the WHO/UN themselves report, "in some countries, one-third or more of women had their daughter subjected to the practice by a trained health professional . . . Evidence also shows that the trend is increasing in a number of countries" (WHO/UN 2008, 12). While it is unclear how many of these cases involve the removal of at least some portion of the clitoral hood, there is ample evidence of interventions that are even less invasive than this being carried out in a hospital setting. For example, in parts of Indonesia, Malaysia, and in some other Muslim communities, the most common form of female circumcision involves "nicking the clitoris [or clitoral hood] with a sharp instrument to cause bleeding but no permanent alteration of the external genitalia" (Shell-Duncan and Hernlund 2000, 5). As A. Rashid and colleagues report, "a hospital based study in Malaysia has shown FGM to be a common practice among the Malays but with no clinical evidence of injury to the clitoris or the labia and no physical sign of excised tissue" (Rashid, Patil, and Valimalar 2010, no page numbers; referring to Isa,

Shuib and Othman 1999). However, the WHO/UN do not tolerate such procedures, nor do they welcome the trend toward "medicalization": according to the WHO/UN, "Trained health professionals who perform female genital mutilation are violating girls' and women's right to life, right to physical integrity, and right to health" (WHO/UN 2008, 12) regardless of the severity of the procedure (see also Askew et al. 2016).

Ritual "nicking" is increasingly common in immigrant communities as well. In 1996, for example, several women from the large Somali community in Seattle asked their doctors at Harborview Medical Center if they would agree to perform the procedure on their daughters—along with circumcision for their sons—as a replacement for the more invasive rite that was likely to be carried out "either on a return trip to Somalia or by Somali midwives in the United States" (Shell-Duncan and Hernlund 2000, 5). According to Doriane Coleman (1998), "the hospital initially declined the request, telling the women that in this country only boys are circumcised" (740). However, "the immigrants were . . . candid about their commitment to practice some version of the procedure despite" the U.S. law which prohibits all forms of FGM. For in their view, "the procedure [was] necessary, both as a cultural matter [and] as a religious matter because the oral teachings of their clerics require it" (741; see also Arora and Jacobs 2016).

The doctors eventually agreed to do the procedure, reasoning that a "symbolic nick" would be much less harmful to the girls than what they were likely to be exposed to otherwise. When news of the decision leaked out, however, the hospital was suddenly "besieged by outraged opponents of female circumcision" (quoted in Coleman 1998, 745) who sent "hate mail and death threats" to the doctors "for weeks" (748). Thus, "although the so-called Seattle compromise would have involved no removal of tissue and would have been performed under anesthesia on girls having given consent, the plan was blocked by intense lobbying from anti-FGM activists as well as by an outpouring of negative public opinion" (Shell-Duncan and Hernlund 2000, 6).

Once again, the African parents were perplexed. As Ylva Hernlund and Bettina Shell-Duncan (2007) report: "In a private conversation later with two of the Somali women, who labeled themselves not only as refugees but also as social service providers in another city, they talked at length about this politically charged situation. It had not occurred to these extremely bright, articulate, and politically astute women professionals that a simple

pinprick of the clitoris could be illegal under U.S. law, while their own sons legally underwent much more invasive procedures [i.e., routine male circumcision]" (17–18).[17]

Explaining the Different Perceptions

Given everything that has been said so far, how might we begin to explain the very different perceptions that Westerners seem to have when it comes to female genital "mutilation" (on the one hand) and (on the other hand) both female genital "cosmetic" surgeries and male forms of nontherapeutic genital alteration? One possibility, mentioned earlier, is that Westerners are simply more familiar with these latter kinds of surgeries, such that they don't seem quite so strange and barbaric (DeLaet 2009; Johnson 2010). As I have written elsewhere about the comparison between FGM and male circumcision, when Westerners speak of "FGM," they are apparently calling to mind primarily "the most severe forms of female genital cutting, done in the least sterile environments, with the most drastic consequences likeliest to follow." When people speak of "male circumcision," by contrast, they appear instead to be thinking of "the least severe forms of male genital cutting, done in the most sterile environments, with the least drastic consequences likeliest to follow." This then leads to the intuitive impression "that 'FGM' and 'male circumcision' are 'totally different' with the first being barbaric and crippling, and the latter being benign or even health-conferring" (Earp 2014a; see also Earp 2015a, 2015d). However, as Androus (2004) has pointed out, there is a fatal flaw in this "Western" way of thinking:

> This attitude that male circumcision is harmless [happens to be] consistent with Western cultural values and practices, while any such procedures performed on girls [are] totally alien to Western cultural values. [However] the fact of the matter is that what's done to some girls [in some cultures] is worse than what's done to some boys, and what's done to some boys [in some cultures] is worse than what's done to some girls. By collapsing all of the many different types of procedures performed into a single set for each sex, categories are created that do not accurately describe any situation that actually occurs anywhere in the world. (3)

Moreover, as Toubia (1999)—the Sudanese surgeon and women's health advocate—has pointed out, there is a significant power differential to consider as well:

> A major difference between male and female circumcision is that the female procedure is primarily carried out in Africa, which is currently the least dominant culture in the world. The male procedure is also common in the same countries, but it is also common in the United States, which is currently the most dominant culture in the world through its far-reaching media machine. This historical situation has made it easier to vilify and condemn what is common in Africa and sanctify what is popular in America. (5)

We can now bring our analysis back to the policy of the WHO/UN on FGM as presented earlier. As critics have pointed out, while the WHO, UN, and other such organizations are nominally global in their scope and constitution—as opposed to being explicitly Western—there is also a significant asymmetry in terms of the actual "bargaining power" between the Western and non-Western nations. To use a different terminology, a great deal *more* power is held by the so-called "rich nations of the [global] North" (including the United States)—where FGM is not customarily performed—and a great deal less power is held by the so-called "poor nations of the [global] South," where, in many communities, it is performed, and is deeply embedded in the local context (Shweder 2005, 185). Thus, this argument runs, the "consensus" statements of such "global" authorities may not reflect a genuine consensus, but rather the particular norms and values, or even idiosyncratic cultural traditions that happen to be comparatively popular in the more powerful nations. As Shweder (2005) has suggested: "[the] rules of the cultural correctness game have been 'fixed' [by] First World" institutions (185).

A similar perspective has been advanced by Abdullahi Ahmed An-Na'im (1995; quoted in Harris-Short 2003): "Western hegemony . . . profoundly influences ruling elites, as well as scholars and activists in the South or the Third World," he writes, such that "it is misleading to assume genuine representation of popular perceptions and attitudes toward human rights in our countries from the formal participation of 'our delegates' [in] international fora" (133).

RETURNING TO THE WHO/UN POSITION

It should be clear by now that I am sympathetic with this view. Indeed, I do not think that the WHO/UN position reflects truly universal values (for a general discussion, see Mutua 2004); and to the extent that the values it does reflect happen to have been formulated in terms of universal moral principles, I do not think that such principles are being consistently applied.

The WHO/UN position, recall, is that *all* forms of FGM are morally impermissible. This is deemed to be the case regardless of the type or extent of the intervention, regardless of the cultural or even clinical context, and notwithstanding anyone's beliefs to the contrary. As the WHO/UN (2008) state explicitly: "Female genital mutilation of any type has been recognized as a harmful practice and a violation of the human rights of girls and women" (8). This is a strong position. How do the WHO/UN defend it? There seem to be three main strands to their argument:

(i) The *harm* strand. This strand suggests that FGM is harmful to health, harmful to sexuality, and harmful to overall well-being.

(ii) The *discrimination* strand. This strand suggests that—even if the harms of FGM could somehow be minimized—it would still constitute "an extreme form of discrimination against women" (1) because it is a "manifestation of gender inequality" (15).

(iii) The *rights* strand. This strand suggests that FGM is a violation of "fundamental human rights." For example, it is a violation of the "right to . . . physical integrity" (1). Moreover, since it "is nearly always carried out on minors" who cannot provide consent, it is also "a violation of the rights of the child" (1).

Obviously, these strands are not entirely distinct. For example, the *discrimination* strand overlaps with the *rights* strand since the WHO/UN argue that FGM violates the human rights principle of "non-discrimination on the basis of sex" (2008, 9). The *harm* strand might overlap with the *rights* strand as well: as Shweder (2005) notes, "If [FGM] is a harmful practice and you are prepared to defend the idea that there are natural, objective, or inalienable rights . . . then it is but a small step to include the right to be free from physical and psychological harm as a basic human right" (186). And finally, the *discrimination* strand and the *harm* strand could be seen as overlapping as well: surely, being discriminated against on the basis of one's sex could be psychologically harmful, at least, and, depending upon the particular manifestation of the discrimination, perhaps harmful to health, etc., as well.

Harm

Let us start by looking at the *harm* strand. According to the WHO/UN (2008):

> Female genital mutilation has no known health benefits. On the contrary, it is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic. The removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences. (1)

I contend that this *harm* argument—certainly on its own—is far from sufficient to establish that all forms of FGM are impermissible regardless of the cultural context; and I suggest, moreover, that the WHO/UN are applying this argument in an inconsistent manner. I will take the above sub-claims out of order, and analyze them one by one.

First—it is not the case that *all* forms of FGM are "painful and traumatic," at least not in a way that is particularly morally meaningful. Minor forms of FGM (such as "pricking") that are carried out with anesthesia—as is increasingly being done in a range of contexts (see above)—are no more painful than any number of experiences that a child or adult is likely to experience in the course of daily living (although such "pricking" may of course be psychologically disturbing, depending upon how it is carried out, at what age, whether there is cooperation from the individual, what her attitudes are toward the procedure, and so on). On the other hand, some forms of FGM are *extremely* painful, and seem to be experienced as profoundly traumatic on any recognizable conception of that term. I am inclined to think that at least some such forms may be impermissible regardless of the cultural context—particularly if they are carried out on children, for reasons I will soon explain.

But I also recognize that the experience of even extreme pain is not necessarily interpreted in the same way in every culture (or by every individual). Sometimes pain can have instrumental value; for example, in some groups, such as the Rendille of Kenya, "women reject the idea of using anesthesia when being excised and instead emphasize the importance of being able to withstand the pain of being cut as preparation for enduring the pain of childbirth and as demonstrating maturity" (Shell-Duncan and Hernlund 2000, 16). As Lyons (2007) notes, "The opportunity to gain social status by a demonstration of courage and endurance in the face of physical suffering has been cited by many writers [as] an important part

of the positive value associated with female and male initiation rituals, cross-culturally" (6). At the same time, however, in Europe and North America, there appears to be a pervasive assumption that only boys and men should have to tolerate painful experiences as a way of showing courage, "particularly in connection with warfare and sports" (6). This may be part of the reason, Lyons suggests, that painful rituals undergone by males, compared to females, provoke less of a reaction of repugnance in most Westerners. Consistent with this view, as Shell-Duncan and Hernlund (2000) note, "there appears to exist in the West a tolerance of, and perhaps appreciation for, the assumption that masculine ideals are honed through painful initiations that respond to group needs" (16).

Similar to the Rendille women of Kenya, adolescent males in some groups who undergo painful initiation rites look down on anesthesia as well. As the account by Nelson Mandela I quoted from earlier illustrates, boys may be expected to "suffer in silence" as their foreskins are cut off, despite the agonizing pain that is involved. Indeed, these rites are, among other things, designed to be tests of masculinity: the pain is part of the point (see, e.g., James 2005). Now, whether such painful rites or rituals can possibly be justified on moral grounds, or under what conditions, is a complicated question, but the question in this case does not arise. This is because it is clear that the WHO/UN do not regard the experience of extreme pain and/or trauma as being sufficient to justify a *universal* prohibition on genital cutting, since they have taken no position on male circumcision, including its most excruciating forms.

A similar analysis applies to the claim that "the removal of or damage to healthy, normal genital tissue interferes with the natural functioning of the body and causes several immediate and long-term health consequences." Some forms of FGM do not remove healthy, normal genital tissue (for example, pricking or piercing); and if they are performed in a superficial enough manner, it is not clear in what sense they could be said to be "damaging" to the genitals either. Nevertheless, even these "minor" forms of FGM are seen as impermissible by the WHO/UN, including in medicalized cases where both immediate and long-term (adverse) health consequences would be comparatively unlikely to ensue. By contrast, even the most minor—and widespread—forms of male circumcision typically entail the removal of the adult equivalent of up to 100 square centimeters of "healthy, normal genital tissue," with mean reported values for foreskin surface area ranging from about 30 to 50 square centimeters (see Kigozi et al. 2009; Werker, Terng, and Kon 1998). To remove such a large quantity

of "healthy, normal genital tissue" necessarily "interferes with the natural functioning of the body." For example, it interferes with (eliminates) the protective functions of the foreskin (exposing the head of the penis to irritants from the environment, such as urine and feces in the diapers of the youngest of boys, and to rubbing against clothing thereafter; see, e.g., Still 1972); it also interferes with (eliminates) all sexual functions and related erotic activities that involve manipulation of the foreskin itself (see Ball 2006; Earp 2015c, 2016a, 2016b, 2016c; Frisch and Earp 2016; see also Harrison 2002 re: "docking").

Likewise, female genital "cosmetic" surgeries that are popular in Western countries—such as labiaplasty or clitoral reshaping—certainly "remove healthy and normal genital tissue," and also carry a nontrivial risk of "immediate and long-term health consequences" (BSPAG 2013). Nevertheless, the WHO/UN have not taken a position on either of these latter surgeries, suggesting that it is not the mere interference with "healthy, normal genital tissue," nor the presence of some degree of risk of adverse health consequences that they see as being *sufficient* to justify a universal prohibition on FGM.

The claim that "female genital mutilation has no known health benefits" is very interesting. First, this claim was evidently inserted as a point of specific contrast with male circumcision, which is mentioned at least once in WHO/UN (2008) statement, as follows:

> In contrast to female genital mutilation, male circumcision has significant health benefits that outweigh the very low risk of complications when performed by adequately-equipped and well-trained providers in hygienic settings. Circumcision has been shown to lower men's risk for HIV acquisition by about 60% . . . and is now recognized as an additional intervention to reduce infection in men in settings where there is a high prevalence of HIV. (11)

Several points are worth mentioning here. First, the WHO/UN in this passage are very careful to qualify *just what kind* of male circumcision they have in mind—which is the specific kind that happens to be popular in the United States, and, if not popular in other Western countries, at least familiar: namely, "medicalized" male circumcision such as might be carried out in a clinic or a hospital (see, e.g., Carpenter 2010; see also Bell 2015; however note that the U.S. version of the surgery is typically carried out on infants, for which there is currently no controlled evidence of a protective effect against subsequent acquisition of HIV, whereas the

data concerning HIV protection in Africa were derived from circumcisions performed on adult volunteers; for further discussion, see Bossio, Pukall, and Steele 2014). This is in contrast to (a) the WHO/UN's comparative silence on male circumcision as it is performed in so-called "traditional" settings in Africa and elsewhere, where it is done, as I have suggested, under similar conditions to FGM, in the same communities, and for similar reasons—often with comparable or even much more severe adverse health consequences (as illustrated by the example of the Xhosa of South Africa between 2008 and 2014), and (b) the WHO/UN's systematic conflation of the most extreme types of FGM with the comparatively minor, medicalized, and anaesthetized versions of the procedure that are common in many places around the world.

Thus, when the WHO/UN refer to FGM, they choose to describe only negative effects that have been associated with the most extreme and unhygienic forms of female genital cutting—and then they present these as being typical of all forms of female genital cutting. When they refer to "male circumcision," by contrast, they choose to describe only positive effects that have been associated with the most minor and hygienic forms of male genital cutting—and then they present these as being typical of all forms of male genital cutting.[18] This is consistent with the view I presented earlier concerning the very different "prototypes" that many people seem to have in mind when they think about male vs. female forms of genital cutting.

There is much more that could be said about the "health benefits" claim regarding male circumcision, and about the claimed lack of such benefits in the case of female genital cutting, but there is not adequate room to address these matters here. Suffice it to say that it is far from clear that nontherapeutic genital cutting can be categorically distinguished on the basis of sex by an appeal to health benefits. For a brief introduction, see this endnote.[19]

Discrimination

Now let us turn to the question of *discrimination*. As the WHO/UN (2008) state:

> In every society in which it is practised, female genital mutilation is a manifestation of gender inequality that is deeply entrenched in social, economic and political structures. Like the now-abandoned foot-binding in China and the practice of dowry and child marriage, female genital mutilation represents society's control over women. Such practices have the

> effect of perpetuating normative gender roles that are unequal and harm women. (5)

On what basis do the WHO/UN advance this thesis? Certainly, it cannot be deduced from the work of the anthropologists they cite in their references section, several of whom have gone to great lengths in recent years to challenge the very perspective that is summarized in the quote above. For example, they cite a well-known paper by Fuambai Ahmadu (2000), the Sierra Leonean–American anthropologist I referred to earlier, who chose to be circumcised as an adult through the Bondo women's secret society of her native Kono ethnic group. As she writes:

> I [share] with feminist scholars and activists campaigning against the practice a concern for women's physical, psychological, and sexual well-being, as well as for the implications of these traditional rituals for women's status and power in society. Coming from an ethnic group in which female (and male) initiation and "circumcision" are institutionalized . . . and having myself undergone this traditional process of becoming a "woman," I find it increasingly hard to reconcile my own experiences with prevailing global discourses on female "circumcision." (283)

For example, contrary to the view that female genital-altering rituals necessarily represent "society's control over women" (and what does that mean?)—or that they are always associated with "unequal gender roles," Ahmadu (2000) argues that:

> Among the Kono there is no cultural obsession with feminine chastity, virginity, or women's sexual fidelity, perhaps because the role of the biological father is considered marginal and peripheral to the central "matricentric unit." . . . Kono culture promulgates a dual-sex ideology, which is manifested in political and social organizations, sexual division of labor, and notably, the presence of powerful female and male secret societies. The existence and power of Bundu, the women's secret sodality, suggest positive links between excision, women's religious ideology, their power in domestic relations, and their high profile in the "public arena." (285)

There are of course "normative gender roles" among the Kono in Sierra Leone. But then, there are normative gender roles in every society, including in Western countries. What Ahmadu seems to be arguing is, first, that the role/status associated with being a woman in Kono society is not necessarily "lower" than the role/status associated with being a man, and, second, that Kono genital-altering rites are not "unequal" in a way that is necessarily harmful to women. Instead, since both girls and boys

are initiated into Kono secret societies, the rites are at least superficially egalitarian; and, at least as concerns the female version, to Ahmadu they are also empowering.

The WHO/UN also cite the work of Lori Leonard. Leonard has done groundbreaking work with the Sara ethnic group in Chad, where she noticed a "disjoint" between the portrayals of female genital cutting in the mainstream Western literature and the "stories told in Sara villages" (2000, 170–71). This disjoint "highlighted the narrow spectrum covered by existing interpretations, as well as the dearth of alternative stories of female genital cutting currently circulating" in the Western discourse (*ibid.*). For example, among the Sara,

> Village residents uniformly report that the impetus for the adoption of female genital cutting has come from adolescent girls, who organize the ceremonies, obtain the resources required to participate . . . and find and "hire" the excisor. Village authorities, traditional leaders, and parents are not involved in the planning or execution of female genital cutting ceremonies, and with few exceptions, are vocal in their opposition to the practice. [The] supreme religious and spiritual leader [of the community] has forbidden girls to get cut, has levied fines against those who do it, and has refused to attend the dances that are part of the girls' coming-out ceremonies. . . . Mothers, none of whom have been cut, are not allowed to participate in the ceremonies, and in general, they neither understand nor support the decisions of their daughters. (174)

For their part, the daughters "describe their participation as entirely voluntary." When asked why they chose to participate, "girls underscored their sense of agency, saying 'it was my will,' and [that] the cutting ceremonies were 'something that interested me'" (175).

It is unclear how the situation described by Leonard could reasonably be interpreted as an example of "society controlling women" based on "unequal" and "harmful" gender roles. Indeed, on the basis of her experience with the Sara, Leonard explicitly recommends against the "application of grand narratives or over-arching theories" (185) in trying to explain the great diversity of female genital-altering rituals that exist in different societies. She suggests, rather, that such rituals need to be understood on the basis of immersion in the local context—not based on an "advocacy" agenda whose very premise is to eliminate such rites. Yet this is precisely the agenda and the premise that have been adopted by the WHO/UN.[20]

Rights

Finally, let us turn to the question of *rights*. Here, I think that the WHO/UN are on the strongest footing for suggesting that all forms of FGM are impermissible. For, if there is such a thing as a "right to physical integrity," then even the most minor, sterilized, anesthetized "prick" might be considered to violate such a right.

However, it is a bit more complicated than that. Consider the case of an adult African woman such as Fuambai Ahmadu. Ahmadu was educated in the West—with a PhD from the London School of Economics—and also felt deeply connected to her Kono ethnic heritage. When she was 21, she traveled to Sierra Leone, and—by all appearances—*chose* to undergo female circumcision (or "mutilation" in the language of the WHO/UN). The WHO/UN (2008) however, do not distinguish between adult women and minor girls in their analysis. Instead, FGM refers to "*all* procedures involving partial or total removal of the external female genitalia . . . for non-medical reasons" (1).

How might one explain this position? If one considers, first, the theory of the WHO/UN (2008) that FGM *of any type* is harmful, and, second, if one considers their assumption that FGM is *always* linked to "control over women" (5), then perhaps the idea is that even adult women cannot provide genuine consent when it comes to making certain decisions about their own genitals. I find this assumption to be extremely implausible, but let us just assume it is true. If it is true, then the WHO/UN would need to explain why they have not launched any campaigns to "eliminate" so-called female genital cosmetic surgeries—technically FGM according to the WHO/UN definitions—as they are practiced in Western societies. In fact, if one looks to the Appendix of the WHO/UN (2008) report, and turns to a small sub-section entitled, "Further Considerations," one finds an interesting clue:

> Some practices, such as genital cosmetic surgery and hymen repair, which are legally accepted in many countries and not generally considered to constitute female genital mutilation, actually fall under the definition[s] used here. It has been considered important, however, to maintain a broad definition of female genital mutilation in order to avoid loopholes that might allow the practice to continue. (28)

By "the practice," the WHO/UN evidently mean, "the practice as it is performed in non-Western countries." One is reminded of the dilemma

faced by the British government in 1985: how can one craft language that allows for genital-altering surgeries that are popular among Western women (for "enhancement" reasons), but that simultaneously disallows genital-altering surgeries that are popular among African women (for "cultural" reasons)? How can one do so, moreover, despite the fact that there is no anatomically objective line that can be drawn between them, nor very likely a principled way to distinguish one woman's "enhancement" from another one's "culture"? The WHO/UN strategy, apparently, has been to adopt a "broad" definition that does not permit any "loopholes" through which an "African" practice might slip through, while simply declining to enforce their own definitions in Western countries (except in the case of African and/or Muslim immigrants in such countries, in which case the definitions are treated as valid; see Dustin 2010).

Children

What about when it comes to children? Do children have a "right" to "physical integrity" that is necessarily violated by *all* forms of genital alteration that are performed for nontherapeutic reasons? If so, then we could confidently conclude that—at least before an age of adulthood or consent—*all* forms of FGM really are impermissible, including (possibly) even across cultures. Of course, all forms of nontherapeutic male and intersex genital cutting would also have to be deemed to be impermissible (before an age of consent) on these grounds, because all such interventions also involve the "violation" of a child's "physical integrity." Indeed, as noted earlier, I am sympathetic with this view, and I have argued that medically unnecessary alteration of children's genitals should be discouraged, regardless of the sex or gender of the child, at least in the context of the societies with whose legal, moral, and cultural environments I am most familiar (i.e., England, the United States, and similar). In other words, since even the most minor forms of FGM—such as a "prick" to the clitoral hood—are impermissible according to the WHO/UN, and since, on the WHO/UN's own theory of fundamental human rights, discrimination on the basis of sex is impermissible, it would not be morally defensible to adopt a sexist double standard in the analysis of children's "basic rights" with respect to preservation of their physical integrity.

However, there is a prior question here. Namely: *do* children, in fact, have a right to physical integrity that could reasonably be construed as

being violated by even the most minimal forms of FGM as defined by the WHO/UN?

Let us dispose of a potential red herring. It cannot be the case that the WHO/UN regard a child's physical integrity as being absolutely inviolable. We know this because the WHO/UN make an exception, in their definition of FGM, for so-called "medical reasons." On this view, if there is a valid *medical reason* to "partially or totally remove the external female genitalia" or to cause "injury to the female genital organs," then such an intervention would not count as a form of mutilation—i.e., something that is bad by definition—but could rather be considered permissible. Thus, according to the WHO/UN, it may at least sometimes be permissible (or even desirable) to "violate a child's physical integrity," namely, if there is a "medical reason" for doing so.

As Shweder (2013) has written, "One hesitates to engage in a full blown semantic analysis of the meaning of the word 'medical' . . . [but] narrowly speaking, medical means doing things to the body aimed at preventing, alleviating or curing a disease or functional disability" (35). The problem is, what is a "disease"? And what is a "functional disability"? It is well known that there is no particular consensus about the meaning or referents of these words, even within so-called Western medicine (see generally, Rosenberg and Golden 1992)—so it is unlikely that there could be a universal consensus about their meanings that would apply to every culture.

But let us try to illustrate this idea—about "disease"—using a Western example (though one that is by no means exclusive to the West) that should be fairly intuitive in this discourse. Let us say that a child has gangrene on her leg due to a bacterial infection. The leg is beginning to rot; the infection is spreading up her limb. Most people—and on this occasion, although I am not an anthropologist, I think it would be fair to say "most people, *in every culture*"—would say that it is permissible to infringe upon the child's physical integrity in order to saw off the infected limb, before the infection spread to other parts of the body. I assume that the reason such a violation is seen as being permissible is because it is presumed to be in the best interests of the child, where "best interests" is taken to mean, "most conducive to the child's overall well-being, all things considered."[21]

Since in this case, it would not be possible to delay the intervention until the child reached an age of consent (and could therefore give permission for her physical integrity to be "violated" on the basis of her own judgment

about what would best promote her well-being) without actually sacrificing the very thing about the intervention that would make it in her best interests in the first place, it is clear that performing the intervention prior to the possibility of obtaining the child's consent is permissible.

If that much is right, then it seems to me that the ultimate moral goal in this case is not so much to "treat disease" with "medicine" (*per se*), but rather to *promote the child's overall well-being, all things considered*. If so, then it would not be the case that something's being "medicine" (or not) is morally decisive in and of itself, but rather its being instrumental in some way to promoting the—overriding—goal of advancing the child's best interests. If something *is* instrumental in this way, then I propose that it should be called an *enhancement*.

Enhancement

In this section, I am going to argue that it should be considered permissible, all else being equal,[22] for parents to "enhance" their children in the sense I have just described. Just to be clear, and to put it another way, what I mean by the word "enhance" is: "make decisions that are instrumental to the promotion of their child's overall well-being, all things considered" (for further discussion of this argument, and to see how it fits in with the wider "enhancement" debate in biomedical ethics, please see Earp et al. 2014, and Maslen et al. 2014).

A couple of observations can now be made. First, I assume that this is a principle that really every culture would endorse. That is, I assume that most well-informed, rational people around the world, regardless of their particular cultural background, would agree that parents should be able to "enhance" their children in the sense I have defined. If this principle is ultimately seen as being valid, therefore, it would not be subject to charges of cultural imperialism, and that seems to be a quality worth striving for.

Second, I think that such a principle is better at capturing commonsense moral intuitions—at least compared to the WHO/UN's "medical reasons" principle—concerning when it might be permissible to "violate the physical integrity" of a child. Consider the use of orthodontics to straighten a young person's teeth—for "cosmetic" reasons, let us say, rather than strictly "medical" ones (i.e., reasons aimed at maintaining or restoring some straightforward function, such as the ability to effectively chew food). While braces do not actually remove any tissue from the child's body (and while that is a relevant moral consideration, as we shall see), they do certainly *alter* the child's body, and as some might argue, in a somewhat

serious and invasive way. Moreover, braces are painful; they carry certain risks (of, e.g., infection); their effects are, for all intents and purposes, irreversible; and they are put on, in most cases in Western societies, before an age of legal majority.[23] Yet if it is only permissible to "violate a child's physical integrity" for "medical reasons"—as I have suggested is implied by the position of the WHO/UN—then we would have to conclude that cosmetic orthodontics are not permissible for children, even though (I take it) most people would be inclined to say that they are.

It seems, therefore, that the WHO/UN's moral principle that I suggested had the most promise for being able to justify the assertion that *all* forms of FGM are impermissible (namely, that it is not permissible to "violate the physical integrity" of a child except for "medical reasons") actually does not stand up to scrutiny. For, when such a principle is applied to a common Western practice that, as I see it, is clearly permissible, it seems to yield the conclusion that such a practice is not permissible, which undermines the credibility of the theory.

Let us now try the principle I have suggested instead. I claim that it is permissible (all else being equal) for parents to "enhance" their child(ren), in the sense of making decisions that are in the child's best interests—*whether or not* the means of doing so happens to be in the medical domain. According to this analysis, it seems that cosmetic orthodontics actually would be properly considered to be morally permissible for children (in most cases), notwithstanding the fact that they would infringe upon the child's physical integrity for plainly "nonmedical" reasons. Such permissibility is especially likely to hold if the child actively desires or requests the orthodontics (or can at least participate in the decision-making process), as opposed to a situation in which the orthodontics had to be forced upon an unwilling child despite sustained and well-considered resistance (see **Maslen** et al. 2014 for a related argument about "hyper parenting").

This analsis rests on a number of partially interrelated factors: (i) the widely-appreciated aesthetic improvement that comparatively straight teeth are generally taken to represent; (ii) the associated social and psychological advantages that typically go along with such perceived improvement; (iii) the relative stability across time and space of the underlying perceptual biases which give rise to the aesthetic preferences that confer such social advantages; (iv) the fact that these perceptual biases, aesthetic preferences, and associated norms do not appear to be, themselves, unjust (e.g., they are not racist or sexist); (v) the very low risk of both "medical" and

"nonmedical" disadvantages associated with orthodontics (i.e., "trade-offs" that might count against the intervention); and consequently (vi) the lack of any indication that there is more than a handful of adults who feel seriously harmed in virtue of having had braces when they were younger (see Earp 2015a, 2015c). This last point is one to which we will return.

So what is the more general issue? To my mind, the key question here is the following: *How can we know whether a proposed enhancement is in fact in the child's best interests (and thus a true, rather than merely intended, enhancement)—and who should be able to decide* (see, e.g., Parens 2014, 147–48)? Clearly, some enhancements are more controversial than others. Sending one's child to school, for example, is obviously an enhancement as I have defined it (even though some children would rather stay at home and play); as is "forcing" one's child to brush her teeth, eat her vegetables, and so on, among many other examples that could be imagined. By contrast, removing part(s) of a child's genitals (whether the child happens to be female, intersex, or male) for so-called cultural reasons, or even for intended prophylaxis, is not quite so obviously in the child's best interests, considered from an impartial perspective. Indeed, even in cultures (or sub-cultures) in which the retention of intact genitalia is for the most part socially stigmatized, such tissue-removal is nevertheless the source of frequent controversy and disagreement (Glick 2005; Goldman 1998; Gollaher 2000).

One reason why it is controversial is that, in a mundane sense, it involves a physical trade-off or loss: healthy, functional tissue is (at minimum) damaged, and (more typically) permanently excised, depending upon the type of male or female circumcision. Whether this loss is "worth" the purported gains in socio–cultural, religious, spiritual, or even prophylactic benefits that supporters of male and female circumcision typically attribute to them will depend upon numerous factors: how much value one places on having intact genitals, how closely one identifies with the culture or sub-culture in which one has been raised, and so on. In cases such as this, that is, cases in which a proposed enhancement involves certain physical or functional trade-offs—and especially when the overall value of such trade-offs rests upon subjective norms and preferences that are highly variable between cultures and individuals—it seems fair to suggest that the intervention should ideally be delayed until such a time as the individual who will be affected by it has the opportunity to make an informed decision. As my colleagues and I have recently argued:

> Whilst adults are in a position to decide whether effect X is valuable enough (to them) to justify incurring impairment Y, children do not yet have the capacity or the life experience to make such trade-off decisions. They do not know what they will value when they grow up and nor do their parents. Whilst an intervention that improves X may count as an enhancement for the individual who does not care much about Y, another individual, valuing Y over X, will view the very same outcome as an impairment. In such cases—that is, cases in which the very status of an intervention's being an (overall) enhancement vs. an impairment is controversial—the weight of considerations should shift toward delaying the intervention until the individual who will actually be affected by it has sufficient capacity to decide. The more permanent and substantial the trade-off, the more this argument has force. (Maslen et al. 2014, 4)

Applying the Argument to Genital Cutting

What does this argument suggest about the permissibility of FGM? The answer to this question, it seems, must depend upon several factors. Is it *conceivable* that at least some forms of "nonmedical" genital modification performed on a female child or adolescent might turn out to be, in some society, in the overall best interests of the child—and that this would be uncontroversial enough, in that context, to fall under the purview of reasonable parental decision making? As I have been learning from the work of anthropologists such as Shweder, Ahmadu, and Leonard, societies are very diverse, and the world is a complex place. Some societies might be organized in ways that, without having been immersed in them myself, I might not be in a position properly to evaluate. So it occurs to me that, in some contexts, at least *some* forms of alteration to the female genitalia (before an age of formal adulthood or ability-to-provide consent, as those thresholds are reasonably understood in the relevant context, and without some kind of urgent medical need) *might* be in the child's best interests, and that this *might* fall within the purview of appropriate parental judgment.

But several crucial variables are involved here. For instance, the more tissue that is removed of a certain kind—specifically, tissue with properties that are regarded as being valuable by a significant proportion of those who are familiar with the tissue (for example, in virtue of retaining this tissue on their own bodies)—the less likely it is that the intervention could be considered to be in a girl's overall best interests. To illustrate, removing the entire external clitoris, compared to removing a small amount of tissue from the labia majora, seems much more likely to be the sort of thing that

a girl might later, upon gaining a different perspective (perhaps by moving to a different society with different norms about genital aesthetics) turn out very seriously to resent. Similarly, the more hygienic the circumstances of the operation, the more likely it could be considered to be in the girl's best interests, and the less hygienic, the less. Finally, the more it is the case that the intervention's very status as being an enhancement (as opposed to a diminishment, or even a mutilation) is contested or controversial in some society, then the more it would be better to let the girl make a decision about it herself, at a later age, when she could take into consideration the fullness of her circumstances.

Importantly, on this last point, female, male, and intersex genital cutting practices are becoming more contentious in more societies over time (Dreger 2006; Gollaher 2000; Hernlund and Shell-Duncan 2007; Svoboda 2013, 2015). Partly, this is due to the flow of information (and people) through media, migration, and so on: individuals are less and less likely to live in perfectly isolated communities, where the norms that govern whether some intervention is widely seen as being an enhancement in some context can be comparatively easily controlled (see Earp 2013b; see also Hernlund and Shell-Duncan 2007). Referring to a community of Somali immigrants in Sweden, for example, Sara Johnsdotter and Birgitta Essén (2016) argue:

> migration gives rise to cultural reflection: All the motives for [female] circumcision in Somalia are turned [inside] out in exiled life in Sweden. What was once largely seen as "normal" and "natural" about . . . cut and sewn genitalia was questioned in Sweden, when the women were met with shocked reactions among healthcare providers in maternal care and delivery rooms. A thitherto strong conviction that circumcision of girls was required by religion was questioned when Somalis met Arab Muslims, who do not circumcise their daughters . . . . The fear that their daughters would be rejected at marriage if uncircumcised disappeared in the light of the immense Somali diaspora in the West, where Somali men can be expected to accept and even appreciate uncircumcised wives. In addition, the risk of stigmatization and ostracism disappeared when living in an environment where most girls are not circumcised. (4)

Cultural change can happen in many ways, of course, and not always through the mechanism of migration. Consider the case of infant male circumcision in the United States (and to a lesser degree, Canada): this is certainly a popular, if waning, birth custom in North American culture, and many parents believe that they are *enhancing* their child's genitals by

authorizing the removal of his foreskin in the first few days after he is born. They may believe that a circumcised penis is more aesthetically appealing, for example, or that circumcision is necessary for proper hygiene (Rediger and Muller 2013). Or they may think of the foreskin as a "useless flap of skin" (Rabin 2009) that is prone to infection or other medical problems. In light of these common assumptions, they may even believe that having surgically modified genitalia is the "default" status for boys and men throughout the West.

But now there is the Internet.[24] Many American men, without having to travel to other societies in order to gain a different perspective, are learning that the U.S.'s habit of circumcision sets it apart from most of its peer nations in the rest of the industrialized world (Morris et al. 2016; Wallerstein 1985). They are finding out that European and Australasian doctors, for instance, are for the most part unimpressed by the claims of American doctors that circumcision has "health benefits" that "outweigh the risks" (Forbes 2015; Frisch et al. 2013; Kupferschmid et al. 2015; see also Earp and Darby 2015; Freedman 2016; Frisch and Earp 2016). They are learning about the dubious establishment of male circumcision as a "medicalized" procedure in the late 1800s (Aggleton 2007; Gollaher 2000), and are questioning how it came to be settled as a cultural norm. They are finding out about the anatomy, innervation, and functions of the foreskin, and about the ways in which these aspects may contribute positively to sexual experience (see Ball 2006; Bossio, Pukall, and Bartley 2015; Cold and Taylor 1999; Earp 2016b; Earp and Darby 2015). They are learning that the foreskin may be the most touch-sensitive part of the penis (Bossio, Pukall, and Steele 2016; Earp 2016a; Sorrells et al. 2007), and that only 1/2 of 1 percent of boys will ever need a circumcision for therapeutic reasons prior to the age of 18 (Sneppen and Thorup 2016; Frisch and Earp 2016).

Many of them feel very angry (see Boyle et al. 2002; Hammond 1999; Silverman 2004); they may even use the language of "mutilation" to describe their circumcised state (see, e.g., Watson 2014). It is not uncommon for such men to feel as though something was "taken from them" that they ought to have had the chance to experience for themselves, and make a decision about in their own good time (Hammond 1999; Watson 2014). Part of the reason for this feeling, as I have noted elsewhere, is that "the genitals (in particular) might plausibly be seen as having a special, even unique psychosexual significance compared to other parts of the body, which could make their un-consented alteration more likely

to be experienced (later on) as a harm" (Earp 2015c, 45). Another reason might be the widespread cultural and legal norms that emphasize autonomy and a right to (bodily) self-determination in Western societies (Ludbrook 1995; Southan 2014), as well as norms about nondiscrimination on the basis of sex or gender. These men ask—if my sister's genitals are protected by law in this country, why were not mine (Maloney 2016)? Indeed, there is evidence that, conservatively, tens of thousands of English-speaking circumcised males are currently practicing something called "foreskin restoration" (Bigelow 1995; Carlisle 2016; Hammond 1997; Novak 2011; Schultheiss et al. 1998; Warren 1999).[25] This is an arduous process of stretching the remaining tissue from the shaft of the penis up over the glans using weights, tapes, and other instruments, over a period of several years. Such a sustained effort to "restore" some semblance of a pre-circumcised state suggests that circumcision is a serious issue for a substantial number of men.

The same is true for female circumcision. While many African women feel *enhanced* by having modified genitals—feeling more beautiful, "cleaner," more "smooth" and "neat" (Abdulcadir et al. 2012; Manderson 2004)—increasing numbers of them are aware of just how controversial their local customs have become on the world stage (Hernlund and Shell-Duncan 2007). Many of them are learning about how other cultures and societies regard the innervation and functions of the clitoris and/or labia. Some of them are dating outside of their cultural groups—perhaps especially if they live in an immigrant community in a Western country. They are finding out that "cut" genitals are *not* considered beautiful by the prevailing groups in such contexts, and so on (Johnsdotter and Essén 2016). Accordingly, they may feel humiliated, deprived, diminished—and yes, "mutilated" (see, e.g., Abdulcadir et al. 2010; see also http://www.clitoraid.org/stories). There is even some evidence of women seeking reconstructive surgery of their genitals to try to reclaim what was "taken from them" when they were too young to fully understand what was happening (e.g., Foldès, Cuzin, and Andro 2012; Foldés and Louis-Sylvestre 2006; Paterson, Davis, and Binik 2012; Sambira 2013).

In light of these considerations, I would like to return to my argument about enhancement. In doing so, I wish to suggest that if a proposed enhancement intervention has the following features, it would be morally preferable[26] for the intervention to be delayed until the individual who will actually be affected by it can make an informed decision about the state of his/her/their own body:

(i) The intervention is (for all intents and purposes) *irreversible* (for example, because it physically removes a part of the body—especially a part of the body that is seen as having value by a significant proportion of those who retain it).

(ii) The intervention can be *delayed* without losing the very properties (or too many of them) that are presumed to make it an enhancement in the first place.

(iii) The very status of the intervention as being an enhancement—as opposed to a diminishment or even a mutilation—is contentious, assuming a free flow of information, and that the relevant parties are reasonably well-informed about the intervention, its likely effects, the relevant anatomy, differing cultural perspectives regarding it, and so on.[27]

How contentious? I suggest that the status of an intervention as being an enhancement—when such an intervention irreversibly changes the body in a nontrivial fashion (such as by removing healthy, functional tissue), and yet can be delayed—should be very well settled in a society before anyone takes out a knife. Perhaps the bar should be set rather high. For example, we might say that the status of the intervention as being an enhancement should be comparable to the status of so-called medically necessary surgeries in Western societies. For in that case, the violation of the child's physical integrity might even be quite radical—and yet no one would say that it shouldn't be done.

CONCLUSION

My proposed framework will not be pleasing to everyone. It seems that it might allow for at least *some* forms of female genital cutting/alteration in *some* contexts around the world to be done for *some* reasons other than purely "medical" ones. But since the local norms that might inform such a decision cannot be simply assumed to be morally reprehensible (as the WHO/UN seem to do for any norm that could inspire nontherapeutic alteration of female genitals in non-Western settings), and since some forms of female genital alteration are comparatively minor, and can be done under sterile conditions, then it seems to me that I cannot rule out such a possibility (no matter how unpalatable I find this conclusion personally). At the same time, it seems that some genital-altering customs that are popular in Western countries, such as infant male circumcision or

female genital "cosmetic" surgeries (especially as performed on teenagers or younger girls), might need to be considered to be much more morally problematic than they currently are considered to be. However, I believe that the "enhancement" principle I have proposed, along with the specific qualifications I have offered, avoids the extremes of moral relativism (that is, I think it would be endorsed, at least in broad terms, in most cultures around the world) as well as cultural imperialism and moral hypocrisy (since I suggest that it should be applied to Western practices on the very same basis as non-Western ones). I hope this moves the debate forward in a productive way.

EDITOR'S NOTE

Due to space limitations in the printed journal, the Acknowledgments, Notes, and References sections of this paper are available in the online PDF version only. See muse.jhu.edu/article/622485/file/supp01.pdf.

NOTE: In the present document, these sections have been appended directly below.

ACKNOWLEDGEMENTS

I sincerely thank Joseph Mazor, Daniel Goldberg, Kirsten Bell, Michael Hauskeller, Robert Darby, John Danaher, Martin O'Reilly, Francelle Wax, Ashley Trueman, Andy Vonasch, Andrew Buskell, two anonymous reviewers, and various members of the Department of History and Philosophy of Science at the University of Cambridge for providing feedback on earlier versions of this manuscript. Thank you also to Richard Shweder, Rebecca Steinfeld, Erik Parens, Nancy Berlinger, and Fuambai Ahmadu for in-depth discussion of some of these ideas. This work was carried out initially at the University of Cambridge and then finished during my time as a Resident Visiting Scholar at The Hastings Center bioethics research institute in Garrison, New York; I am extremely grateful to Millie Solomon of The Hastings Center for inviting me to stay on as a Visiting Scholar, and to the entire Hastings Center staff for providing such a welcoming environment in which to read, write, and debate. The arguments presented in this paper are solely my own, and do not necessarily reflect the views of any of the people just mentioned.

NOTES

1. The debate over what to call the set of practices involving nontherapeutic modification of (female) genitalia is a minefield (see, e.g., Ahmadu 2016; Davis 2001; Shell-Duncan and Hernlund 2000). I will mostly use "FGM," not because I endorse this term myself (see Earp 2014c), but because this is the term employed by those whose position I spend the most time critiquing. I will also use such terms as "female genital cutting," "female circumcision," "female genital alteration," and so on, as needed throughout the paper.
2. Other popular counterexamples include the Holocaust, slavery, child sacrifice, etc. Of course, which version or versions of moral relativism these examples are supposed to refute, and on what basis, would be a very long discussion in its own right; for an engaging overview of the issues, see Gowans (2015).
3. In *Sex and Social Justice*, Nussbaum (1999) ostensibly limits herself to "cases that involve substantial removal of tissue and/or functional impairment; I make no comment on purely symbolic procedures that involve no removal of tissue" (119). This hedge is a little bit misleading, however, for at least

two reasons: (i) there are a number of FGM practices that fall between "substantial removal of tissue" and "no removal of tissue," and (ii) the actual cases she uses for illustration throughout her discussion, as well as the studies she appeals to, often conflate the more invasive and unhygienic forms of nontherapeutic female genital cutting (along with their probabilistic effects) with more minor forms or forms carried out under hygienic conditions.

4. Note that human rights can be understood in many different ways. Sometimes they are taken to be self-evident; sometimes as being grounded in a "minimal" human nature; sometimes they are seen as merely legal conventions, etc. See Dembour (2006) for a nice discussion.
5. As Winter, Thompson, and Jeffreys (2002) note, the terms "Western" and "non-Western" are not unproblematic. Nevertheless, in this paper, "the West" shall be used to refer to "the industrialized, urbanized, wealthy nations with high GDPs and per capita incomes, which have been shaped, culturally, economically and politically, by Western European liberal capitalist philosophy: namely the USA, Canada, Western Europe, Australia and New Zealand" (Winter et al. 2002, 73); "non-Western" refers to all other nations.
6. More formally, a group (or person) is guilty of—presumably culturally biased—moral hypocrisy if:

   (i) The group, call it Group A, with cultural practice A* (that Group A believes to be permissible), draws a conclusion concerning Group B, with cultural practice B* (that Group B believes to be permissible), according to which B* is "objectively morally wrong," on the basis of perceived-to be-sufficient reasons R; AND
   (ii) It is the case that if one were to apply R to A* from Group A, it would entail that A* is "objectively morally wrong" in just the same way that B* is, according to the original analysis used by Group A to condemn the practice endorsed by Group B; AND
   (iii) Group A has not in fact applied R to A* (for whatever reason; perhaps A* is familiar to Group A and is therefore simply taken for granted), OR Group A has in fact applied R to A* but only in a superficial or self-serving manner, thus failing to reach the (otherwise justified) conclusion that A* is "objectively morally wrong" (if B* is).

7. For one example, consider Mary Daly's (1978) well-known statement that "African genital mutilations" are "unspeakable atrocities . . . incapable of being expressed in words because inexpressibly horrible" (462). Another oft-cited example is A. M. Rosenthal's (1995) op-ed in the *New York Times*: "Here is a dream for Americans . . . . The dream is that the U.S. could bring about the end of a system of torture that has crippled 100 million people

now living upon this earth and every year takes at least two million more into an existence of suffering, deprivation and disease . . . . The torture is female genital mutilation . . . . The purpose is to insure virginity and destroy sexual pleasure. It is a form of male control, perhaps the ultimate except for murder." As the rest of this essay will demonstrate, many of the most jarring assertions from this quotation by Rosenthal are simply false, having been (apparently) uncritically recycled from the anti-FGM activist literature available at the time. For more on the problem of uncritical reporting on nontherapeutic genital altering procedures in the *New York Times*, see Earp (2016a).

8. It is important to acknowledge that there is a minority of "insiders" who oppose FGM in their communities, many of whom have been effective in combatting the practice(s) within their respective spheres of influence (see, e.g., Shweder 2013, 254; see also Wade 2012a). Similarly, there is a minority of circumcised men who strongly oppose nontherapeutic childhood circumcision (see Silverman 2004); however, they have been much less effective in gaining recognition from the global human rights community, health agencies, and so on (for an excellent discussion of why that may be the case, see Carpenter 2014; see also van den Brink and Tigchelaar 2012, and Kennedy and Sardi 2016).
9. By contrast, as Shweder (2013) notes: "When challenges have arisen to male circumcision Jewish men have been willing and able to exercise their critical reason and their considerable political and moral influence in defense of their ethnic tradition." He goes on: "This has not been true of the policy shaping abilities of educated circumcised African women. On the global scene and in legislative bodies in North America and Europe they lack visibility and political clout. Yet, they too are attached to (and find meaning and value in) their ethnic traditions" (354).
10. As Martha Minow (2000) notes: "Dueling accusations of false consciousness can escalate with no end. Indeed, there is a risk of infinite regression here. You say that women in my culture have false consciousness, but you say this because of your own false consciousness—or I think this because of my own false consciousness, and so forth. These kinds of exchanges are essentially incorrigible. No facts of the matter can prove or disprove false consciousness without a prior agreement about what one ought to want" (131). See also the discussions by Erik Parens (2014, 145) and Daniel Weinstock (2014).
11. Note that in some parts of Northeast Africa and the Middle East, where female genital cutting has become associated with some versions of Islam in particular, it is sometimes regarded as being necessary for preserving a girl's "virginity"

and "chastity," which I see as morally objectionable (Earp, 2014b). However, whether the cutting is or isn't regarded this way depends on the particular family or community; and the extent to which it is associated with, much less a consequence of, such sexist norms, is murky. Many scholars believe that both male and female genital cutting rituals have pre-historical origins, and only later came into contact with Arab–Islamic culture at which point they may have been absorbed into, or layered on top of, pre-existing gender asymmetries that focus on female, rather than male, sexual purity (Shell-Duncan and Hernlund, 2000; Caldwell, Orubuloye, and Caldwell 1997). The point is that the norms that single out women and girls as needing to be chaste are associated with some cultures and ideologies but not others; and there is no clear or consistent relationship between such norms and the presence or absence of female genital cutting rites (Ahmadu 2000, 285; Abdulcadir et al., 2012).

12. When the "moment" finally did arrive, Mandela saw "a thin, elderly man emerge from a tent and kneel" in front of him. "Without a word, he took my foreskin, pulled it forward, and then . . . brought down his [knife]. I felt as if fire was shooting through my veins; the pain was so intense that I buried my chin in my chest. Many seconds seemed to pass before I remembered the cry, and then I recovered and called out, '*Ndiyindoda!*' ['I am a man!']" (*ibid.*)
13. As I wrote in Earp (2016b), what the available research does suggest 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 [was] removed without their permission. Other women who have undergone such procedures do not feel this way. 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 [little] recourse" (from the Appendix, 30, available at: https://www.researchgate.net/publication/285578712_In_defence_of_genital_autonomy_for_children).

14. As Dustin (2010) states, "Whether the medical lobby really believed that there is a clear distinction between an unacceptable cultural practice and a legitimate cosmetic operation, or whether there was pressure from private clinics and surgeons for financial reasons is difficult to judge. But the lengthy passage of the Act was indicative of the power of the organized medical lobby in Britain" (15–16).
15. A similar situation exists in the United States. While anti-FGM legislation in some jurisdictions technically includes procedures that might be "favoured by Western women" (McColgan 2011, 17), they "use only language that addresses the 'ritual' or . . . belief-based cutting of African immigrant bodies," thus "mark[ing] out relations between the state and its [citizen's] bodies that differ depending on birthplace, cultural context, and skin color" (Davis (2002, 21, quoted in McColgan 2011, 17).
16. In these countries, even adult women cannot consent to "medically unnecessary" procedures affecting their own genitals due to very strict anti-FGM laws (Berer 2010; Matthews 2011; Sheldon and Wilkinson, 1998). In practice, however, women of European descent seem to have free reign to modify their genitals for "cosmetic" reasons, whereas women of African descent are prohibited from undertaking any such modifications. For a particularly striking illustration of this double standard, see: https://www.youtube.com/watch?v=Cu1gmUuDniU.
17. As noted, the "more invasive procedure" being referred to is infant male circumcision, as it is customarily practiced in the United States (and to a lesser degree in Canada). This practice was adopted in the late 1800s from England, where it was thought to provide, *inter alia*, a "cure" for masturbation and masturbation-related ailments, both physical and spiritual (Darby 2005, 2015), and it was vigorously promoted on those grounds by John Kellogg, the inventor of cornflakes, among other influential religious men of New England. As Kellogg (1889) wrote: "A remedy [for masturbation] which is almost always successful in small boys is circumcision. The operation should be performed . . . without administering an anesthetic, as the brief pain attending the operation will have a salutary effect upon the mind, especially if it be connected with the idea of punishment" (295). Circumcision was also heavily promoted by Lewis Sayre, an ambitious orthopedic surgeon of the era, who "claimed he was successful in using male circumcision to cure paralysis and hip-joint disease, and to 'quiet nervous irritability.' He later

extended his treatment to hernia and stricture of the bladder" (Aggleton 2007, 18). By 1894, American physicians had identified "an astounding array of maladies that could be cured through male circumcision. These included eczema, oedema, elephantiasis, gangrene, tuberculosis, hip-joint disease, enuresis, general nervousness, impotence, convulsions and hystero-epilepsy" (Aggleton 2007, 19). Today, some American physicians continue to promote circumcision (Carpenter 2010), primarily as a form of partial prophylaxis against sexually transmitted infections—that is, infections to which the child may one day be exposed, depending upon his future behavior, and for which there are alternative modes of prevention (see Frisch and Earp 2016). For example, the American Academy of Pediatrics (AAP) has recently suggested that the potential health benefits of neonatal circumcision "outweigh" the associated risks of the surgery in developed countries (Blank et al. 2012; but see Darby 2015), a view that was later echoed by the U.S. Centers for Disease Control and Prevention (CDC 2014a, 2014b). However, this conclusion is inconsistent with that reached by medical bodies outside of the United States (see Frisch and Earp 2016 for a discussion), and both the AAP and CDC have been criticized on scientific grounds by representatives from peer organizations in England, Canada, and mainland Europe (Frisch et al. 2013, Kupferschmid et al. 2015; see also van Howe 2015). Acknowledging these criticisms, a key AAP task force member later retreated from the "benefits outweigh the risks" claim in a published editorial, citing a "lack of a universally accepted metric to accurately measure or balance the risks and benefits" as well as "insufficient information about the actual incidence and burden of nonacute complications" (Freedman 2016, 1). Nevertheless, a majority of American males continue to be circumcised, and the ones who are, tend to elect circumcision for their sons. The most commonly stated reasons are "so that he will look like his father," and "so that the penis will be easier to clean" (Brown and Brown 1987; Rediger and Muller 2013). A circumcised penis is considered "normal" in the United States, and an "uncircumcised" (intact) penis "abnormal." The surgery is performed on healthy infants, and it involves the removal of approximately 50% of the motile skin system of the penis (Taylor, Lockwood, and Taylor 1996). Despite updated AAP guidelines (Blank et al. 2012), it is still done in many cases without an anesthetic (Yawman et al. 2006).

18. This "wedge" strategy is apparent in the WHO/UN's very choice of terminology. As they discuss in an Appendix, "During the first years in which the practice was discussed outside of practicing groups, it was generally referred to as 'female circumcision.' This term, however, draws a parallel with male

circumcision and, as a result, creates confusion between these two distinct practices" (WHO/UN 2008, 22). Therefore, the female forms of genital cutting were re-labeled "Female Genital Mutilation."

19. With respect to the issue of health benefits as a presumed point of contrast between male vs. female circumcision, there is the potential for a self-fulfilling prophesy here. The claim is that, in contrast to male circumcision, female genital cutting has "no known health benefits." However, the WHO and other Western agencies fund research only into the question of potential health benefits of male circumcision (for a recent discussion see Bell 2015). They do not fund research into the question of the potential health benefits of female circumcision (presumably because such circumcision is regarded by these organizations as being obviously impermissible, no matter how minor or sterilized), and instead fund research looking exclusively for harms (see Hodžić 2013). As I have noted elsewhere (internal references omitted): "On the question of health benefits, suppose it could be shown that removing the labia majora of infant girls reduced their risk of acquiring a urinary tract infection (since there would be fewer folds of moist genital tissue in which bacteria could find a home), as well as, say, cancers of the vulva—or even HIV. It is not biologically implausible. In fact, in countries in which female 'circumcision' is culturally normative, it is often said to confer a range of such benefits, including 'a lower risk of vaginal cancer . . . less nervous anxiety, fewer infections from microbes gathering under the hood of the clitoris, and protection against herpes and genital ulcers.' In addition, female 'circumcision' in such countries is often described as 'more hygienic.' . . . Nevertheless, it is actually illegal in Western countries to conduct the very research by which such 'health benefits' could be 'discovered' in the first place. This is because nontherapeutic surgeries performed on the genitals of healthy girls—no matter how slight, nor under what material conditions—are deemed to be impermissible mutilations in Western law" (Earp 2015b, 3; see also Earp 2015a). Tying these strands together, Kirsten Bell (2005) has highlighted the contradictory nature of the WHO/UN policies on the question of health benefits: "[They] seek to medicalize male circumcision on the one hand, oppose the medicalization of female circumcision on the other, while simultaneously basing their opposition to female operations on grounds that could legitimately be used to condemn the male operations" (131).
20. I would like to say one more word, while we are on the topic of sex-based discrimination. There are some countries and cultures that do in fact discriminate on the basis of sex in their evaluations of the permissibility of nontherapeutic alterations to healthy genitals. However, most of them are

not in Africa or the Middle East. Instead, they include such countries as the United States, England, Australia, New Zealand, Canada, and most of the countries of Europe. In these societies, it is considered permissible for adults to operate only on the healthy genitals of male children and intersex children. By contrast, any adult who operated on the healthy genitals of a female child, no matter to what extent, and regardless of the context or parental motivation, would be subject to criminal prosecution.

21. I am grateful to Joseph Mazor for helping me think through these issues. As Mazor argues in a yet-to-be-submitted paper (a draft of which I have read), it is reasonable to think that a child's right to bodily integrity should be analyzed *in terms of* the child's interests: if a breach of the child's body envelope counts in favor of the child's best interests overall, then (generally speaking) this breach will not be a violation of the child's *right* to bodily integrity. That said, the question remains: how do we know what is, in fact, in the child's best interests when it comes to contested body-envelope breaches, and who should get to decide (Earp 2016d)? As McMath (2015) notes, when it comes to genital-altering procedures in particular, people strongly disagree over what constitutes a benefit vs. harm in the first place, as well as with respect to the questions of personal relevance and perceived relative magnitude of both benefits and harms (see Frisch and Earp 2016 for further discussion). For example, "Some people believe [that male] circumcision benefits the child by bringing him closer to God, while others disagree. In light of such disagreement, some commentators conclude that the parents should decide" (McMath 2015, 689). But this does not necessarily follow. After all, "the child will have an interest in living according to his own values, which may not reflect those of his parents . . . . Only the child himself, when he is older, can be certain of his values." Thus, "if disagreement over values constitutes a reason to let the parents decide, it constitutes an even stronger reason to postpone the decision until the child himself can decide" (*ibid.*). This is similar to the view I defend in the concluding sections of this paper.
22. Please note that a proposed intervention might only turn out to be an enhancement (i.e., in the child's best interests, overall) due to manifestly unjust social pressures or other problematic externalities; in such a case, the intervention would be morally objectionable for other reasons than its role in affecting the child's welfare—i.e., insofar as it would serve to perpetuate those unjust pressures (etc.) which individuals and society should try to mitigate rather than reinforce. But (a) the intervention itself would not cease to be an enhancement, as I have defined it, and (b) it still might be permissible for parents to authorize it for the sake of their child's overall well-being, depending on a

range of factors (a classic argument here is that parents should not sacrifice the welfare of their children on the altar of attempting to change problematic social norms; see, e.g., Parens 2006). Spelling out the conditions under which a putative enhancement would become strictly impermissible due to negative externalities is unfortunately beyond the scope of this essay; but see Carmack, Notini, and Earp (2015) for a hint of my views.

23. I do not suggest that the age of legal majority is the same thing as, nor even a good approximation of, "having the capacity to provide meaningfully informed consent" to some intervention. That capacity develops gradually and in different ways between individuals (and across cultures); it also depends on the intervention in question. Typically, the riskier or more controversial the intervention, the higher the threshold for meaningful consent. Thus, an appropriate age for providing meaningful consent to, say, getting braces, could very well be lower than the age for providing meaningful consent to an irreversible genital surgery that removes sensitive tissue. But I expect that the precise age would depend in large part upon local/contextual factors—and would therefore not be the sort of thing that one could determine "universally" for all cultures.
24. There are of course well-documented cases of men feeling harmed by their circumcisions prior to the age of the Internet (see, e.g., Darby and Cox, 2008); it is just that it has become much easier for such men to find each other and share their stories, etc.
25. Ron Low is the owner of a foreskin restoration device company called TLC Tugger (http://tlctugger.com). In response to my request for an estimate of how many men are engaged in foreskin restoration using just his devices (email dated March 25, 2015), Low writes: "For the 62-day period starting January 1st, 2015 I helped 892 nonrepeat customers start restoring. In the 62-day period that's 14.4 per day. In a comparable 365-day year that would be 5,251 men I'd expect to start with TLC gear. This is conservative since the demand continues to grow, and each quarter shows more customers than the prior one. In 2010 we surveyed online English speaking restorers and saw that only 77 out of 995 respondents has one of my devices. So assuming that market share I am willing to speculate that the total number of online English-speaking men who will start restoring this year is at least (5,251 X 995)/77, or 67,854. So 67,854 English-speaking actively-online men start restoring per year . . . My nonrepeat customer base has been growing 4% per year for the last 10 years, which gives rise to a total active restoring-for-10-years-or-less population of about 572,370. This doesn't include guys with no online presence, and guys with not enough English language skill to find

me, so I call it a very conservative estimate. Of course since there are some gross assumptions, it should be reported rounded off, say 570,000. While this is an unpublished number, I do have 10 years of tax returns attesting to the fact that I make my living selling these devices." Low then provided sales records for the 62-day period mentioned above in response to my request for additional information that would allow me to substantiate these figures.

26. The list that follows is not meant to be a set of necessary and sufficient conditions for "absolute" moral permissibility or impermissibility; instead, it is a suggestion, an offering—a decision-making heuristic that I think most parents from a range of cultural backgrounds would find reasonable and would therefore be inclined to accept upon careful reflection.
27. A skeptic of my argument might ask: what is the moral significance of whether some procedure/intervention is "contentious"? After all, might not someone live in a totalitarian regime that "brainwashed" all of its citizens into complacency about a morally problematic practice that otherwise *would* be considered controversial? In such a case, would I really want to argue that the practice was permissible (because not contentious)? Or, what if some morally benign practice were in fact contentious in some context, but only because those debating the practice were seriously misinformed, or perhaps just wanted to create a fuss? These are not unreasonable objections. Accordingly, I have added the qualifications above concerning a free-flow of information, a basic level of being informed, and so on. Nevertheless, as concerns the present topic, such hypothetical qualifications are not actually needed. This is because, when it comes to the actual types of interventions I am considering—namely nontherapeutic alterations to children's genitals—they *are* contested, and are so in societies that *do* have access to information, exposure to different norms, etc. Of course, if they were not contested in some context, this would not entail that they were morally unproblematic; it might just mean that people's awareness of the morally problematic features of the practices was too low to have an impact on the public debate. Given the increasing interconnectedness of the globe through information technology, however, it seems to me that fewer and fewer people, regardless of their cultural setting, will be in a position *not* to know that many women, men, and intersex people feel seriously mutilated by their childhood genital alterations; and I argue that parents' assessments of the child's best interests should be strongly influenced by this information, weighing in favor of delaying the intervention until an age of consent.

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