Culture, Health & Sexuality

What counts as mutilation—and who should decide? Disrupting received wisdom on genital cutting and modification in the Global North and South

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This is a pre-print of an article currently in press. Please cite as:

Earp, B. D., Abdulcadir, J., & Shahvisi, A. (2024). What counts as mutilation – and who should decide? Disrupting received wisdom on genital cutting and modification in the Global North and South. *Culture, Health & Sexuality,* in press.

Abstract

This Special Collection of articles in *Culture, Health & Sexuality* examines diverse genital cutting practices affecting individuals of all sexes and genders across cultures. It challenges dominant narratives and stereotypes, particularly in relation to male circumcision and what the World Health Organisation (WHO) defines as "female genital mutilation" (FGM), while also touching on intersex genital "normalisation" procedures to highlight the complexity and interconnectedness of these practices.

The papers reveal that culturally prescribed genital cutting varies widely in methods, meanings, motivations, and outcomes, with simplistic distinctions based on sex, gender, or cultural origin being highly misleading. The collection emphasizes the need for a more holistic, cross-cultural approach to studying and understanding these practices.

Key themes include:

1. The interconnectedness of female, male and intersex genital cutting in many cultures.
2. The role of power dynamics and cultural imperialism in shaping perceptions and policies.
3. The medicalization of genital cutting practices in various contexts.
4. Unintended impacts of selective criminalization of female genital cutting.
5. The influence of hegemonic masculinity and heteronormativity on male genital cutting rituals.
6. The complex relationships between consent, coercion, and cultural pressure.

The editors' introduction, below, highlights that the moral and legal status of genital cutting practices often depends more on political power than on factors such as consent, medical necessity, or physical severity. It calls for a more nuanced understanding of genital modification that resists simplistic categorizations and acknowledges the diverse lived experiences of individuals and communities across cultures.

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Editors' introduction

Female, male, and intersex forms of genital cutting, surgery, mutilation and/or modification have, for several decades, been studied largely in isolation from one another, with scholars from different backgrounds publishing their work in different journals and attending different meetings and conferences. However, this is starting to change. Increasingly, it is argued that diverse genital cutting practices, including those affecting persons of different sexes and genders in cultures of the Global North and South, must also be analysed more collaboratively and holistically.

Such an approach is necessary not only for practical purposes (for example, sharing resources and insights across scholarly and geographic divides), but also ethically and scientifically, given the overlapping social motives and often intertwined causes of different types of genital cutting within a given culture (discussed below). This Special Collection brings together some of the richest and most nuanced analyses of such practices published in *Culture, Health and Sexuality*, a journal that has long been at the forefront of fostering critical perspectives on this issue.

Taking a birds-eye view, the collection shows that culturally prescribed (that is, customary or medically unnecessary) genital cutting or modification, especially of children, comes in many different forms, with substantial variation in methods, meanings, motivations and outcomes both within and between cultures, sexes and genders, as well as some striking similarities. Such practices are geographically widespread, and may be undertaken at different ages, with varying levels of agency or choice. They may be customary within dominant or marginalised groups; associated with power or resistance to power; and be both personally and politically significant, whether as practices to be celebrated or condemned.

In some cases, genital cutting is experienced as a harmful mutilation; in others, as a beneficial enhancement. The former interpretation may be more common when the cutting is non-consensual; the latter, when it is sought voluntarily. But there are exceptions in either case. Either way, the practice may be more or less medicalised, more or less normalised, more or less controversial.

In addition to practices mostly affecting children, there are now growing debates around genital modifications performed in adolescence or adulthood, including female genital "cosmetic" surgery—with procedures such as labiaplasty increasingly performed during the teenage years various Western countries; US-funded mass circumcision campaigns in Africa for HIV prevention, targeting adolescent boys and young men; and even gender affirming surgery for trans and non-binary individuals (the vast majority of these take place after age 18). Across all types of modification, however, facile distinctions based on sex or gender are breaking down, revealing complex moral and political fault lines—and also the need for deeper inquiry.

Of all the many ways in which human sexual anatomy can be pricked, cut, or surgically altered, whether within or outside of a clinical environment, which ways should be accepted,

and which challenged? Based on whose ethical theory? Which standards of evidence? And how should we ultimately decide?

Crossing boundaries

Most of the practices discussed in this collection concern non-intersex or "endosex" individuals (with the notable exception of Smith & Hegarty, 2021). However, the analyses have implications for individuals of all sex characteristics, not to mention gender identities. When it comes of contested cultural practices in the transnational policy arena, complex legal, ethical, conceptual and practical questions around the appropriate conditions for genital modification—whatever the size, shape or colour of the anatomy in question; whatever the age, sex or social location of the individual—cannot be kept within orderly lines.

At a conceptual level, for instance, debates about criteria for determining whether a given procedure should be characterised as "cultural," "cosmetic" or "medical" (or perhaps "medically necessary") may end up informing, constraining or problematising the criteria that are used for other procedures. To illustrate, if we decide that the attempted relief of distress, ideals about authenticity, religious devotion, harm reduction, or the pursuit of health benefits (among other possible motives) justifies the performance of one type of procedure by a clinician, should the same reasons apply to all the others? Why or why not?

Ditto for debates about consent. How old must a person be for their consent or agreement to undergo an elective genital procedure to count as ethically valid? Does the answer depend on the sex of the person? Their gender? Their racial or ethnic background? Or should the same standard apply to everyone?

On a more practical level, a specific form of surgery intended for members of one sex or gender category (say, infant "male" circumcision) may end up affecting persons who identify with a different sex or gender category (say, transgender women). Similarly, a given type of procedure (say, trimming of the labia) may be considered a "cosmetic" procedure if requested by women of some ethnic backgrounds, but "cultural" if requested by others. Accordingly, a major lesson to be learned from the collection is that all forms of genital cutting or surgery must be critically evaluated by looking beyond conventional boundaries, not only of sex and gender, but also of race, religion, ethnicity, immigration status, and so on.

This is necessary to break down simplistic stereotypes, avoid easy answers, and recognise the limits—and even distortions—of dominant discourses. Consider the dominant Western discourse on what the World Health Organization (WHO) terms "female genital mutilation" or "FGM." According to this discourse, "FGM" is a quintessentially African practice; it is "deeply-rooted" in tradition, and is a form of sexist discrimination targeting passive young girls, primarily to "control their sexuality." It is invariably harmful to health and sexuality, and has no legitimate offsetting benefits. It is mutilating—by definition—and therefore never an aesthetic procedure, unlike "cosmetic" genital surgeries in the West. Finally, it is not based in religion but is "merely" a cultural practice: one that must be criminalised and eradicated to protect potential victims.

In contrast, the dominant discourse on male genital cutting, primarily penile circumcision, turns most of these ideas on their head. Such practices are constructed as being either totally incomparable to "FGM," or the polar opposite. Thus, the cutting of a child's healthy penis, in this discourse, is either a "modern" therapeutic innovation in countries such as the USA; or, in so-called "traditional" settings, a practice associated with male strength and virility. According to this discourse, the practice does not discriminate against males, even in societies where boys, but not girls, lack legal protection against non-therapeutic genital cutting; and setting aside occasional surgical mishaps, neither is it harmful to health or sexuality. Instead, proponents claim, it carries numerous benefits, both physical and psychosocial. Meanwhile, for some groups, it has foundations in religion, and so must be tolerated and never banned.

This is a comforting narrative for many, especially those born and raised in the USA, where medicalised male circumcision remains a prevalent cultural norm, and "FGM" is—by contrast—imagined as a foreign practice: something fundamentally backward, done by and to people of colour, including immigrants, from far-away lands. However, as the articles in this Special Collection make clear, it is an incomplete and seriously misleading narrative, one that relies on and entrenches cultural imperialism, neocolonialism, sexism, and racism. Indeed, virtually every claim or stereotype about "FGM" and "male circumcision" from the dominant discourse—as summarised above—is challenged, disrupted, nuanced, or refuted by one or more papers in this Collection.

Consider the idea that "FGM" is quintessentially African. By focusing on customary or religious forms of cutting that are more common in parts of South and Southeast Asia, some

of the papers in this Collection undermine "common knowledge" about "FGM" and its relation to male circumcision. In parts of India, Malaysia, Indonesia, Sri Lanka, Thailand and Singapore, both male and female genital cutting are practiced in tandem in some communities, often in a medicalised form. In these communities, the ritual for boys is, typically and by most accounts, more physically severe than the one for girls; both practices are often rationalised as "hygienic" measures; and both are widely seen as being religiously required.

Regarding sexual control, both male and female genital cutting are associated, in some contexts, with a desire to "tame" sexual impulses believed to be excessive; in others, they are seen as sexual or aesthetic enhancements, or a license to *become* sexually active. Health-related consequences also overlap depending on the skill of the practitioner, the extent of tissue removal, and whether sterile instruments are used. Finally, criminalisation of female, but not male or intersex, genital cutting has had numerous unintended negative consequences, including an increase in risk to girls in certain settings. These practices—and policy responses to them—deserve a fresh look, setting aside common assumptions. This Special Collection is an excellent place to start.

Highlights from the Collection

The scholars whose work is represented here come from diverse backgrounds and share a range of perspectives. As they show in their work, perspective matters. To get a handle on genital cutting, beyond stereotypes and simplifications, it is important to keep an eye on who has power, control or influence over whom. Who is criticising, colonising, criminalising, dominating, exploiting or "developing" another? Popular myths about other groups' genital cutting customs have long been used to draw all-too-convenient distinctions: between civilisation and barbarism; hygiene and filth; beautification and disfigurement; modernity and tradition; science and superstition; "us" and "them."

In her classic study, **Ellen Gruenbaum (2005)** provides context for these claims. As she argues, it has been common since the early twentieth century, with the rise of the women's rights movements in the USA and Europe, for "traditional practices" such as female genital cutting "to be blamed for oppressing women in Africa and the Middle East." Although other factors, many of them traceable to or exacerbated by Western colonialism, including "war, famine, high rates of disease and infant and child mortality, and lack of educational

opportunities," have often posed far greater challenges to well-being, a focus on "traditional practices" (portrayed as being entrenched in an unenlightened, unchanging culture) has provided "an additional justification for colonial control and missionary intervention" (p. 434).

However, then, as now, the way these practices have been imagined and described by Western critics has not reflected the actual scope of rationales for genital cutting in different cultures, the heterogeneity of attitudes or changing beliefs within each society, or even what is physically at stake for those affected. Thus, in the popular media, as well as in various advocacy campaigns, explanations for non-Western-associated female-affecting practices "are frequently simplistic, emphasizing a single, underlying explanation, such as 'male dominance', and inferring that the purpose is to prevent women's sexual fulfilment" (Gruenbaum, 2005, p. 430). Despite the voluminous literature demonstrating "wide variation in practices, reasons, and consequences" for both male and female genital cutting, opponents of the latter "fail to differentiate between the types and tend to privilege the most serious and damaging practices—especially severe infibulation—the most unhygienic methods, and the most coercive circumstances." Gruenbaum concludes that "images of broken glass and rusty knives, of thorns and infibulation, and of the use of force, occupy an unduly privileged position in international popular discourse" (p. 430, internal references omitted).

Not all is "variation" however. Some of what we know applies widely. For example, when performed on children without their consent or against their will, genital cutting necessarily involves significant power asymmetries, and typically plays a role in upholding ethnic, political, intergenerational and/or gender-based hierarchies in many cultures. Another nearly universal finding is that ritual female genital cutting of children almost only ever occurs in societies with a pre-established practice of ritual male genital cutting of children, but not vice versa, suggesting that the former may be structurally dependent on the latter. Thus, as **Anna Wahlberg, Birgitta Essén & Sara Johnsdotter (2019)** explain, in Somalia, as in virtually all societies "where girls are circumcised, boys are also ritually circumcised," with the two types of cutting "often regarded as socially and symbolically complementary practices" (p. 620). Although, like Gruenbaum, they acknowledge that rationales for the practices can vary depending on context, they suggest that "common motives" can be found for both, "such as beautification, cleanliness and as a way to 'enhance' or accentuate the male and female

body." They also note that "both procedures intentionally – and without medical [necessity] – alter the genitals on children who are too young to consent or make informed choices" (*ibid.*).

Given this overlap or perceived complementarity between practices, some authors question the tendency to keep them separate, or cast them as opposites, in scholarship, law and policy. As **Hannelore Van Bavel, Gily Coene and Els Leye (2017)** argue in their study of the Maasai people of Tanzania, "the artificial isolation of female from male circumcision conceals [the] similarities and the embeddedness of female genital cutting within broader social and gender norms" (p. 1344). One consequence of this isolation and differential treatment has been that girls, but not boys, are increasingly "circumcised" at younger ages: "Performing female genital cutting on neonates or infants [is] motivated by an eagerness to hide the continuation of the practice from opponents who might warn authorities – a tendency that is also observed in other communities where [only] female genital cutting is illegal" (p. 1352).

The connection runs deeper. As **Tasneem Kakal and colleagues (2023)** show, among the Amhara community of Ethiopia, the selective criminalization of the women's, but not the men's, traditional rite of passage has not only driven the former underground, making it potentially more dangerous, but the latter is now used as "cover" for the former. Using "FGM/C" to refer to female genital mutilation/cutting, they write: "Due to FGM/C's illegal status, different strategies were used to evade the law and maintain anonymity ... At times, parents [of girls] pretended they had sons, or that they were celebrating another male circumcision or social gathering when organising their daughter's FGM/C" (p. 903).

Such findings replicate the results of **Jo Boydon (2012)** from more than a decade earlier, suggesting little has been learned from her and others' critiques of what she describes as "misguided efforts to eliminate female circumcision in Ethiopia" that ignore the socio-structural context within which genital cutting of children of both/all sex characteristics occurs. Boydon, like Kakal and colleagues in their more recent publication, reports that "boys' circumcisions are sometimes used to mask operations on girls, a practice alluded to by the metaphor, 'to castrate the mule, they pushed the donkey to the ground' (*beklolemakolashet, ahiyanankebalelut*). If challenged by the authorities, guests bear witness to having attended a wedding or a male circumcision ceremony." She suggests that the

selective ban on female genital cutting, implemented in response to international pressures, may in some cases "have increased, rather than reduced, risks to girls" (p. 1117).

Such concerns are corroborated by **Claudia Merli (2010)** through her groundbreaking work with Malay-speaking Muslims in Southern Thailand. In Satun province, she reports, male genital cutting is practiced in the open, with boys between the ages of 7 and 12 positioned on tables, desks or the floor of a raised platform to enable public viewing, with government, religious and medical officials on hand to oversee or conduct the mass initiation into Islam. Merli characterises the resulting spectacle—"the audience crowding the area and circulating freely in front [and among] the tables, the noise, cries and screams of some boys, all contributing to a bustling and confusing atmosphere"—as a type of "conquest of male bodies by the bio-politics of governmentality" (pp. 731 and 735).

Meanwhile, the associated religious initiation for girls is done within the privacy of the home: it is "only the indigenous midwife or *bidan* who performs the mild cutting or pricking of the clitoris as part of her responsibilities" (p. 733). Noting that the female version of the ritual has not (yet) been medicalised nor co-opted by agents of the state, she detects a form of female empowerment or defiance: "In refusing to hand over to the surgeons the performance of female *sunat* [pricking or circumcision], women claim their Shafi'i identity by resisting the complete conquer[ing] of their bodies" (p. 735). Drawing her observations together, she questions the "theoretical and ethical implications of studying genital cutting and focusing exclusively on one of the two practices rather than, as this paper claims to be necessary, considering them as inextricably connected" (p. 725).

Indeed, as **Annette Smith and Peter Hegarty (2020)** point out, there more than "two" interconnected practices to consider. Smith and Hegarty draw our attention to surgeries on children born with intersex traits. As they show, these so-called "genital normalisation" procedures create, reinforce or exaggerate supposedly "natural" bodily binaries around which gender-based systems oppression operate. They also caution that, within the logic of such systems, practices of one kind may be used to legitimise another. For example, some scholars have argued that non-therapeutic penile circumcision—a common US birth custom—may have historically laid the groundwork for greater acceptance of intersex surgeries, insofar as both practices are performed on a non-voluntary basis (and in the absence of a physical health emergency) to conform the child's inborn sexual anatomy to what is socially expected for

members of their assigned gender. For another example, in the 1960s, as Smith and Hegarty relate, US physicians sometimes compared "modern Western" clitoral surgeries on girls with congenital adrenal hyperplasia (CAH) to "traditional African" clitorectomy: "Their reasoning was that as the two forms of clitorectomy were analogous, and since African clitorectomies were long standing," Western clitorectomies "were also acceptable" (pp. 548-9). However, with subsequent consciousness raising—fuelled in no small part by racist "othering" and selective stigmatisation of "African" female genital cutting—efforts to *distinguish* the two types of procedure became increasingly common.

One approach to drawing such distinctions been to associate "African" genital cutting with "cultural" or "traditional" practice, to supposedly contrast with modern "medical" surgeries performed in Western countries on intersex infants and boys. But as **An Van Raemdonck (2019)** explains, medicalised female genital operations are common in many African countries, including Egypt. As she notes, in the 1950s—around the same time intersex procedures were becoming institutionalised in the United States—"Egyptian doctors discussed the possibility of there being a *medical* need for [female genital cutting] when parts of the female genitalia were deemed too large," echoing reasons still given by Western providers for so-called "feminising" clitoral reduction surgeries on girls with CAH (see Smith & Hegarty, 2020). "Some combined this medically based discussion with religious arguments," Van Raemdonck continues. "Then and today, the vision that a girl might be in need of genital surgery and that this decision is best left to a medical professional finds support from both medical and religious authorities" (p. 1180).

A similar mix of medical and non-medical factors can be seen in the "Voluntary Medical Male Circumcision" (VMMC) programme currently sponsored by the World Health Organisation (WHO), as discussed by **Sarah Rudrum, John L. Oliffe & Cecilia Benoit (2017)**. The authors focus on the Stand Proud, Get Circumcised campaign introduced in 2012 by the Uganda ministry of Public Health and funded by the United States Agency for International development (USAID). The campaign was based on the results of three randomised trials on adult voluntary penile circumcision conducted in the early 2000s that reported a 50-60% relative risk reduction in female-to-male transmission of HIV. As Rudrum and colleagues explain, however, a fourth trial looking at male-to-female transmission suggested an *increase* in the risk of transmission to female partners of circumcised men:

> there is no direct benefit to women whose HIV-positive partners circumcise, and circumcision may increase the risk to women if couples resume sex following surgery before the wound has fully healed. It is speculated that circumcision will indirectly benefit women through reduction in HIV among potential male partners; however, the extent of such a benefit has not been identified (p. 226, internal references omitted).

Despite the lack of direct benefit to women—and the potential increase in their level of risk—posters for the Stand Proud, Get Circumcised campaign featured attractive-looking women accompanied by such misleading phrases as "I am proud I have a circumcised husband because we have less chances of getting HIV," or, dropping references to HIV altogether and playing instead on men's sexual insecurities, "Forget size, you mean you're not circumcised!" According to Rudrum and colleagues, "by neglecting to highlight the evidence that women are not directly protected or that other tools of prevention including condoms remain important despite circumcision, [the posters] fail to promote an overall HIV-prevention message (p. 237). Instead, they "signal how men might more closely align to *hegemonic masculinity* by being circumcised, not necessarily for the body aesthetic itself but for the masculine capital it purportedly carries in attracting the opposite sex" (p. 229, emphasis added).

The concept of "hegemonic masculinity" is also invoked by **Anathi Ntozini and Hlonelwa Ngqangweni (2016)** in their study of gay Xhosa men's experiences of ulwaluko (traditional male initiation) in South Africa. As they note, "[e]ven though an initiate may experience excruciating pain, he must ignore it and unequivocally declare his manhood," whereas if a man cries, "he is seen as inferior, a sign associated with femininity or regression to childhood" (p. 1310). However, additional challenges are faced by gay initiates due to their noncompliance with heteropatriarchal notions of masculinity: "their sexual orientation may be viewed as compromising the sacredness of the practice." Notably, according to the authors, participation in the ritual carries with it an implicit assumption that gay initiates have "decided to 'convert' to heterosexuality." And although the men might wish to avoid this interpretation by declining to take part in the ritual, gay Xhosa men "have little power within these heteropatriarchal contexts, and this may facilitate their 'consent' to vestiges of domination and oppression within their own community settings" (2016, p. 1310).

Questionable "consent" as well as heteropatriarchal domination are not limited to adolescent rites in Africa. As **Romeo B. Lee (2006)** shows, Filipino boys who are not circumcised may face relentless teasing and even physical beatings for being *supot* ("uncircumcised") until they comply with the prescribed initiation. However, the term *supot* does not just refer to an intact penis: it implies one is a "coward or *bakla* ('homosexual'), for lacking the courage to experience the pain and anxiety associated with the procedure" (p. 229). Boys in his study also believed that, without being circumcised, they would be "publicly ridiculed" and that "women would be disinterested in them" (p. 231). Thus, we see in a variety of contexts an equation between homosexuality and femininity, and a demand for boys to repudiate these qualities to win the respect of their peers—and please presumptively female sexual partners— namely, by undergoing a deliberately painful genital cutting ritual without expressing weakness or emotion, thus proving oneself to be a "real" man.

As a final example, **Larissa Remennick (2022)** provides an analysis of penile circumcision in Israel. Although in Israel such circumcision is overwhelmingly performed in the neonatal period, in line with Jewish tradition, Remennick writes of a state-sponsored mass circumcision campaign from the 1990s aimed at genitally intact Jewish adolescent boys and men. Having immigrated to Israel after the collapses of the Soviet Union, these men soon discovered that undergoing the operation was not a matter of choice, but rather, a necessity for joining "the Jewish collective." However, in sending this message, the campaign reflected and reinforced a "hegemonic" Israeli masculinity, which according to Remennick is "intertwined with militarism, nationalism and ethnic hierarchies" (p. 704). As the former Soviets crossed the border into Israel, "the religious and medical arms of the State rapidly mobilised to put together the 'adult-brit assembly line' [a 'brit' is a Jewish circumcision] to align tens of thousands of these new citizens with the national-religious norm." As she writes, a "mass campaign for correcting ex-Soviet Jewish masculinity was [thus] mounted without a shadow of public criticism or concern for these vulnerable newcomers' psychological wellbeing and changed body image, let alone human rights" (p. 705).

Concerns about body image and human rights are also at the heart of the study by **Malin Jordal, Gabriele Griffin & Hannes Sigurjonsson (2019)**, who consider the practice of clitoral reconstructive surgery following ritual female genital cutting. Based on qualitative interviews with women from Somalia, Eritrea, Gambia, Sierra Leone, and Iraqi Kurdistan who had immigrated to Sweden, they find that many of the women experienced their cut

genitalia as “normal” during childhood and early adolescence, only to later see themselves as damaged, disfigured, or “different” from others in Swedish society. By contrast, they viewed clitoral reconstructive surgery as a chance to “repair the damage done to their genitalia” through the previous, ritual cutting, so that they could “pass as normal” in social and sexual relations—having adopted a new notion of “normal” consistent with feminine bodily ideals of the host society (p. 709). Although clitoral reconstructive surgery does not physically “restore” any of the excised tissues, and might even introduce further risk of potential damage to sensitive tissues, it seems that, for many of the women, the ability to *choose* a genital operation for themselves—in contrast to what was imposed on them as children—held significant symbolic value: “they hoped that surgery would give them a sense of restitution” (p. 713)

Final reflections

The papers collected here cover a wide range of practices and procedures, affecting persons from different countries and cultures, and of all sex characteristics and gender identities. One of the most striking themes to emerge from these papers, considered together, is that the perceived moral and legal status of these diverse practices, whether female, male, or intersex, does not seem to depend—at least not primarily—on any the following factors: whether they are consensual or non-consensual; whether they are medically necessary or unnecessary; whether they are more or less physically invasive; whether they are done by a professional or traditional practitioner; whether they are performed for religious reasons or secular ones; and whether they are relatively risky or safe. Instead, in many contexts, the most strongly predictive factor for how a given type of genital cutting or surgery is morally or legally categorised is, quite simply, political power: for example, laws and attitudes may track whether the practice is customary among, or at least familiar to, culturally dominant groups, or whether the practising group is deemed to be a cultural threat.

This seems to be true on a country-by-country level, at least in terms of prevailing moral views among the populace, but it is also true internationally, in terms of global governance and policy. Specifically, the forms of genital cutting that are currently normalised in the USA—internationally, the most powerful geopolitical actor for more than half a century—are openly allowed in virtually every jurisdiction, and widely seen as being positive or neutral; whereas the forms that are considered “foreign” to US culture have been criminalised in

many parts of the world, as well as roundly condemned as violations of human rights. (This may also have something to do with the overrepresentation of US Americans, and US funding, in international health and human rights agencies.)

Thus, for example, we find that both nontherapeutic penile circumcision (a popular US birth custom) and intersex 'normalisation' surgeries (introduced into modern medicine primarily by US doctors) are widely permitted, even when performed on infants and children who cannot consent. Meanwhile, female genital "cosmetic" surgeries, including labiaplasty, can be performed on teenage girls in Western countries without any legal or professional consequences. And yet, anatomically similar female practices associated with cultures of the Global South, and thus alien to Western culture, are categorically banned in all their forms—from the smallest "prick" to infibulation. In some countries, including England and Australia, this prohibition extends even to medicalised forms of such cutting irrespective of a woman's consent.

Whether such apparently "gerrymandered" distinctions can be sustained is an open question. Certainly, the articles collected here call for greater appreciation of the ways in which processes and practices of genital modification resist easy answers. To assume that any form of genital cutting or modification is as simple as a government, NGO, or researcher might prefer for it to be is to misunderstand the place of genitals in the past and in the present, both for individuals and for society. Ultimately, we need theories—scientific, social and ethical—that can accommodate the actual, lived diversity of female, male, and intersex genital cutting practices without simply privileging the customs of more powerful individuals and agencies within and between societies.

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