



## Medically Unnecessary Genital Cutting and the Rights of the Child: Moving Toward Consensus

### The Brussels Collaboration on Bodily Integrity

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# Medically Unnecessary Genital Cutting and the Rights of the Child: Moving Toward Consensus

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What are the ethics of child genital cutting? In a recent issue of the journal, Duivenbode and Padela (2019) called for a renewed discussion of this question. Noting that modern health care systems “serve individuals with a wide array of preferences about how their bodies should look and function,” they asked how physicians and policymakers should respond to requests for procedures “that may be rooted in cultural or religious values, or perhaps ... social preference rather than good medical practice” (4). The impetus for their article was a recent high-profile U.S. federal court case—the first to test the 1996 American law prohibiting “female genital mutilation” (FGM). Legally, this term refers to the intentional cutting or sewing of “the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years.” No allowance is made for what the law calls “custom or ritual.” The sole exception is for medical necessity.<sup>1</sup>

We do not take a position on the legal merits of this sole exception. Instead, we seek to clarify and assess the underlying *moral* reasons for opposing all medically unnecessary genital cutting<sup>2</sup> of female minors, no matter how severe. We find that within a Western medicolegal framework, these reasons are compelling. However, they do not only apply to female minors, but rather to nonconsenting persons of any age irrespective of sex or gender.

Keeping our focus exclusively on a Western context for the purposes of this article, we argue as follows: Under most conditions, cutting any person’s genitals without their informed consent is a serious violation of their right to bodily integrity. As such, it is morally impermissible unless the person is nonautonomous (incapable of consent) and the cutting is medically necessary (Box 1).

For consensual cutting (i.e., cutting with the ethically valid consent of the affected individual), expected medical benefits or even nonmedical benefits may reasonably factor into a person’s decision to request a genital-altering procedure. A consenting individual can determine whether the downsides of the cutting are worth the expected upsides in light of their own considered preferences and values (Aurenque and Wiesing 2015). These preferences and values may often differ from those of the individual’s parents and may also vary substantially from person to person both within and across communities.

For nonconsensual cutting (i.e., cutting without the ethically valid consent of the affected individual), the threshold for proceeding should be higher. In other words, the mere prospect of health-related (prophylactic), sociocultural, faith-based, cosmetic, or other perceived benefits cannot normally justify the nonvoluntary infliction of an acute lesion, including tissue damage or removal—with the associated risks and potential long-

1 18 U.S. Code §116. Female genital mutilation: <https://www.law.cornell.edu/uscode/text/18/116>. A second exception is listed for certain obstetric procedures carried out by a licensed medical practitioner in connection with childbirth; however, conceptually, these fall under the same definition of medical necessity employed in Box 1. Note: We do not assume that the capacity to provide ethically valid consent to medically unnecessary genital cutting is necessarily tied to the age of legal majority, such as 18 years as in the federal statute. In some cases, persons under the age 18 may have sufficient maturity to make an adequately informed decision about whether to undergo a given body modification that may not be strictly medically necessary (see Murphy 2019). We do not enter into the philosophical debate about the precise conditions under which a legal minor can provide ethically valid consent to various procedures. However, the developing autonomy of young people is an important factor and we affirm that their considered preferences and values about their bodies should be taken seriously at any age (Alderson 2017; Earp 2019).

2 We follow Duivenbode and Padela (2019) in using the term “genital cutting” rather than “genital mutilation” to refer to the diverse set of practices described in Box 2, apart from our reference to the U.S. legal term and to the World Health Organization typology where applicable. For detailed discussions about this choice in terminology and the relevant background issues, see, e.g., Bell (2005), Brink and Tigchelaar (2012), Davis (2001), Johnsdotter (2018), Njambi (2004), and Onsongo (2017). For a contrary perspective, see Burrage (2015).

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term consequences, both physical and psychological—on the most intimate part of another person’s body (Goldman 1999; Smith and Stein 2017).

**Box 1 What makes an intervention medically necessary?**

Although the term is left undefined in the federal statute, a common understanding is that an intervention to alter a bodily state is medically necessary when (1) the bodily state poses a serious, time-sensitive threat to the person’s well-being, typically due to a functional impairment in an associated somatic process, and (2) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat (Earp 2019). “Medically necessary” is therefore different from “medically beneficial,” a weaker standard, which requires only that the expected health-related benefits outweigh the expected health-related harms. The latter ratio is often contested as it depends on the specific weights assigned to the potential outcomes of the intervention, given, among other things, (a) the subjective value to the individual of the body parts that may be affected, (b) the individual’s tolerance for different kinds or degrees of risk to which those body parts may be exposed, and (c) any preferences the individual may have for alternative (e.g., less invasive or risky) means of pursuing the intended health-related benefits (Darby 2015). We argue that although the weaker, “medically beneficial” standard may well be appropriate for certain interventions into the body, it is not appropriate for cutting or removing healthy tissue from the genitals of a nonconsenting person. If someone is capable of consenting to genital cutting but declines to do so, no type or degree of expected benefit, health-related or otherwise, can ethically justify the imposition of such cutting. If, by contrast, a person is not even capable of consenting due to a temporary lack of sufficient autonomy (e.g., an intoxicated adult or a young child), there are strong moral reasons in the absence of a relevant medical emergency to wait until the person acquires the capacity to make their own decision.

As Munzer (2018) argues, materially and symbolically “salient” parts of the human body, such as the face, breasts, vulva, or penis, are “socially important and valued, and are often considered striking or tied to a person’s sense of identity” (p. 18). Because of a child’s unique vulnerability and the close relationship of the genitals in particular to one’s embodied sexuality, “interfering with a child’s genitals [has exceptional] salience compared to interference in the absence of a medical indication with many other parts of a child’s body,” and is “generally worse” than other such forms of interference (17–18).

How do these observations apply to the recent court case? The defendants were members of the Dawoodi Bohra, a religious sect within the Musta’li Isma’ili Shi’a branch of Islam, who were living in Detroit, MI, where the alleged cutting took place. According to the available evidence, the form of female genital cutting typically performed among the Dawoodi Bohra is the scraping, nicking, or partial removal of the clitoral prepuce or hood: FGM Type IV or Ia on the World Health

Organization (WHO) typology (Bootwala 2019; see Box 2). As alluded to by Duivenbode and Padela (2019), such partial removal or reshaping of the clitoral hood, along with certain modifications of the labia and related procedures, are commonly classified as “cosmetic” genital alterations when requested by adults over the age of 18 years. It is thus plausible that the sheer alteration of healthy female genital tissue is not inherently mutilating (or a net harm) as implied by the WHO (see Box 2), insofar as the individual desires the alteration, is competent to consent to it, and regards it as a bodily enhancement.

There may of course be other reasons to object to medically unnecessary genital alterations even in consenting adults (e.g., the reinforcement of problematic norms). But insofar as “mutilation” is meant to signal a moral problem, it is plausibly the nonconsensual nature of such alterations that is most relevant to their suspect ethical status. That Duivenbode and Padela (2019) fail even to mention consent in their discussion is striking.

What could explain this omission? “Botox clinics,” Duivenbode and Padela (2019) observe, “help some people look younger, and breast augmentation might help others feel more attractive—such procedures are part and parcel of some doctors’ daily practices.” Ostensibly in the same vein, they continue, “[n]early 80% of American men are circumcised for religious/cultural reasons, despite the health benefit remaining ambiguous” (5).

But that is not quite right. Genitally intact American men are not typically subjected to circumcision: Without their consent this would be criminal assault and battery. Neither does any substantial proportion of such men pursue circumcision voluntarily for health-related or other reasons. Rather, in the United States—in contrast to most other Western countries—a majority of male infants are routinely circumcised for cultural or (far less often) religious reasons at the behest of their parents (for discussion, see Earp and Shaw 2017). This uncomfortable fact cannot be avoided by simply conflating such things as voluntary Botox administration or breast augmentation with nonvoluntary genital cutting of healthy children. Consent makes a moral difference (Alderson 2017; Archard 2007).

In the Detroit case, the alleged ritual cutting of girls was done by a physician, with sterile equipment, in a clinical environment—contrary to the popular stereotype about such cutting maintained by Western media (Bader 2019). However, the fact that nonvoluntary genital cutting can sometimes be made less physically, if not emotionally, harmful through medicalization does not necessarily make it any less wrongful. A person can be wronged without being harmed, and vice versa (Archard 2007). In bypassing (or preempting; see Möller 2017) a person’s ability to set and maintain their own bodily or sexual boundaries, nonconsensual genital cutting may wrong the person regardless of the level of harm caused, unless, as noted, the person is nonautonomous and the cutting is medically necessary—and thus cannot reasonably be deferred (see Box 3 for further discussion).

**Box 2. Non-Western “FGM” as compared to Western-style “cosmetic” female genital cutting. Adapted from Shahvisi and Earp (2019); internal references omitted.**

Category	<p>“Female genital mutilation” (FGM) as defined by the WHO: namely, all medically unnecessary procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs—widely condemned as human rights violations and thought to be primarily nonconsensual</p>	<p>Female genital “cosmetic” surgeries (FGCS): widely practiced in Western countries and generally considered acceptable if performed with the informed consent of the individual (cf. intersex cases, which are still primarily nonconsensual)</p>
Procedures + WHO typology	<p>Type I: <b>Alterations of the clitoris or clitoral hood</b>, within which Type Ia is partial or total removal of the clitoral hood, and Type Ib is partial or total removal of the clitoral hood and the (external portion of the)* clitoris [i.e., glans and sometimes part of the body]</p> <p>Type II: <b>Alterations of the labia</b>, within which Type IIa is partial or total removal of the labia minora, Type IIb is partial or total removal of the labia minora and/or the (external)* clitoris, and Type IIc is the partial or total removal of the labia minora, labia majora, and (external)* clitoris</p> <p>Type III: <b>Alterations of the vaginal opening</b> (with or without cutting of the clitoris), within which Type IIIa is the partial or total removal and appositioning of the labia minora, and Type IIIb is the partial or total removal and appositioning of the labia majora, both as ways of narrowing the vaginal opening**</p> <p>Type IV: <b>Miscellaneous</b>, including piercing, pricking, nicking, scraping, and cauterization</p>	<p><b>Alterations of the clitoris or clitoral hood</b>, including clitoral reshaping, clitoral unhooding, and clitoroplasty (also common in “normalizing” intersex surgeries)</p> <p><b>Alterations of the labia</b>, including trimming of the labia minora and/or majora, also known as “labiaplasty”</p> <p><b>Alterations of the vaginal opening</b> (with or without cutting of the clitoris), typified by narrowing of the vaginal opening, variously known as “vaginal tightening,” “vaginal rejuvenation,” or “husband stitch”</p> <p><b>Miscellaneous</b>, including piercing, tattooing, pubic liposuction, and vulval fat injections</p>
Examples of relatively high-prevalence countries	<p>Depending on procedure: Burkina Faso, Chad, Cote d’Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Indonesia, Iraqi Kurdistan, Liberia, Malaysia, Mali, Mauritania, Senegal, Sierra Leone, Somalia, Sudan, and concomitant diaspora communities</p>	<p>Depending on the procedure: Brazil, Colombia, France, Germany, India, Japan, Mexico, Russia, South Korea, Spain, Turkey, the United States</p>
Actor	<p>Source: UNFPA Traditional practitioner, midwife, nurse or paramedic, surgeon</p>	<p>Source: ISAPS Surgeon, tattoo artist, body piercer</p>
Age at which typically performed	<p>Depending on the procedure/ community: typically around puberty, but ranging from infancy to adulthood</p>	<p>Typically in adulthood, but increasingly on adolescent girls or even younger minors; intersex surgeries (e.g., clitoroplasty) more common in infancy, but ranging through adolescence and adulthood</p>
Presumed Western legal status	<p>Unlawful</p>	<p>Lawful</p>

(Continued)

**Box 2. discussion.** Given that there is overlap (or a close anatomical parallel) between each form of WHO-defined “mutilation” and Western-style FGCS, neither of which is medically necessary, one must ask what the widely perceived *categorical* moral difference is between these two sets of procedures. Controlling for clinical context—which varies across the two sets and is often functionally similar—the most promising candidate for such a difference appears to be the typical age, and hence presumed or likely consent-status, of the subject. Indeed, this perceived difference in consent-status accounts for the troubling racial double standards observed in some Western countries, whereby women from minority communities (typically of color) will be denied genital-altering procedures offered to women from the majority culture (typically white); the presumption appears to be that the former, but not the latter, are incapable of consenting to the medically unnecessary cutting of their own genitals (for discussions, see Boddy 2016; Conroy 2006; Dustin 2010; Shahvisi 2017). In any case, it does not appear to be the degree of invasiveness (which ranges widely across both sets of practices), specific tissues affected, or the precise medical or nonmedical benefit-to-risk profile of medically unnecessary female genital cutting that is most central to determining the moral acceptability. Rather, it is the extent to which the affected individual desires the genital cutting and is capable of consenting to it. The same principle, we suggest, should apply to persons of all sexes and genders.

\*We have added the qualification in parentheses. This is because the official WHO typology wrongly equates the external, visible portion of the clitoris with the entire clitoris, thereby diminishing the anatomical and sexual significance of the latter. Most of the clitoris, including the majority of its erectile tissues and structures necessary for orgasm, is underneath the superficial skin layer of the body—like an iceberg—and therefore cannot be removed without major surgery (which does not occur in any recognized form of FGM; see Abdulkadir et al. 2016). This may help to explain why, contrary to popular belief in Western societies, women and girls who have been subjected to WHO-defined FGM of various types usually retain the ability to experience orgasm and can experience sexual pleasure (Ahmadu and Shweder 2009; Catania et al. 2007). This does not, of course, mean that the sexual experience of these women and girls is no different than it would have been without the cutting, nor that the cutting is risk-free with respect to potential sexual harms. Rather, it is to dispel the common myth that FGM is sexually disabling per se—a myth that may itself cause harm to women and girls who have experienced FGM and believe that they are (therefore) incapable of sexual enjoyment (Mohamed et al. *in press*).

\*\*In practice, the most severe instances of medically unnecessary narrowing of the vaginal opening regarded as infibulation (FGM) leave a smaller introitus and often cause greater functional difficulties than analogous procedures regarded as “vaginal rejuvenation” (FGCS). However, the WHO typology does not distinguish between more or less constrictive outcomes in its definition of Type III FGM, and both infibulation and “vaginal rejuvenation” fall on a spectrum. Thus, there is no anatomically definite line between them, and in some cases they may be practically indistinguishable: e.g., partial re-infibulation versus a so-called “husband stitch” (Edmonds 2013; Foster 2016).

As Duivenbode and Padela (2019) emphasize, the Dawoodi Bohra also practice ritual cutting of boys within their community—namely, male circumcision—and they do so for similar religious reasons, citing in support of both practices a non-Quranic source of Islamic jurisprudence known as the *da’a’im al-Islam* (see Bootwala 2019).<sup>3</sup> Here, circumcision refers to the partial or total removal of the penile prepuce, a highly sensitive

sleeve of functional tissue comprising about half of the motile skin system of the penis (Cold and Taylor 1999; Taylor et al. 1996). Consequently, the typical form of religiously motivated male genital cutting among the Dawoodi Bohra is markedly more invasive than the typical form of such cutting of females within the same community. As Davis (2001) argued nearly 20 years ago, a “collision course” in Western law and policy is created when nonconsensual, medically unnecessary genital cutting of boys is tolerated for any reason, but more minor forms of such cutting of girls are criminally forbidden regardless of the reason in the same regimes.

The “crash,” we suggest, may have just happened in the federal case. Rather than ruling on the merits, Judge Bernard A. Friedman struck down the 1996 American law as unconstitutional, citing jurisdictional constraints. Congress, he argued, did not have the authority to pass a nationwide ban on FGM because it is “local criminal activity,” which is the province of the states. He thus

3 This is a general pattern, in that virtually all groups that practice ritual female genital cutting also practice ritual male genital cutting—but not vice versa—often in parallel ceremonies for similar reasons. “It has been suggested that in many societies, female circumcision was introduced in imitation of the male ritual. Rationales for circumcision of boys and girls vary with local context, but the genital modifications are often performed *with similar motives irrespective of gender*: to prepare the child for a life in religious community, to accentuate gender difference and to perfect gendered bodies, for beautification, for cleanliness, to improve the social status of the child through ritual, and so on” (Johnsdotter 2018, p. 22, emphasis added).

avoided confronting the equal protection issue at the federal level, whilst appearing to be aware of its existence: “As laudable as the prohibition of a particular type of abuse of girls may be,” he wrote, “it does not logically further the goal of protecting children on a nondiscriminatory basis.”<sup>4</sup>

**Box 3. Genital contact in a health care context: harming versus wrongdoing**

One exception to the general prohibition on adults touching children’s genitals pertains to necessary parental (or equivalent) care: for example, changing diapers or help with washing. But this exception applies only insofar as the child requires such help; a parent or caregiver who continued to wash a child’s genitals when the child was capable of such washing on their own would likely be acting inappropriately. Similarly, a doctor or other health care professional who handled—much less cut into or removed tissue from—a child’s genitals beyond what was strictly necessary for diagnosis or treatment would almost certainly be crossing an ethical line. If the child-patient happened to be unconscious or otherwise did not remember the medically unnecessary genital touching (or cutting), this would not normally render the action morally permissible. Thus, although the level of physical or emotional harm caused by genital cutting is one important moral consideration, such that, all else being equal, more harmful cutting is worse than less harmful cutting, the threshold for wrongdoing a nonconsenting person in this context is “mere” medically unnecessary genital touching. A fortiori, nonconsensual nicking, piercing, or other genital cutting or alteration—all of which are more intrusive and typically more painful than “mere” touching—wrong the child irrespective of the level of harm caused, insofar as they are not medically required. More broadly, trust in the medical profession may be damaged when health care providers perform medically unnecessary procedures on the genitals of nonconsenting persons (Barnes 2012).

Another recent legal development concerns a bill in California, introduced but later tabled, that sought to outlaw medically unnecessary “intersex” surgeries, including so-called “feminizing” clitoroplasty, before an age of consent (Gutierrez 2019). The purported goal of most such surgeries is to make the child’s genitals appear more stereotypically masculine or feminine, which some have presumed, albeit without strong

evidence, to be important for their psychosocial development. However, a growing number of individuals subjected as children to such genital cutting claim to have been seriously harmed by what was done to them when they were incapable of understanding the risks and consequences. Moreover, some express great resentment about what they consider a violation of their human rights (Garland and Travis 2018; Human Rights Watch 2017; Monro et al. 2017).

Similar claims are made by a growing number of individuals subjected to medically unnecessary female and male forms of childhood genital cutting, even in societies where such cutting, including relatively minor forms, is culturally normative (Earp and Darby 2017; Hammond and Carmack 2017; Johnsdotter 2019; Moore 2015; Varagur 2016). At a recent global experts meeting on female genital cutting in Brussels, Belgium, in which many of the present authors participated (see Appendix for details), it was widely agreed that the ethics of female, male, and intersex cutting must be considered together. What do ritual nicking or partial removal of the clitoral hood, routine or religious excision of the penile prepuce, and cutting of the healthy clitoropenile organ in cases of perceived ambiguity have in common?

Among other shared features, they are all (1) medically unnecessary acts of (2) genital cutting that are (3) overwhelmingly performed on young children (4) on behalf of norms, beliefs, or values that may not be the child’s own and which the child may not adopt when of age. Indeed, such norms, beliefs, or values are often controversial in the wider society and hence prone to reevaluation upon later reflection or exposure to other points of view (e.g., the belief that a child’s body must conform to a strict gender binary; that surgery is an appropriate means of pursuing hygiene; that one’s genitals must be symbolically purified before one can be fully accepted; and so on). In this, they constitute painful intrusions into the “private parts” of the most vulnerable members of society, despite being of highly contested value overall (Chambers 2018; Sarajlic 2014). This is in contrast to medically necessary interventions (Box 1), which are almost universally valued—that is, valued irrespective of local epistemologies, individual bodily preferences, religious commitments, or cultural background—which explains why such interventions are usually permissible even in temporarily nonautonomous persons (Earp 2019).

Duivenbode and Padela (2019) are right to note that “procedures performed within the confines of a health care system are not always directly related to health outcome benefits.” As they go on to state, “Our individual preferences, cultural and religious values, and societal norms necessarily inform some of what doctors do” (5). But it matters who “we” are when considering “our” preferences and values. If the imagined individual is a baby or young child, we do not yet know what their preferences or values will be when they grow up. This is especially true in present-day multicultural societies in

4 The “local criminal activity” he had in mind appears to be physical assault. See *United States v. Jumana Nagarwala et al.*, No. 17-cr-20274 (E.D. Mich. Nov. 20, 2018) <https://www.scribd.com/document/393706333/Judge-dismisses-several-charges-in-FGM-case#download> (the quotation from Friedman is also from this ruling). For a recent argument that medically unnecessary female and male genital cutting are already unlawful, as physical assault, if performed without the person’s own consent—that is, without the need for a special statute “banning” either one—see Svoboda, Adler, and Van Howe (2016, 2019). For a discussion of competing religious claims in law, e.g., with respect to Judaism or Islam, see Merkel and Putzke (2013). See also Aurenque and Wiesing (2015).

the age of the Internet. People encounter many different ways of life. Many reconsider or even reject the cultural traditions or religious beliefs with which they were raised (Johnsdotter 2019; Pew Research 2018). When it comes to such personal, subjective, and often strongly emotional matters as the state of one's own sexual or reproductive organs, the grounds for predictive certainty are even less secure (Earp and Darby 2017).

A child's right to bodily integrity may not be absolute (Mazor 2019). But in most cases, medically unnecessary, nonconsensual genital cutting will not pass a threshold of being clearly in the child's long-term best interests (which includes their weighty interest in being able to decide about such high-stakes bodily interventions for themselves) so as to make it morally permissible (Fox and Thomson 2017; Schüklenk 2012). Certainly, this is the case in Western countries with a strong tradition of individual rights, such as the United States. In these countries, children are taught from a young age that their genitals are not even to be touched by others, apart from required medical examinations or other limited exceptions (Box 3), before they can exercise their sexual autonomy (Earp and Steinfeld 2018; Townsend 2019).

Accordingly, social change efforts in such countries should aim to protect all nonconsenting persons, regardless of sex or gender, from medically unnecessary genital cutting. We do not suggest that criminal sanctions are necessarily an appropriate mechanism for pursuing such efforts, especially insofar as such sanctions tend to be selectively applied to members of already-marginalized groups (Ben-Yami 2013; Berer 2015; Creighton et al. 2019; Johnson 2013). Rather, clear ethical statements from professional medical bodies; social campaigns geared toward education and consciousness-raising; respectful debate and dialogue among interested parties; moral and material support for dissenters from within practicing communities; and non-hypocritical cross-cultural engagement will be important for making sustainable progress. Meanwhile, as Davis (2001) noted all those years ago, "as long as the U.S. continues to countenance" routine and religious circumcision of infant males, or as we explore in Box 2, supposedly "cosmetic" genital operations on non-consenting female or intersex minors, "the criminalization of even the 'ritual nick' cannot fail to dilute the persuasiveness of the official stance against [non-Western forms of female genital cutting], while carrying the unmistakable taint of intolerance and double standards" (567).

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## APPENDIX. ABOUT THE AUTHORS

This work grew out of informal discussions among participants in the G3 International Experts Meeting on FGM/C in Brussels, Belgium, May 20–22, 2019, along with other scholarly collaborators. We are physicians, ethicists, nurse-midwives, public health professionals, legal scholars, political scientists, anthropologists, psychologists, sociologists, philosophers, and feminists from Africa, Asia, Australasia, Europe, the Middle East, and the Americas with interdisciplinary expertise in child genital cutting practices across a wide range of cultural contexts. Although we do not necessarily share a single policy perspective with respect to such practices, nor a uniform moral assessment of every feature of them, we are united in a concern about widespread inaccuracies, inconsistencies, double standards, and Western cultural bias in the prevailing discourses on genital cutting of children. Some of us have evolved in our thinking over the years in response to scholarship illuminating such problems (e.g., Abdulcadir et al. 2012; van den Brink and Tigchelaar 2012; Bell 2005; Darby and Svoboda 2007; Davis 2001; DeLaet 2009; Earp 2015; Earp et al. 2017; Ehrenreich and Barr 2005; Johnson 2010; Merli 2010; Njambi 2004; Obiora 1996; Onsongo 2017; Svoboda 2013; Tangwa 1999). Together, we argue for a more coherent, sex- and gender-inclusive approach that recognizes (1) the special vulnerability of young

people—regardless of the ethnicity, religion, or immigration status of their parents—to medically unnecessary genital cutting and (2) the moral importance of bodily integrity, respect for bodily/sexual boundaries, and consent. The authors are listed alphabetically.

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