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Harms of the current global anti-FGM campaign

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Received 2 April 2025
Accepted 6 July 2025

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To cite: Ahmadu FSN, Bader D, Boddy J, *et al*. *J Med Ethics* Epub ahead of print: [please include Day Month Year]. doi:10.1136/jme-2025-110961

ABSTRACT

Traditional female genital practices, though long-standing in many cultures, have become the focus of an expansive global campaign against 'female genital mutilation' (FGM). In this article, we critically examine the harms produced by the anti-FGM discourse and policies, despite their grounding in human rights and health advocacy. We argue that a ubiquitous 'standard tale' obscures the diversity of practices, meanings and experiences among those affected. This discourse, driven by a heavily racialised and ethnocentric framework, has led to unintended but serious consequences: the erosion of trust in healthcare settings, the silencing of dissenting or nuanced community voices, racial profiling and disproportionate legal surveillance of migrant families. Moreover, we highlight a troubling double standard that legitimises comparable genital surgeries in Western contexts while condemning similar procedures in others. We call for more balanced and evidence-based journalism, policy and public discourse—ones that account for cultural complexity and avoid the reductive and stigmatising force of the term 'mutilation'. A re-evaluation of advocacy strategies is needed to ensure that they do not reproduce the very injustices they aim to challenge.

INTRODUCTION

In cultures around the world, people have, for millennia, engaged in a wide range of practices to modify human genitalia: through pricking or piercing; adornment with jewellery; stretching, cutting or excising tissues; or more recently, through surgical reshaping in a medicalised context. These practices may affect people of a wide range of ethnic identities and backgrounds; religious and secular people; people in the Global North and South; and people of a wide range of ages, from infancy to adulthood.[1] They may be medicalised or unmedicalised; voluntary or non-voluntary; and associated with different types or degrees of risk, as well as different potential benefits. These benefits—including perceived social benefits, such as a feeling of heightened connection to one's group—are commonly reported.[2–4] They need to be understood and acknowledged if one is to account for some groups' or individuals' commitment to take on or reproduce these genital practices.

Each of these various genital practices may elicit starkly different attitudes—from enthusiastic endorsement to harsh condemnation depending on one's values and point of view.[4] For example, some people strongly support transgender surgeries, including for legal minors (in select cases), but passionately object to physically similar surgeries in children born with intersex traits. Some people express outrage at ritual practices involving a 'prick' to the vulva of prepubescent girls, but show little concern for the ritual penile circumcision of newborn boys. Some people see cosmetic labiaplasty as an appropriate option for older adolescents, as long as they have parental permission, whereas others see the same practice as harmful and oppressive, even for consenting adults.

Different *moral* reasons—for and against these different practices—are also offered to justify certain positions. Some of these reasons focus on contested claims of harm or benefit; others focus on children's rights, consent and bodily autonomy; still others are grounded in notions of parental decision-making authority and the value of family privacy.[5 6]

Such debates and disagreements apply even to the present authors. Some of us, for example, are morally opposed to all genital 'cutting' practices that are neither strictly voluntary nor medically necessary, irrespective of the person's sex or gender. Others believe that religious or customary practices for boys, but not girls, should be allowed. Still others maintain it is up to parents to decide what is best for their children, and that the state should refrain from interfering with any culturally significant practices unless they can be shown to involve serious harm.

Despite our diverse disciplinary expertise in anthropology, sociology, psychology, criminology, law, gender studies, medicine and bioethics, we are united by one shared concern. This common ground has inspired us to collaborate across disciplines and perspectives to write this paper. Our primary concern here is to draw attention to the harms that may be caused by the lack of accuracy, objectivity, fairness and balance in public representations of these diverse practices.

Among other things, we are concerned that, out of all the genital practices alluded to above—carried out across cultures, age ranges, sexes and genders—there has been a systematic tendency to cordon off and single out, for purposes of condemnation and critique, *only* those practices affecting non-intersex females, and among these, *only* those

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that are customary in the Global South, especially in Africa (or in diaspora communities), while ignoring similar practices that have long been customary in powerful countries of the Global North.[1 3 5 7 8]

These female-only, Global South-associated practices have been collectively labelled by the WHO and various activist groups as 'Female Genital Mutilation' or 'FGM'. The label and its acronym thus conflate multiple distinct practices carried out by different groups for different reasons, while expressing a uniformly condemnatory judgement irrespective of harm level, medicalisation, religious or cultural significance to the family or community, or even the capacity of the individual to consent.[7 9 10] The WHO developed a typology loosely based on severity: type 1 affecting the clitoral prepuce and potentially also the clitoris tip; type 2 affecting the labia with or without also affecting the external clitoris, and type 3 including cutting and closure, or infibulation. Type 4 is added for other sorts of 'non-medical' procedures to the female genitalia deemed to be harmful, including 'pricking' or 'nicking' of the vulva without tissue removal.[11]

And yet, in virtually all of the societies where there is a high prevalence of 'female circumcision', male circumcision is also performed with an equivalent or even higher prevalence, often for comparable reasons, on children of similar ages under broadly similar conditions.[5 9 10 12]

Acknowledging ongoing controversies surrounding appropriate terminology (eg, female genital *mutilation* vs *modification* vs *cutting* vs *surgery* vs *circumcision*, and so on, all of which have their adamant defenders), we adopt the more neutral expression 'female genital practices' throughout this paper. This term allows us to refer inclusively and descriptively to a diverse set of practices without prejudging their ethical, medical or cultural status. We also use broader qualifiers such as 'African', 'South Asian', 'non-Western' or 'Global South' to indicate the sociocultural and geographical contexts in which these practices are commonly found. When citing laws, WHO classifications, advocacy campaigns or other sources that employ the term 'FGM', we retain their original language, placing 'FGM' in quotation marks to reflect its status as a contested and politicised label.

The most common explanations for why female-only, primarily African, practices should be treated categorically differently from all other comparable practices, whether on children or adults in the Global North or South, are based in large part on misleading, often racialised, stereotypes, unrepresentative extreme examples, Western sensationalism and cultural exceptionalism, exaggerations of risk, and not a small amount of misinformation (see box 1 for a brief overview of related points).

Here, we suggest that any critiques, campaigns, moral debates or legal reforms that *are* undertaken, whether now or in the future, should be based on high quality evidence, accurate generalisations, rational discussion, and above all, a fair and inclusive consideration of *all* forms of genital 'cutting' or 'modification'. In short, it is unacceptable to single out female-only, primarily African, practices for critique or advocacy.

The selective focus on 'FGM' in international advocacy campaigns and global health policymaking has had numerous unintended, harmful consequences for many of the women and girls these campaigns and policies are ostensibly trying to protect. In what follows, we highlight some of the most significant harms of the 'global anti-FGM campaign', with particular—though not exclusive—attention to its impacts on diaspora communities in the Global North.

Box 1 Highlights of 'Seven Things to Know About Female Genital Surgeries in Africa'.[52]

1. Research by gynaecologists and others has demonstrated that a high percentage of women who have had genital surgery have satisfying sexual lives, including desire, arousal and orgasm, and that the frequency of their sexual activity is also generally comparable to other women.
2. The widely publicised and sensationalised reproductive health and long-term medical complications associated with female genital surgeries in Africa are infrequent events and represent the exception rather than the rule.
3. Female genital surgeries in Africa are viewed by many insiders as aesthetic enhancements of the body and are not judged to be 'mutilations'.
4. Customary genital surgeries are not restricted to girls and almost always coexist with customary genital surgeries for boys.
5. The empirical association between patriarchy and genital surgeries is not well established.
6. Female genital surgery in Africa is typically controlled and managed by women.
7. The findings of the WHO Study Group on Female Genital Mutilation and Obstetric Outcome are the subject of criticism that has not been adequately publicised. The reported evidence does not support sensational media claims about female genital surgery as a cause of perinatal or maternal mortality.

The silencing of alternative voices

The different voices of African and other affected women from practising communities are particularly important in understanding the diversity of their experiences. But the global advocacy discourse prioritises one set of views—the so-called 'standard tale' of 'female genital *mutilation*'.[6 13 14] The term 'mutilation' was introduced to a wider international audience during the World Conference on Women in Copenhagen in July 1980, where Fran P Hosken, a Western activist and outsider to the communities in question, presented on the issue. Her presentation drew criticism from many African women, some of whom boycotted the session in protest, viewing her perspective as ethnocentric and insensitive to their lived realities. This protest became emblematic of broader frustrations with the dominance of Western narratives in discussions about female genital practices.[15 16]

In the decades since, the terminology and accompanying narrative have gained widespread traction, becoming the dominant global framing. They are now frequently reinforced through popular accounts—such as those published by supermodels,[17] whose personal experiences are seen as representing all women affected by cultural or religious-based female genital practices—and marginalises the voices and experiences of women and communities who hold other views of these practices.[2–4 13 14 18 19]

Second-wave Western feminists who popularised the standard tale saw the various female genital practices of African and South Asian women as emblematic of women's universal suffering under patriarchy, and affected women were framed as victims.[20 21] Today the victim/mutilation narrative is hegemonic: it informs media, government and international organisations' responses to all forms of female genital practices originating beyond the Global North or among diasporic communities within it.[3 6 10 14 19] Its hegemony is maintained when those who

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presuppose its truth silence voices and elide practices that defy the standard tale.[8 14 18 19] This hegemony in global advocacy discourses closely mirrors the broader dominance of powerful Western actors in global politics, where Western priorities, perspectives and frameworks often shape international agendas and marginalise local voices and alternatives.[7]

Despite the laudable ideal for journalists to look at all sides of any story, mainstream media coverage of female genital practices in Africa has been heavily reliant on sources from within a well-organised opposition movement and has selectively promoted and all too often acted in the interest and service of activist organisations. In North America, Australia and European countries like the UK and Sweden, such coverage has frequently fallen short of journalistic standards of impartiality, often using stigmatising and denigrating language that fuels suspicion and surveillance of migrant communities.[22–24]

Mainstream news outlets in these Western countries have played a central role in constructing and amplifying the dominant, abolitionist narrative of 'FGM', rarely including dissenting or contextualised community voices. One prominent example is *The Guardian*'s Global Media Campaign to End FGM, notably endorsed by then UN Secretary-General Ban Ki-moon.[25] Similarly, the *BBC* and *CNN* have featured advocacy-driven coverage focused on eradication, often lacking cultural nuance.[26 27]

Social media platforms—such as Twitter, Facebook and YouTube—have enabled transnational debate. However, these online spaces are also marked by cyber abuse, 'clicktivism' and the widespread dominance of the standard tale, which tends to silence alternative perspectives—especially those of women from practising communities who do not identify as victims.[28] These dynamics underscore the need for more balanced, evidence-based journalism that acknowledges the diversity of practices and experiences and avoids the reductive and stigmatising force of the term 'mutilation'. Here we note some ways that this silencing of alternative views takes place in the hope that a fuller and more equitable perspective can result.

The sharp distinction drawn by Western publics between 'traditional' ('FGM') and biomedically approved ('FGCS', female genital cosmetic surgery) female genital practices also maintains the hegemony of the standard tale.[7 8 29–32] Labiaplasty, a cosmetic surgery in which the female genitals are pared and reshaped, is gaining popularity in the Global North. Some of its forms fall squarely within the WHO's guidelines as FGM, type 2, and possibly type 3.[31]

Though for the most part medically unnecessary and primarily performed for aesthetic reasons, such cosmetic surgeries are legitimised in Western law and discourse and are also performed on under-18 girls.[33] Yet aesthetic rationales for African, Islamic or other non-Western-associated female genital practices (eg, an appreciation in parts of North-East Africa for a 'smooth and clean' genital look)[4 29 30] are routinely overlooked or dismissed. Non-Euroamerican communities who claim to cut for aesthetic reasons, including the creation or enhancement of bodily integrity (affirming or producing femininity), are thus silenced, seen as lacking the capacity to think purposefully about their practices. There is thus evidently a double standard, in that operations devised by biomedically trained plastic surgeons and cosmetic gynaecologists for girls of the Global North, including children as young as nine and ten, are tacitly approved by governments and intergovernmental agencies, while anatomically similar procedures performed elsewhere and on others are condemned.[1 5 7 8 10 29–34] The ethnocentric and racialising bias of such judgements is clear. Refusing to include female genital cosmetic surgeries in WHO categories of 'FGM' reinforces the idea that African or South Asian female genital practices are something unique, not to be considered on a continuum with genital practices in Western societies. This facilitates stereotyping and supports a dubious distinction between 'them'—barbaric others—and 'us'—the civilised, biomedically informed.[1 3 7 8 10 14 18 29–34]

One might also point to the tyranny of 'types' promulgated by the standard tale. Despite being the least common, infibulation (the sewing together of the outer labia, type 3) has come to stand for all forms of female genital practices in the popular imagination. Thus, communities that practise other forms, such as some Shia Muslims, who reportedly excise a small amount of skin from a girl's prepuce, the so-called clitoral hood, as a religious duty and rite of inclusion, are immediately deemed 'mutilators'.[35] While some Shia and some Sunni Muslims argue that a notion of gender equality underlies the practice—in communities where both boys and girls undergo ritual circumcision—the use of the term 'mutilation' shuts down meaningful dialogue.[3 6 10 18 19 35 36]

In contrast, boys who undergo circumcision, whether performed by so-called traditional operators or medically trained personnel, are rarely considered victims of mutilation, and the various forms of male genital practices—some as altering as infibulation—elude equivalent scrutiny. Also, the ideology of gender binarism, that asserts there can be only two genders, determined by biological sex—which is predominant in the Global North—influences biomedicine. In the case of so-called intersex 'normalization surgeries' for children born with 'ambiguous' genitalia, the rationale—to conform an individual's body to cultural expectations for one's expected gender—shares similarities with rationales for some traditional or religious genital practices.[10 37 38] However, the cachet of biomedicine insulates these operations from being discussed and evaluated within the terms of a common ethical framework.[3 5–10 14 19 31]

The hegemony of the standard FGM discourse is also evident when, to secure resources, those who are employed by quasi-political global institutions to do health and development work must frame their activities in its terms. Efforts to improve conditions in accord with local priorities thus depend on local actors adhering to external donors' views, with home-grown initiatives, such as medical safety or modified 'cutting', being obscured and un(der)funded.[8 14]

We need to ask: What is lost in this process of silencing? Which cultural meanings are flattened out? What sensibilities are masked? In short, what obstacles to the understanding of global social and moral complexity does the standard narrative produce? Further debates and disagreements should be carried out with all ideas and all practices on the table, without shaming and silencing those whose experiences are not in line with the standard tale of 'FGM'.

Healthcare

Practices conceived of as 'female genital mutilation' are condemned by politicians, campaigners and health practitioners, who contend that they generate long-term psychological trauma and physical health complications that cannot be consented to even by adult women.[39] This orthodoxy is complicated by the fact that 'FGM' is an umbrella term covering a wide range of practices with widely varying health risks.

What is almost entirely absent from the public conversation on 'FGM' is discussion of the ways in which the dominant discourse on 'FGM' can *itself* be damaging to the health and well-being of those within associated communities. In this section, we review some of these harms by considering the clinical encounter, the effects on communities and services, and the broader impact on

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our knowledge and on the fidelity of our representations of little known 'others'.

Non-Western-associated forms of and rationales for female genital practices are highly politicised, and Western governments are keen to demonstrate their management of the issue by creating and maintaining bureaucracies to gather information on the populations who are believed to be affected. Due to its intimate nature, healthcare settings have become a major site of such data collection. As a consequence, nowhere are the problems with the anti-FGM discourse more immediate than in patients' encounters with medical professionals, where attempts to seek healthcare become, for particular racialised groups, sites of state surveillance and policing.[39–42]

In various jurisdictions, medical professionals are encouraged, even required, to gather information about 'FGM', even in the context of consultations which are unrelated to the practice.[39–43] This creates a situation which may be damaging for those seeking care as well as for healthcare professionals unable to reconcile this surveillance duty with their personal and professional ethical principles.[44] Particularly when the patient's presenting complaint is unrelated to any prior genital procedure, such data gathering risks undermining the provision of effective healthcare, by drawing focus away from a patient's needs. Rather than simply someone in need of support for a specific health concern, the patient becomes a victim, perpetrator or criminal, with the confidential space of encounter intruded on by biopolitical concerns which ignore these immediate needs.[40–42] Attempts to seek healthcare may be reduced to disrespectful or humiliating interrogations about their genitals, which distract from effective history-taking, diagnosis and treatment of active medical issues and directly contribute to a sense of violation of integrity.[40–42 45 46]

Furthermore, such conversations may be (re)traumatising.[40 42 47] Healthcare providers' preconceived notions, based on problematic political narratives about the 'typical' experiences of affected women, encourage ill-considered and unfounded assumptions about adult women's health, including sexual health, based on what are assumed or imagined to be their past experiences.[47] Health professionals readily frame the experiences of affected women as 'child abuse', but do not commit to protect its victims from reliving these experiences with the same protective zeal afforded to others.[40–42 47] In the face of a pattern of interactions along these lines in clinical encounters, it is not surprising that those with heritage in affected groups at times disengage from healthcare,[46 47] resulting in worse health outcomes in other domains. The negative health impacts of prejudiced information-gathering are thus threefold: distress produced by the questioning itself, and consequences of that distress; inaccuracy in diagnosis and care; and vulnerable populations' loss of trust in and subsequent eroded engagement with healthcare services.[47–49] This aligns with the results of research regarding the health impacts of racism that shows that problems arising during individual clinical encounters can undermine the institutional trust and engagement, and consequently the health, of the wider community with heritage in affected groups.[8 40–42 45 50]

The dominant discourse on 'FGM' is primarily produced by politicians, campaigners, intergovernmental organisations and the media—each of which has a stake in constructing and defending a particular ideological stance in relation to these practices.[3 14] While any expectation of entirely 'value-free' analyses and studies is unrealistic, more nuanced, evidence-based work by clinical researchers and social scientists has had limited influence on the prevailing discourse, including within medicine.

This leads to a separate set of concerns, which in turn affect policy and services. For example, the umbrella term 'female genital mutilation' and the commonly used WHO typology discussed above, conflate many disparate practices while also, some would say, 'gerrymandering' out others (such as cosmetic labiaplasty) that have been deemed to have vaguely medical purposes.[3 14 51] These socially constructed categories are treated as medically significant tools of demarcation and degrees of harm, and yet the evidence is inadequate to make such judgements.

Existing research on longer-term health complications (obstetric and otherwise) and the causal mechanisms that may be involved is often of poor quality.[3 51–53] In many Global North countries, the degree of political, media and medical attention afforded to practices prevalent in some Global South countries is not proportionate.[6] Research, training and interventions which bolster the standard tale tend to attract a disproportionate share of funding and attention, at the expense of other, more urgent, health issues which may affect the same communities.[51] Funding for research on female genital practices classified as 'FGM' is highly politicised due to the strength of the prevailing paradigm. Approaches aligned with the dominant discourse are prioritised over those based on alternative biomedically sustainable hypotheses. The literature on female genital practices prevalent in the Global South is accordingly skewed towards the dominant discourse.[3 51]

Funding for such research and services tends to focus on prevention of these practices and criminalisation of affected women, rather than on providing care to those living with any long-term consequences. Similarly, data collection for policing purposes is privileged above patient well-being. Failures at the clinical and community level result in particular communities withdrawing from healthcare, leading to lacunae in knowledge and data on other health issues and increasing the risk of maltreatment.

Trauma and harm

The link between 'female genital mutilation' and trauma is often presumed rather than investigated. WHO asserts: '[FGM] is known to be harmful to girls and women in many ways. First and foremost, it is painful and traumatic'(p1).[54]

People often use 'trauma' for any sort of emotional distress or disturbance, but there are many definitions of trauma, emanating from a broad range of disciplines. What is and is not traumatogenic (trauma-inducing) varies across sociopolitical context and time. Trauma and its symptoms 'do not exist in a political vacuum',(p34).[55] but rather political, social and legal norms inform reactions to experiences that may or may not be experienced as traumatic. While certain female and male genital practices, whether they are called mutilation, circumcision or surgery, can be painful or traumatic, any broad characterisation of 'FGM' as *first and foremost* traumatic is problematic and misleading for a number of reasons.

It is crucial to recognise that trauma is a complex phenomenon which does not necessarily accompany all forms of pain, injury or 'cutting' (whether surgical or incidental). In the terms of psychological and psychoanalytical practitioners and theorists, trauma is the development of symptoms that accompany an experience that is 'unassimilable'.[56] Traumatic symptoms appear at the point at which an experience does not, effectively, make sense and this can be in the present or retrospectively. The challenge to assimilation, however, may stem from Western health narratives that are presumptive about the effects of female genital practices among African or South Asian women and furthermore take for granted that the individual is paramount over the community.

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Anthropological work on personhood and identity has looked at the ways in which the 'I' may be connected to the larger kin group or community. One's body may be perceived as belonging to a larger group with which a person strongly identifies, rather than being subject to individual choices and preferences. This strong sense of identity, as belonging to a particular kin group, age set, ethnic group or religious community, affects decisions regarding bodies and personal property.[2 53 57] Decisions are not always taken by individual selves but are subject to a consensus among those who have the authority to make such decisions. While this sort of collective decision-making is sometimes regarded derisively by Western commentators as a kind of brainwashing or subjugation, such derision denies the lived reality of many women's experiences of their bodies, selves and desires in these contexts. Indeed, the derision may itself be traumatic.[58]

Most affected women themselves rarely use the word 'trauma' to describe their experiences of the practices. If they describe the experiences in negative terms, they may use words such as 'difficult' or 'painful', but some of them may simultaneously describe the experience as celebratory, empowering, important and significant.[2 4 53] This may even accompany experiences of pain, but this pain, when made sense of in its cultural context, does not equate to trauma.[58 59]

Researchers and clinicians often use the mostly biomedically based DSM-5 (the current version of the *Diagnostic and Statistical Manual of Mental Disorders*) to assess trauma, with a focus on post-traumatic stress disorder (PTSD). While narratives of women who have experienced a cultural or religious-based procedure may contain descriptions of symptoms that fall into the PTSD nosological category (such as 'unwanted upsetting memories', 'negative affect', 'nightmares' or heightened sensations, vigilance or sleep disturbance), the cross-cultural validity of PTSD as a construct and its use in migrant populations has been widely contested, because it applies Western cultural understandings to people who do not necessarily equate the experience of pain as directly causing trauma.

Even if women report unwanted upsetting memories, heightened vigilance, sleep disturbance, recurrent memories or flashbacks during medical consultations, a prior genital procedure may not be the primary cause for their distress. Indeed, several life events may account for their sorrow or disturbance, at the time of assessment. For example, other premigration stressors in affected women, such as the burning of their home or property, being abducted, experiencing sexual violence, being attacked with a weapon, loss of family members or witnessing murder, may lead to an increase in depression and trauma. In short, it is important to consider factors other than a female genital procedure in the aetiology of distress, and indeed, a focus on the latter as *the* cause of PTSD may mean that clinicians overlook, dismiss or render these factors irrelevant.

The current global anti-FGM discourse is itself replete with deleterious and potentially trauma-inducing effects, which may impact women from low-prevalence and high-prevalence countries.[8 42 47 59] In an effort to prevent non-Western female genital practices, NGO (non-governmental organisation) activists have placed much emphasis on negative health outcomes, outcomes which, although possible, are not automatic. While such strategies might dissuade some from future actions, the narrative also can lead some women to process their own experiences through the lens of a maimed, symptom-ridden body. Such narratives have the capacity then to shift women's attentional processes to vigilance and an emphasis on physical ailments, moreover encouraging a single-cause interpretation and risk inducing a misattribution in which pains and losses are to be understood as the result of a previous genital procedure.[60]

There are many accounts of women whose self-esteem plummeted after hearing negative comments about the practice, testifying to damaging effects of the anti-FGM discourse to women's sense of self and self-esteem.[58 59 61] Many of the anti-FGM narratives produced by NGOs and state campaigns have also represented communities and parental relations negatively.[42 58 59] Such narratives inherently downplay or denigrate the ceremonial and cultural importance of the practices, an importance which often supports the self-esteem of the women who experience it.[2 4 6 19 47] This denigration can produce a sense of alienation from the families and their communities, and sometimes their own bodies, and can sometimes itself produce traumatic symptoms.

Contemporary myths and stereotypes

Recent quantitative and qualitative research reveals that affected migrants who expect a permanent future in the Global North overwhelmingly opt to stop their cultural or religious female genital practices.[22 62 63] Nevertheless, the belief persists that migrants are committed to preserving these traditions, and stories of 'FGM' practices after immigration abound in public discourse and news reporting, despite a lack of evidence, and indeed evidence to the contrary. Such misrepresentation and stereotyping fuel suspicion towards minority communities and families, resulting in harmful consequences for the girls and families involved.[23 34 40 42 63]

Public anti-FGM discourse in the Global North is often based on oversimplification, misinformation, misuse of data and stereotyping, which reinforces unfounded rumours and leads to distorted news reporting.[3 42 63] The impact on public opinion contributes to harmful social actions like surveillance, restrictions on travel, unjustified child protection orders, racial discrimination and cultural misunderstanding. It can result in a misreading of women's needs, a denigration of women's voices and thus harm to the very women and girls who are supposedly those needing protection.[17 34 39 41]

One misrepresentation is due to overestimates of those 'at risk'.[33 48 58] Although most migrants to Western countries discontinue these traditions, many countries continue to include, in their calculations of risk, *all* daughters of migrants from 'FGM'-practising countries, regardless of their family's actual current practices. The large numbers resulting from these inflated statistical projections contribute to alarming public perceptions. Migrants' ethnicity and religion become markers of risk, contributing to a form of racial profiling whereby migrants become a population of suspects.[18 24 40 42]

Despite the rarity of verified cases and actual violations of anti-FGM laws in Western host countries,[23 63] the suspicion and stereotyping of the anti-FGM discourse leads to claims that illegal practices must have gone 'underground'.[64] This suspicion leads to unsubstantiated rumours being reported in the mass media as fact, including claims of 'kitchen-table cutting' in homes, 'vacation cutting', and midwives flying in to carry out 'FGM parties' in Global North cities.[63] Such rumours feed on and perpetuate Western presumptions of oppressive relations in migrant families, which are represented through a Western lens as more patriarchal and more sexist than others—in short, 'backwards' and not modern, unlike the dominant Western society's image of itself.[8 10 34 40]

At the same time, titillating sensationalism—for example, focusing on female genitals and sexuality, honour issues, etc—has been used by news media to generate audience attention, but in this case, it leads to vilification of migrants, infantilisation

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of people and their cultures, and failure to recognise the agency of the women concerned and their communities.[3 6 17] These harmful myths have real consequences for girls and women from these communities.

Anti-FGM law and policies

This sensationalism, myth peddling and level of suspicion have legitimated laws and policies of surveillance that are causing harms to people and undermining notions of equality before the law.[8 22 34 40 41]

Although these laws and policies purport to protect girls, they can also do the opposite. These harms include (1) Undermining equality by creating double standards in the law, its interpretation and/or enforcement; (2) Undermining privacy, autonomy and self-determination of individuals, families and communities, including through oversurveillance of ethnic and racialised families and girls; and (3) Undermining social trust, community life and human rights. At their worst, interpretation and enforcement of laws have objectified girls and women as passive victims, undermining their rights and credibility and compromising the rule of law, community life and trust in state institutions and professionals.[18 40–42 59]

Anti-FGM laws in the Global North create several sets of double standards. The first establishes differential treatment between adult women on the basis of their cultural heritage or country of origin: as discussed above, what is termed 'female genital mutilation' is associated with 'custom and ritual' of women with non-Western heritage, and it is prohibited and incurs harsh penalties, while what is termed 'female genital cosmetic surgery' is permitted and engaged in by adult Western women and girls, and sometimes celebrated as female empowerment.[7 8 10 29 31 34]

The second type of double standard establishes different legal protections between, on the one hand, girls from communities that practise 'FGM' and, on the other hand, all other children—including girls from non-'FGM' practising communities, as well as boys and children with intersex traits. While male and intersex genital modifications are permitted in most countries, even when clearly non-voluntary and medically unnecessary, female genital practices in non-Western communities are criminalised. A third type of double standard affects adult women originating from 'FGM'-practising communities, where all forms of female genital practices are condemned or banned, compared with adult men worldwide, as no Western countries prohibit male genital practices.

Family and administrative law in Western countries can have harmful consequences for privacy and autonomy of family life despite generally being understood as a means to protect the vulnerable. In cases involving female genital practices, these legal processes work in the opposite direction, often harming the supposed subjects of the law's protection: girls and women. Implementation of law means that the state (eg, in the UK and Sweden) can intervene on a lower threshold of proof: a 'balance of probabilities' as opposed to the 'beyond a reasonable doubt' required in criminal cases.[23 39–41]

In legal cases involving the protection of girls considered at risk of 'FGM', girls may be objectified and temporarily made into wards of the state. In some situations, girls have been subjected to repeated invasive medical examinations, photographed and pressured to serve as witnesses in criminal trials, including trials against their own parents or carers.[18 23] For example, in Australia, two girls were subjected to bodily surveillance, including through medical examinations, over the course of 6 years before both the prosecution and the defence agreed, and the appeal court found, that the medical evidence demonstrated that the genitalia of the girls were normal and there was no evidence of injury.[18 19]

Because anti-FGM laws construct parents as potential perpetrators, the law disrupts trust within families and causes harm to entire communities.[24 40–42] In England and Wales, FGM Protection Orders can include confiscation of passports, impacting private and family life, and punishing the potential victim. Children and families may be cut off from extended families based on very little or no evidence and judged on a low standard of proof: judges (in the case of England and Wales) and social administrators (in the case of Sweden) may be influenced by wider societal misconceptions about 'FGM' and by problematic estimates of numbers of girls at risk. The misconceptions lead to disproportionate legal impacts.[23 34 41 42 63]

Anti-FGM legislation harms not only those punished and made punishable by law, but also entire families and communities whose social trust is ruptured, and ethnic and racialised groups who are framed as suspect populations susceptible to 'FGM', whether they historically practised 'FGM' or are merely stereotyped as having done so.[22 34 39 41] Further, law, policies and campaigns against 'FGM' are nested within neocolonial development frameworks that construct African or South Asian women's female genital practices as barbaric and primitive, both antithetical to and inimical to development.[1 3 8 10 14 18 29 31 34 40]

In some European countries, people working in regulated professions (nursery care, teaching, social work, healthcare) are legally subject to mandatory reporting: even though they are often ill-informed about the practices or issues, they are required to inform responsible authorities if they learn that a female child or an adult in their care was cut at some point in their lives, even prior to immigration. Such mandatory reporting requirements trigger a range of surveillance mechanisms that place affected women, girls and their families under undue scrutiny and suspicion. This has resulted in loss of trust among and within communities, including between parents and schools, and between patients and healthcare practitioners.[40–42] As outlined above, these professionals—required to act as informal law enforcers—may also be harmed, whether by implementing or by refusing to enforce policies that many believe compromise their professional integrity.

Laws against 'FGM' in Western countries have resulted in the marginalisation of migrant communities, reinforcing exclusionary practices and contributing to their social stigmatisation.[10 34 40 41 47] While intended to protect, such legislation can serve as a tool of exclusion, deepening the divide between these communities and the broader society.

CONCLUSION

The familiar discourse around 'FGM' is rousing. It is a rhetorically effective galvaniser of the zero-tolerance eradication campaigns it was designed to motivate. We, the many coauthors and supporters of this article, are critical of that discourse. We believe the harms, injustices and costs associated with it (and associated campaigns) must be taken seriously. We believe the discourse has foreclosed critical reasoning and dispassionate analysis of relevant empirical research and kept significant facts and policy questions out of sight. Indeed, we think the time has come to recognise the harm caused by the 'FGM' acronym and reject the word 'mutilation' when portraying any of the male and female genital practices mentioned in this report, unless referring to particular individuals' interpretations of their own bodies. In offering our critique, we recognise that anti-FGM

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activism is often morally motivated (as a battle against the subordination of women and violence against them) and that some of the harms and injuries that have followed in its zealous and righteous wake may be unintended or unanticipated. Nevertheless, the harms and injustices we describe are real and serious. They are damaging to medical care and professional ethics in medicine, to fairness in the way crimes are defined and prosecuted in our legal systems, to the parental rights and family life privacy of immigrant minority groups, to democratic principles of equal citizenship, to journalistic impartiality, and to the self-esteem of women from targeted ethnic and religious heritage communities. All this needs to be acknowledged, discussed and addressed.

We have written this critique to expand that conversation. Over the past four decades, great damage has been done to the process of rational policy formation by misleading and sensational media coverage of affected women from practising communities in the Global South. In concert with anti-FGM activist organisations, mainstream newspapers in North America, Europe and Australia have firmly fixed in the minds of their readers a typifying 'dark continent' 'female genital mutilation' image based on the atypical practice of infibulation, which should not be confused with the far more common forms of female genital practices that continue to prevail in many African and South-East Asian societies, and which are gaining in popularity among cosmetic surgeons and majority populations in North America and Europe (although never under the label 'genital mutilation'—the expression 'designer vagina' is sometimes used).[29]

Additionally, while reading the mainstream media coverage of 'FGM', one would never know that the custom does not selectively pick on women. Almost without exception, wherever there are female genital modifications, the local social norms regarding genital alteration are gender inclusive or gender equal and approvingly call for male genital modifications as well. Political patriarchy may have rather little to do with it.[1 65]

In sum, the horror-inducing 'mutilation' stereotype popularised by anti-FGM activist organisations and their supporters in the mainstream media has obscured and significantly distorted the picture of reality. It has kept basic facts about the genital practices of affected women from the Global South out of sight, and hence out of mind, while leaving unaddressed (and hence unanswered) a surprising number of questions of the sort that ought to be of interest to journalists and policy-makers. We hope this critique of the mutilation discourse will encourage intellectually courageous journalists, policy-makers and public commentators to report and evaluate those facts and address those questions, while striving for balance, justice and critical reasoning in their engagement with the full range of genital practices performed in the contemporary world.

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Acknowledgements We gratefully acknowledge Giorgia Decarli, Michela Fusaschi, Sahar Ghumkhor, Michelle C. Johnson, Corinne Kratz, Claudia Merli, and Bettina Shell-Duncan for their intellectual support and foundational contributions to the development of this article.

Contributors All authors are researchers with long-standing engagement in the field. They participated in an in-person, 3-day writing workshop held in Sweden in June 2023. Following the workshop, writing groups continued to develop and refine their respective sections. These contributions were later integrated by a smaller editorial team (SJ, EG, JR) into a unified manuscript. All authors (FSA, DB, JB, MC, NC, RD, BDE, BE, EG, SH, SJ, SKa, SKo, CK, MCL, LL, CLS, RMM, SO, CP, MP, JR, NS, AS, RS, LW) contributed substantially to the conceptual development and writing of the article. SJ serves as the guarantor for this article.

Funding This work was funded by the Swedish research council Forte (2023-01165).

Competing interests None declared.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

Data availability statement Data sharing is not applicable as no data sets were generated and/or analysed for this study.

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