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Cuts into Children's Future: a Comparative Analysis between FGM, Male Circumcision and Intersex Genital Surgeries

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Abstract:

Many international and regional human rights' measures were adopted to eliminate female genital modifications, as they are performed in lack of medical necessity and interfere with the growth of healthy genital tissue, which can lead to severe consequences for women's physical and mental health. The aim of this paper is to contribute to the discussion on other practices that are carried out on children without their consent and without therapeutic reasons, such as male circumcision and intersex treatment. These practices will be discussed by examining three different arguments: the best interest standard, the do no harm principle and the right to bodily integrity combined with the children's right to an open future. In doing so, the intent is to find out if by opening the discussion to other forms of early non-therapeutic genital interventions it could be a way to improve the protection of children against embodied practices that are grounded on cultural/social norms.

Keywords: *children, body, integrity, rights, harm, self-determination, non-discrimination*

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Introduction

Currently there is a growing concern and attention regarding sex and gender stereotypes because they are often the cause of several forms of human rights violations, as the Office of the High Commissioner for Human Rights (OHCHR) committee outlined in his report (OHCHR 2013). For example, several customs and traditions that are prejudicial for the health and life of children are linked to sex and gender norms (Committee on the Rights of the Child 2003) that are deep embedded in a certain culture, society or religion. The global early adolescent study showed through an analysis carried out in 15 countries, concerning the way in which sex and gender stereotypes are learned and enforced, that, in particular those that are related to higher physical or psychological risks, are rooted into childhood (Blum 2017, 4).

Fortunately, at legal level, during the last century the relationship between children and parents underwent profound changes. Particularly through the valuable contribution of the UN convention on children's rights and through the European charter of fundamental rights, parents no longer have authority upon children: rather, they have responsibilities towards them. By that, it is meant that children, in line with the Universal Declaration of Human Rights, are holders of rights such as the one to be cured, maintained, instructed and educated, and are a separate social category no longer subject to the parents' power (Van Beuren 1998). Parents have the responsibility to ensure that their offspring have the necessary tools to enforce the rights that they bear. In every context the child's best interest is the pivotal element of evaluation. Similarly, in every decision, even judicial, what must be promoted is the overall psychophysical well-being of the child, whereby the child's right to an open future should be guaranteed.

In this children rights framework, the intent of this paper is to question genitalia-altering practices on infants – in particular, female genital modification (FGM)¹, male circumcision and intersex² genital surgery. In these

¹ Some argue that the adoption of two different definition (circumcision and mutilation) for the non-therapeutic surgical alteration of male and female genitals already reflects the double standard that is used to approach these practices and “that it hinders objective discussion of the alleged benefits, harms, and risks”. (Svoboda and Darby 2009). The term FGM will be used in this article by perhaps referring with the M not to Mutilations but to Modifications as proposed by Fusaschi (Fusaschi and Cavatorta 2018, 6).

² There is an ongoing debate concerning the terminology (Balocchi 2012), in this article the term “intersex” will be used instead of that of disorders of sex development (DSD) or others as it is a non-pathologizing umbrella term used by the intersex movement that includes a large number of natural sex characteristics variations (such as chromosome patterns, hormones/gonadal structure, and/or sexual anatomy). Some of these variations could be seen directly at the birth of an individual, others can be discovered during the course of life, while yet others will never be discovered.

practices, sex and identity (gender, cultural or religious) are defined. Given they are performed on infants, the alterations occur without their personal consent and without medical reasons. The focus will be indeed just on those practices that require the removal or alteration of healthy tissue from the genitalia of children without the involvement of the treatment of an actual disease.

The question that inspired this paper was for which reason, in a human rights framework where universality, equality and non-discrimination principles are fundamental, different approaches have been adopted towards genital alteration practices in relation to the sex of the involved child. While indeed FGM is perceived as a culturally unacceptable practice that is prohibited in almost every country, male circumcision instead, notwithstanding a number of newspapers' articles that report the death of circumcised boys³, is generally perceived as a private, mostly religiously, acceptable practice that is normally harmless. Male circumcision is indeed lawful in almost every country, only few States are considering to ban or at least medicalize the practice to avoid the most harmful consequences.

In the case of genital surgeries on intersex children, made available thanks to the technological advancement within the medical sector on the base of the 'optimal gender of rearing' theory, that will be discussed in section 1.3, they have been described as a solution to solve the 'problem' represented by the atypicality of intersex bodies and therefore accepted as a medical procedure regardless the claims of the intersex community since the '90 about the harmful consequences of the intersex genital surgeries and their rather cosmetic than therapeutic nature.

This paper analyses the different forms of genital alteration practices on non-consenting children in order to evaluate if due to the unnecessary and often irreversible nature of these interventions they are compatible with the children's best interest, the do not harm principle and their right to bodily integrity.

1. Genital Alteration Practices

1.1 Female Genital Modification

Female genital mutilation/cutting, or, as it will be called throughout this article, modification⁴, is a ritual practice, that is carried out for various

³ Just to mention the last one, of March 2019, concerning the death of a 4 month old boy in Italy available at https://www.ilmessaggero.it/italia/circoncisione_morto_bimbo_reggio_emilia-4382934.html (last visited October 2019).

⁴ The term female mutilation or cutting will nonetheless be used where it is required to guarantee the consistency with the wording of the documents that are cited or examined.

cultural, religious, socio-economic, gender-related, and alleged hygienic or health reasons (Leye 2008). Historically it was carried out mainly in African countries⁵, but due to the current immigrant waves nowadays it is also performed in European countries, and it is estimated that more than 200 million girls and women alive today, have been cut (UNICEF 2016). In 1997 in a joint statement the World Health Organization (WHO), United Nations Children's Fund (UNICEF) and United Nations Population Fund (UNFPA) defined female genital mutilation as all kinds of intentional alteration or injury to female genital organs that is performed without any medical reasons (WHO 2008). The (WHO) has identified four forms of FGM that are: Type I, the clitoridectomy, that involves the partial or total removal of the clitoris and/or the prepuce; Type II, the excision, that involves the total or partial removal of the clitoris, the labia minora and in some cases the labia majora; type III, the infibulation namely the narrowing of the vaginal opening through the creation of a covering seal; Type IV that includes all other harmful procedures to female genitalia for non-medical purposes (pricking, piercing, incising, pulling of labia). Several of the interventions included in type IV are among the least severe forms of FGM, nonetheless they are perceived from the WHO/UN as a harmful practice and a violation of the human rights of girls and women even if some of those interventions such as the genital piercing can be performed hygienically, under appropriate conditions and does not require the removal of genital tissue.

1.2 Male Circumcision

The roots of male circumcision are not yet certain, but it has been speculated that it is one of the oldest procedures carried out even before the introduction of Judaic and Islamic traditions (Smith 2009). Male circumcision is practiced all over the world, and even though the percentage of circumcised boys is diminishing, it has been estimated that currently about one-third (WHO 2010) of the world's male population is circumcised. Male circumcision is a Jewish and Muslim ritual, but also other religions and cultures practice it, because they understand it *inter alia* as rite of passage toward 'manhood' (Wilcken 2010). Thomson noted that the male circumcision can be seen as 'sexing the infant male boy', both because there is an 'understanding of the skin as feminised flesh and because of the way in which pain and risk have

⁵ It has perhaps to be noted that between the 18th and 19th century interventions on female genitalia were performed even in western countries (Obiora 1997, 298-299). Indeed, in Canada, United Kingdom and United States, where it continued until 1970, those interventions were performed as a "treatment" for "... hysteria, lesbianism, masturbation, and other so-called female deviances." (Toubia 1993, 21).

a role in defining the male body, masculinity and male privilege' (Thomson 2008). In other countries such as the USA, male circumcision is carried out routinely for mainly health related reasons (Morris *et al.* 2017; U.S. CDC 2014; American Academy of Pediatrics 2012), such as: prevention of HIV⁶, prevention of penile cancer and cervical cancer, and protection against urinary tract infections and sexual diseases.

Circumcision is performed usually on young boys soon after the birth or at least before the age of 13, by removing all or part of the foreskin. About 30 to 50 centimeters of erogenous tissue are removed by the circumcision (Cold and Taylor 2009; Werker *et al.* 1998). In all cases the circumcision includes the loss of most touch-sensitive portion of the penis (Bossio 2016; Earp 2016; Sorrels *et al.* 2007).

1.3 Intersex Genital Surgeries

The medical treatment of people with intersex traits has its roots into the 'optimal gender of rearing' theory developed during the 1950s by the psychologist John Money and his team at the John Hopkins University (Money and Tucker 1975; Money and Ehrhardt 1972). John Money and his colleagues, believing that infants have a malleable gender identity, reassigned surgically a child born male, whose penis was amputated during a circumcision, to the female gender by creating female genitals and starting a hormonal treatment. After this first 'experiment' starting from Money's view, that the infant's gender identity is like a *tabula rasa*, and that such identity could be moulded in either gender with appropriate, proportionate hormonal treatment and education, the standard treatment of infants born with ambiguous genitalia became the assignment through medical intervention to the male or female sex/gender⁷. The intent, as presented by medical literature, was to 'fix the sex' by 'normalizing' the genitalia in order to ensure to the child 'a gender normative behavior' (Tamar-Mattis 2014) and 'prevent confusion and upset of the parents, stigmatization of the

⁶ The promotion of male-circumcision programs in the context of HIV prevention framework has been criticized by some authors that argue that it would expand the practice to countries where it is not carried out for religious or cultural reasons even if there are alternative methods for prevent HIV that are less intrusive and much more effective for the prevention of HIV, such as the use of condom that have no ambiguous evidence about the risks as it is the case of male circumcision (Frisch 2012).

⁷ The criterion for determining the sex/gender was, as Money once stated, is "too small now, too small later", meaning that the clinicians will choose the sex/gender according to the size of the genitals, no matter if the individual testes are functional and produce sperm, or if the baby/infant is chromosomally XY, or if the surgically constructed vagina will be insensitive. If the children have a penis smaller than 2 cm, they will be assigned to female sex/gender (Chase 2002, 130).

child, and serious psychological trauma to both' (Ehrenreich 2005). The early genital surgeries include *inter alia* gonadectomy (removal of healthy viable testes, ovaries or other reproductive organs sometimes recommended to prevent gonadal tumour or the emergence of secondary sex characteristics inconsistent with gender assignment⁸), hysterectomy, hypospadias repair and for the feminizing procedure genitoplasty, clitoral reduction/recession and vaginoplasty⁹. Those surgeries are carried out as soon as possible after birth, ideally for the standard medical treatment within the first 18 months, on children that present at birth atypical genitalia. But the presence of intersex traits is mainly not harmful, the intersex individual is indeed generally healthy; there is only a small number of cases where there is a real health risk, and in which a medical intervention is required to save the life of the intersex child.

2. Legal Approach to Genital Alteration Practices

It seems therefore possible to identify in all three practices a common ground namely that: parents, broader family and/or the community decide to intervene and alter the healthy genitalia of their non-consenting children for non-therapeutic reasons¹⁰.

Perhaps a different approach has been adopted insofar toward the three kinds of genital alteration practices this is shown by the existing different legal reaction in relation to the sex of the child that undergoes the procedure.

The FGM has been recognized as form of harmful practice and violence against women and girls, that has its roots in social structures where there is an inequality between sexes based on the idea of superiority or inferiority

⁸ It has to be noticed that the tumour risks vary among the different types of intersex traits and normally its occurrence is very low before puberty, the gonadectomy, that leads to sterilization, can therefore in several cases be safely postponed to a later age. (Karkazis 2010; Deans *et al.* 2012).

⁹ Until the 1970-1980s, the usual procedure adopted by surgeons by elective feminizing genitoplasty for female assigned infants and children was the clitoridectomy, which included the removal of the corpora and the glans; this practice was then replaced with the clitoroplasty, perceived as less intrusive as it 'only' implies a dissection of the clitoris' skin and subsequent removal of most of the paired clitoral corpora (Minto 2003; Ismail and Creighton 2005).

¹⁰ Where those practices are carried out for unnecessary preventive medical reasons such as to prevent gonadal tumours in the case of intersex children or urinary tract infections in the case of male circumcision to evaluate if they could be count as justified curative treatment, it is possible to report what Holm Putzke already affirmed by comparing male circumcision and the surgical removal of the appendix namely that: "The surgery is not harmless and the benefits are uncertain, no one would ever seriously consider removing the appendicitis as a preventive procedure, simply to escape the remote possibility of the fatal consequences of an inflammation" (Putzke 2008).

of either of the sexes and on stereotyped roles of men and women¹¹. Since 2001, the European Parliament has started to condemn FGM as ‘violation of fundamental rights’¹²; with the resolution adopted in 2012 the European Union (EU)¹³ then called the States to adopt preventive, protecting, and legal measures to outlaw FGM. In 2012 the United Nations (UN) endorsed resolution 67/146, whereby they call for an intensification of the global effort to eliminate FGM and invited the States to adopt criminal dispositions. One year later, in 2013, the Istanbul Convention was approved, and this was the first international legally binding treaty to outlaw different forms of violence against women, including FGM. In this new framework, many EU States already adopted specific criminal legislations that outlaw FGM (Leye and Sabbe 2009; EIGE 2015). Nowadays, even though the practice is still carried out, the extension of the action against FGM is very wide. It does not matter if the harm caused to women is more or less severe, every modification of female genitalia is perceived as a violation of the rights of women and girls, and as an expression of sex-based discrimination, as it based on stereotypical attitudes toward the status of women: truly, the WHO and the UN stated that ‘any kind of medically unnecessary, non-consensual alteration of the female genitalia - no matter how minor the incision, no matter what type of tissue is or is not removed, no matter how slim the degree of risk, and no matter how sterile the equipment used - is by definition an impermissible mutilation’ (Earp 2015, 90).

Nonetheless, there have still been few criminal proceedings against the authors of FGM (Johnsdotter and Mestre 2015). This is because it is very difficult to discover such crimes and to collect enough evidence, both by reason of the victims’ own reluctance to denounce the perpetrators due to the fact that the victims are usually very young, and the close connection to the authors or co-authors of the crime that are often community or family members (EIGE 2013).

The legal framework concerning male circumcision and intersex treatment is profoundly different. The discussion about their possible conflict with children’s rights is slowly raising, but there are generally no specific legally binding provisions governing the performance of male circumcision and intersex surgeries within the EU Member States.

¹¹ Harmful Practices, especially Forced Marriage and Female Genital Mutilation, OHCHR, https://www.ohchr.org/Documents/Issues/Women/WRGS/SexualHealth/INFO_Harm_Pract_WEB.pdf.

¹² European Parliament, *Resolution on female genital mutilation* (2001/2035(INI)).

¹³ European Parliament, *Resolution on ending female genital mutilation* (2012/2684(RSP)).

As per the intersex treatment, the Parliamentary Assembly of the Council of Europe in 2017¹⁴ and the European Parliament in 2019¹⁵ adopted resolutions in which the ‘sex-normalizing’ treatments and surgeries have been condemned and legislations to prohibit them welcomed. Nonetheless, Malta is still the only EU Member State with a legal disposition, adopted in 2015, called ‘Gender Identity, Gender Expression and Sex Characteristic Act’ that explicitly outlaws the sex reassignment treatment and/or surgical intervention on sexual characteristics performed by medical practitioners or other practitioners on minors, if the procedure could be postponed to an age of the involved person where free consent could be given¹⁶. On April 2018 the Portuguese Parliament adopted a new law concerning unnecessary surgeries on intersex children but as underlined by some activists and advocacy groups the law missed the opportunity to ban them as it just recommends the postponement of their performance until children have developed their gender identity¹⁷.

But even if there are just a couple of specific dispositions about intersex medical treatments there have already been some law cases, although few, these include, three rulings by the Colombian Supreme Court¹⁸, two rulings by German courts¹⁹ and one by the Family Court of Australia²⁰. In order to understand the court reasonings it has to be noted that insofar non necessary early genital interventions on intersex infants are still in line with medical guidelines and protocols. In all these cases the courts, therefore, even if they considered the individuals’ right at stake, deliberated mainly on the grounds of the principles of the informed consent doctrine²¹. The Colombian Supreme

¹⁴ Parliamentary Assembly of the Council of Europe, Resolution Promoting the human rights of and eliminating discrimination against intersex people 2191 (2017), 12 October 2017, <https://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=24232&lang=en>.

¹⁵ European Parliament, Resolution on the rights of intersex people (2018/2878(RSP)), 14 February 2019. http://www.europarl.europa.eu/doceo/document/TA-8-2019-0128_EN.pdf.

¹⁶ Law “Gender Identity, Gender Expression and Sex Characteristics”, Act no. XI of 2015, as amended by Acts XX of 2015 and LVI of 2016 and XIII of 2018.

¹⁷ Law No. n.º 38/2018. This law has been criticized by some intersex association as the Portuguese parliament has missed the opportunity to ban such surgeries (<https://www.stopigm.org/portugal-new-law-fails-to-protect-intersex-children/>).

¹⁸ Colombian Supreme Court, sent. T-551/99, sent. SU- 337/99 and sent. T-912/08.

¹⁹ German Court of Cologne sent n. 25 O 179/07. German Court of Nürnberg Fürth, sent. Az. 4 O 7000/11.

²⁰ Family Court of Australia sent. n. 2016 FamCA 7, in Re Carla. It seems important to report the colombian and australian law cases even if not from European countries as only in these cases a court has been called to rule about the parental right to give their consent to unnecessary genital surgeries on intersex children.

²¹ The elements of the informed consent have been established through judicial decisions and they include: the disclosure of information, competency, understanding, voluntariness, and decision-making of the patient. The exceptions to informed consent including emergency, incompetency, therapeutic privilege, and waiver are especially important in critically ill

Court had to rule about surgeries on minors. The Court established a new standard for the informed consent. The judges decided that if the child is under the age of five, parents are entitled to give their consent to sex reassignment surgery, but the consent has to be informed, qualified and persistent while if the child is above the age of five the surgery should be postponed until the child could consent for itself²². The German courts found in both cases the surgeons guilty as they did not give adequate information to the plaintiff about the nature and extent of the surgery, as in both cases the involved people were above the major age. The Australian Family Court designed the gonadectomy proposed to Carla, a 5 years old child, with a variation of sex characteristics, as a therapeutic treatment “necessary to appropriately and proportionately treat a genetic bodily malfunction that untreated, poses real and substantial risks to the child’s physical and emotional health”. For the judge therefore the parental consent in these cases does not fall outside the permissible parental authority.

Finally, with regards to male circumcision, legislation is almost absent in European countries. Some countries are considering the option to ban those interventions such as in Iceland where a bill concerning the ban with a penalty of up to 6 years for everyone who fully or partially removes for non-medical reasons the sexual organs of a child has been presented at the beginning of 2018 in front of the Parliament²³.

What some States are discussing as alternative solution or have already done, with concern to the risks and consequences related to the practice, is to introduce laws that allow circumcision solely if they are performed by physicians²⁴. There have been some interesting law cases related to male circumcision, even if in most of the cases the court was referred because there was no agreement among the parents if the circumcision should be performed or not.

patients and reflect a balancing of autonomy values and society’s interest in the promotion of health. (Sprung 1989; Walter 1997).

²² In Sentencia 377/99 as the child was 8 years old the judges decided that the surgery should be postponed. In Sentencia T-551/99 as the child was 2 years old for the court the parents were entitled to give their consent perhaps the judges did not consider valid the consent as it was nor qualified nor persistent. In the case T-912/08 the court stated that as the child was five years old, the child and the parents, once they are fully informed, together could give joint consent.

²³ Law proposal n. 183 – 114. Mál. <https://www.althingi.is/altext/pdf/148/s/0183.pdf>.

²⁴ The Swedish Parliament enacted on 2001 a law (Sw. Lag (2001:499) om omskärelse) that regulates the circumcision. The law stated that only physician or another person with appropriate training is allowed to perform the circumcision and only with the use of an analgesic or an anaesthetic.

In an Italian law case of 2007 the Court of Padova²⁵ recognized the circumcision of an infant as a violation of bodily integrity but stated also that such a practice is lawful due to its function to pursue the wellbeing of an individual by integrating him into a culture or religion and due to the fact that this practice is deeply accepted by the society. Some years later in 2012 the Italian Court of Como²⁶ recognized the consequences of male circumcision as a causation of a ‘disease’ under the disposition of personal injuries, even if it is followed or not by a complication. The judges indeed stated that in any case such practice causes an anatomical and also functional alteration of the male’s genitalia that is not instrumental to eliminate any pre-existing pathology. This alteration under art. 50 of the Italian criminal code is lawful only if carried out with the consent of the concerned person or in case of a minor of his caregivers, for the court therefore it is necessary that both parents agree to the practice. Furthermore, the same year the Cologne district court of Germany has recognized the male circumcision of a four-year-old, as unlawful due to the violation of the child’s right to bodily integrity²⁷. The Court in fact defined the circumcision as ‘grievous bodily harm’. Specifically, the judges stated that the parents’ fundamental rights are limited by the child’s fundamental right to bodily integrity and self-determination, as the body of the child will be modified in an irreversible and permanent way through the circumcision. Such an alteration will be in contrast with the child’s wellbeing, future interest and even the individual’s right to ‘make his own decision on his religious affiliation’. On the other hand, the parents’ educational right will not be unreasonably impaired if they would wait until the child will reach an age where he could decide freely to undergo circumcision to join the Islamic religion²⁸. In 2015 in the case *B and G*²⁹ concerning a 4-year-old boy and a 3-year-old girl, Sir Mundy, President of the Family Division of the English Family Court, stated that

²⁵ Italian Court of Padova, 05/12/2007, n. 2046.

²⁶ Italian Court of Como, 14/01/2013 n. 1339

²⁷ German Court of Cologne, 7/05/2012, 151 Ana 169/11.

²⁸ The ruling of the Court of Cologne has been sharply criticized and one year later the German Parliament introduced art. 1631(d) in the German Civil Code that provides that: “Care and custody also includes the right to consent to a medically unnecessary circumcision of a male child who is unable to reason or make judgments for himself as long as it is performed according to the standards of medical practice. This does not apply if the circumcision –with regard to its particular purpose – jeopardizes the child’s welfare in any way. In the first six months after birth, an individual authorized by a religious community and with adequate training may perform the procedure without being a medical doctor. Ritual circumcisions can be performed by “a person chosen by a religious community who is especially trained”.

²⁹ Family Court in Leeds, RE B and G (children) (care proceedings), EWFC 3, 14 January 2015.

some forms of the type IV FGM are 'on any view less invasive than male circumcision'. He further stated that 'given the comparison between what is involved in male circumcision and FGM Type IV... in my judgement if type IV amounts to significant harm... then the same must be so of male circumcision'. Nonetheless Sir Mundy then proceeded by arguing that male circumcision, unlike FGM, could be considered an aspect of reasonable parenting as 'society and the law, including family law, are prepared to tolerate non-therapeutic male circumcision performed for religious or even for purely cultural or conventional reasons, while no longer being willing to tolerate FGM in any of its forms'.

From the above, it is obvious that, even though the approach is shifting towards a child's rights framework, genital alteration practices are perceived differently. FGM is being publicly debated, is widely recognized as a traditional practice based on patriarchal gender norms and ritualistic beliefs that constitute, in any case regardless of the produced harm, a severe infringement on women's human rights. Parents under specific or general national European countries law are punishable if they give their consent to FGM. Male circumcision is mainly treated as a widely tolerated private and mostly religious issue and the bodily impairment is seen as acceptable as it is considered by some as beneficial for the child's wellbeing. Parents can consent to it if both agree, otherwise if one parent opposes the practice, the action could be brought in front of the court, that assesses the best interest of the child. The intersex genital surgeries are mainly considered as a medical practice to which parents are empowered to give their informed consent as they are still based on medical indications.

3. The Surrogate Decision-making and the Best Interest Standard

The practices discussed in this paper are carried out on minors that are not able to give their consent. It is generally understood that children do not have the necessary capabilities to give effective consent, as they are not able to fully outweigh the consequences of their consent. In these cases, law provides for caregivers of minors the right to give their surrogate consent, as they are believed to be in the best position to know what is the best course of action for the well-being of the child (Beh and Diamond 2000). But the parental decision-making authority is not unlimited. To prevent parental power abuses, first and foremost, parents must indeed make decisions taking into consideration both the immediate and the long-term best interest of the

child as the parents' surrogate decision-making is part of the parental duty to care and custody the minor by upholding their interests³⁰.

The first step to adopt to analyze the different forms of genital alteration practices would seem therefore to assess if they are in the best interest of the children.

The problem perhaps in these cases is the notion of 'best'. It is indeed a fact that parents that give their consent to those procedures believe to act in their children's best interest, because they accomplish to both their internal values and beliefs and external social and cultural/religious rules and norms. By giving their consent parents indeed aim to guarantee their children's belonging and acceptance within a certain society or community by at the same time avoiding the possible future experiences of harassment, rejection and stigmatization that their children would encounter later in life if they do not conform to such existing social norms on which the practices are based.

As Nekla Kelek writes, for example, 'uncircumcised boys are not accepted in Turkish society; circumcision indissolubly belongs to being Muslims and to the male identity'. Female genital modification is carried out on girls because it enhances *inter alia* the beauty and femininity of a girl and make her also marriageable and socially acceptable (UNICEF 2013) and gain in this way, in some countries, economic security and social status. Intersex genital surgeries were performed for mainly cosmetic reasons and grounded on social justification; indeed, the main concern was about the distress caused by the social stigma of being different, abnormal, not conform to a binary sex and gender system and the following exclusion and isolation from the society and even the lacking bonding with their parents that are often not prepared and therefore shocked and confused about the birth of a child that does not accomplish with their own values and beliefs namely that just two sexes and genders exist.

The parent's intent is therefore benign, they often try to render the child's life easier³¹. For the parents the possible risks and implications associated to the removal of healthy tissue from the sexual organs of their children are indeed outweighed by the social and cultural benefits for the child that, in their view, contribute to the well-being of the child such as their identification and integration with a certain society or community (Sarajlic 2014).

³⁰ UN Committee on the Rights of the Child (CRC), General comment No. 14 (2013) on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), 29 May 2013, CRC /C/GC/14, available at: <https://www.refworld.org/docid/51a84b5e4.html> (accessed: 11/10/2019).

³¹ The importance to adhere to social norms that concerns the sex and gender of an individual is even greater in societies where a huge importance is attributed to such elements of a personal identity (Sytsma 2006).

It is possible to see therefore that the concept of 'best' could not be established and defined unanimously as it has a relative nature, this is because the concept of 'best' is linked to vague and subjective evaluations (Rhodes and Holzman 2014; Kipper 2015). In the case of parental surrogate decision making the problem is that even if parents should reasonably balancing all the concurring factors and make impartial, objective decisions that have the highest benefit for the minor as their main goal, as already even stated by the American Academy of Pediatrics, 'a person who consents responds based on unique personal beliefs, values and goals' (American Academy of Pediatrics 1995). The best interest assessment is indeed 'unnervingly instinctive and highly contingent on the subjective assessment and value framework of the decision-maker' (Stalford 2017, 43). The best interest standard therefore, as already noted by some scholars, does *de facto* not hinder surrogate decision makers to not apply their own prejudices, values and common sense, contributing to mask systematic or societal prejudices (Archard 2013) as the terminology is unclear and contentless (Kennedy 1991; McGuinness 2008).

Given these limitations of the best interest standard linked to the subjective perception of what is the best for the child it seems useful to use the definition of 'best interest' given by Kopelman - namely, 'the option that maximizes the person's overall good and minimizes the person's overall risks of harm', considering therefore under which extend the involved children could be harmed by these practices. By considering the different risks and consequences the intent is to focus on the concept of 'harm', in line with a recent proposal (Diekema 2004) suggesting to connect the best interest standard with the harm principle³². This proposal is linked to the idea that an evaluation of the best interest in relation to the possible harm that could derive from a treatment, may lead to identify more objective conditions and criteria to limit the action of third parties on individuals. In this way, indeed it would not be necessary to evaluate just what would be the 'best' option for the child, but even what would be the likelihood to cause harm by running a cost/benefit analysis.

The harm principle has been therefore used to establish a more 'realistic standard' and 'identify a threshold below which the parental decision will not be tolerated and is not indicated to protect the child' (American Academy of Pediatrics Committee on Bioethics 2016).

³² The concept of "harm principle" was elaborated by John Stuart Mill who recognizes as only acceptable justification for a rightfully exercise of power over an individual the prevention of someone other's harm (Mill 1998).

4. The Harm Principle

By evaluating if these practices are in the best interest of the child therefore the safety and integrity of the child before the practice and with a precautionary approach even ‘the possibility of future risk and harm and other consequences of the decision for the child’s safety’ and integrity will be assessed³³. This section will examine the risks and harm that children may encounter from the anatomical and functional alteration of their sexual organs, if this is not carried out to eliminate a pre-existing pathology. Unless there is a pathology there is indeed no evidence of a medical necessity or urgency of such practices as in the examined cases the shape and size of male, female and intersex infants’ genitalia pose no immediate and future danger for the health of the child.

4.1 Short- and Long-term Consequences

The rate and the degree of the implications vary among male circumcision, FGM and intersex surgical treatments. The kind and extend of the consequences are related to several factors including the instruments that are used, who performs the practice (medical practitioners or not) and in which setting it is carried out (medical or not), but in all cases, there are risks related to the interference with the children’s bodily integrity.

All types of FGM present more or less harmful short- and long-term complications, such as (WHO 2016):

- pain
- bleeding (hemorrhage)
- genital tissue swelling
- fever
- infections
- urinary problems
- shock, death
- sexual problems (decreased sexual satisfaction, reduced sexual desire and arousal)
- psychological problems (post-traumatic stress disorder, anxiety disorders, depression)
- the need for later surgeries

³³ Committee on the Rights of the Children, General comment No. 14 on the right of the child to have his or her best interests taken as a primary consideration (art. 3, para. 1), CRC/C/GC/14, 2013.

For the male circumcision, with a rough estimate, a complication rate of 2-10% was reported, the possible risks are (Smith 1998; UNAIDS 2010; Hammond and Carmack 2017; Boyle 2015):

- pain (Gregory 2002)
- hemorrhage (bleeding)
- sepsis (infection)
- meatal stenosis (narrowing of the urinary opening)³⁴
- scarring, penile head keratinization
- psychological consequences (post-traumatic stress disorder, depression, anger, and intimacy problems) (Goldman 1999)
- sexual complications (painful erections, sensory deprivation, premature or delayed ejaculation, erectile dysfunction) (Gemmell and Boyle 2001)
- death and (partial) amputation of the penis, even if rare.

Yet, although much evidence is still lacking - particularly about the long-term effects of the medical treatments on intersex children - some of the documented consequences are:

- scarring, vaginal stenosis and fibrosis (Krege *et al.* 2000; Alizai *et al.* 1999),
- neoplasia (Lee *et al.* 2006; Steiner *et al.* 2002)
- genital chronic pain (Consortium on the Management of Disorders of Sex Development 2006; Ford 2000)
- loss of sexual function and sensation, for example in cases of clitoral reduction³⁵
- urinary tract fistula (Davies 2005a; Krege *et al.* 2000) and urinary problems (Davies 2005b)
- infertility³⁶
- depression and suicidal inclination due also to the shame and humiliation created by the surgeries and medical examinations that include manipulation of the genitalia, for example in case of a constructed vagina where the entrance of the vagina has to be daily manually dilated³⁷

³⁴ The meatal stenosis is one of the most common reported consequences of circumcision. In line with clinical studies the rate is about 5% to 20% of children that develop meatal stenosis after a conventional surgical non-therapeutic circumcision. (Morten and Earp 2016; Joudi, *et al.* 2011).

³⁵ A study carried out in the UK shows that 78% of women that underwent a clitoral surgery experienced non-sexuality, while 38% of them were unable to have an orgasm. (Minto 2003). The outcomes of a German clinical study show furthermore the low intersex adults' satisfaction with genital surgery and their sexual life. (Köhler *et al.* 2012; Crouch 2008).

³⁶ For example, a child with a too small penis but functionally testes that is assigned to female will lose his potentially fertility testes and penis. (Tamar-Mattis 2012).

³⁷ A study that compare women with variations of sex characteristics to sexual and physical abused women found that women with variations of sex characteristics suffer from a higher psychological distress like self-harming behaviours and suicidal tendencies as abused women. (Schutzman 2007).

- risk that the children will not identify themselves into the sex assigned to them at birth. Estimates of wrong sex assignment vary between 8.5% and 40% (Mouriquand *et al.* 2014; Furtado *et al.* 2012)
- lifelong hormone therapy and the high probability to undergo a huge number of surgical interventions throughout life, due *inter alia* to the fact that the genital surgery could merely conceal the atypical aspect of genitalia, but it could not cure the intersex individual as there is no proper illness involved; rather, a genetic, chromosomal, hormonal, or gonadal variation (Lorenzetti 2015, 117).

Even if there are therefore several risks connected to all three types of genital alteration practices the issue even in this case is to define the concept of harm and establish a threshold below which the parental consent give rise to a physical impairment of the child's bodily integrity.

The Children Act 1989 defines the notion of harm as 'ill-treatment or impairment of health or development' and establishes simultaneously that the harm suffered by a child should be defined as significant with a turn to 'the child's health or development compared with that which could reasonably be expected of a similar child'.

But there are no objective elements or criteria to establish when the harm could be defined as significant, meaning which is the threshold that has to be reached in order that it could be unambiguously established that a certain practice is harmful and therefore not in the best interest of the child. Even the concept of 'harm' is indeed not absolute but relative. As indeed stated by Carol Smart 'harm' is not a 'transcendental notion which is automatically knowable and recognizable at any moment in history by any member of a culture' (Smart 1999, 392). As already noted by some scholars it is indeed a 'culture- and context- sensitive notion, which can be shaped by differing perceptions, assumptions and values, and by conscious or unconscious stereotypes about the object(s) of evaluation (Earp *et al.* 2017). This is shown by the fact that the argument used to deny the similarity between male circumcision and FGM was exactly the different degree and rate of risks and consequences that people normally associate to the two procedures. While FGM is described as a damaging practice without any medical benefit whose mental and physical implications pass, unlike male circumcision, a threshold of harm that is intolerable. Male circumcision is indeed often represented as a less invasive procedure, with possible health benefits (Tobian 2011) and low rates of risks for the wellbeing of the child (Patrick 2007). Who uses this argument have perhaps in mind the most extreme forms of FGM, namely Type II and III. With regard to Type IV of FGM, indeed, the risks connected to the practice are much lower and the procedure, in some cases, is even less invasive than male circumcision as it has been recognized

even in the aforementioned case *B and G*. Furthermore, there is a different approach to the reasons that underpin those practices. The cultural and social roots of FGM are considered, unlike the roots of male circumcision, as harmful *per se* because they express a patriarchal social structure based on stereotypical attitudes toward the status of women. Any kind of FGM is therefore considered a harmful practice regardless of how invasive and risky the procedure is.

In the case of intersex surgeries, the harm and risks associated to the intervention are often considered in a different way. They are indeed considered as side effects of a medical procedure that aims to cure people affected by a pathology instead of risks and consequences of a harmful practice that has its roots into a social and cultural binary sex and gender system.

Even the harm concept therefore give rise to some issues in evaluating the best interest of the involved children due to his social and cultural relative nature.

5. Towards a More Inclusive Approach: Right to Bodily Integrity

Given the relative nature of both the concept of ‘best’ and ‘(significant) harm’ as seen before the cost/benefit analysis seems not to give an unambiguously answer to the question if these practices are in the ‘best interest’ of the involved children. Furthermore a cost/benefit analysis, as already noted by some scholars, could even become a useful starting ground for those who have proposed the medicalization of those procedures, in particular of male circumcision, as a solution to render them safer and less harmful (Erlings 2016; Serour 2013).

In this section the practices will be examined by looking to their compatibility with the right to bodily integrity as already done by some authors while examining the single practices. Even if such genital interventions are carried out in different ways or places such as medical settings, being more or less intrusive and by causing more or less dangerous complications, what all these procedures have in common and distinguish them from other body alteration practices that are carried out on children before they could participate personally to the decision making process, as for example vaccination or even orthodontic treatment, is that they all involve the alteration of functioning intimate and erogenous tissue that contains thousands of highly specialized fine touch receptors and nerve fibres from healthy infant bodies (Earp 2015).

All these procedures therefore are an interference into the bodily integrity of minors. The right to bodily integrity is a fundamental right that is deeply connected to the right to autonomy and self-determination of individuals over their bodies. Ludbrook considers this right indeed as ‘most personal and arguably the most important of all human rights’ (Ludbrook 1995) in particular for children. Interferences with the right to bodily integrity are normally legally irrelevant if the involved individuals give their personal consent. In case of minors those consent is normally given by the caregivers. Caregivers that in the case of genital alteration practices are often not fully informed about the treatment, the possible risks and benefits and the existing alternatives.

In some cases indeed there is a lacking full parental awareness and/or information about the possible risks, consequences, likely outcomes and the existing alternatives of the procedures: FGM and male circumcision³⁸ due to their ancient roots are indeed perceived as routine or standard intervention while the standard intersex medical protocol didn’t provide a full disclosure of the information to the intersex child and often neither to the parents as it was based on a ‘concealment model’. This happened, to guarantee a good bond between parents and children’s, in particular, where the information could lead to confusion as for example the fact that the children may not self-identify with the gender that has been assigned to them (Dreger 1998).

But even if the caregivers would be fully informed about the possible risks the question remains if parents have the authority to give their consent to unnecessary procedures that impair the children’s bodily integrity. The right to bodily integrity is indeed one of those right that fall within the Feinberg’s category of ‘rights in trust’ that should be saved for when the child will reach adulthood (Feinberg 1992). For Ouellette the children’s right to an open future is grounded on the right to bodily integrity and self-determination (Ouellette 2010)³⁹. This right, coined for the first time by Feinberg, ‘protects the child against having important life choices determined by others before she has the ability to make them for herself’ (Millum 2014). Parents by exercising their surrogate decision-making power should indeed take into consideration the effect that their decision has on the child as a ‘human being’ and as a ‘human becoming’ by considering therefore the free development of the child. To understand the meaning of the child’s right to development it is possible to use the ‘capabilities approach’ (Peleg 2013) that suggests conceptualizing

³⁸ A study reports that “some parents noted that there was a lack of access to accurate information regarding risks and benefits of male circumcision” (Sardi and Livingston 2015; Svoboda, Van Howe and Dwyer 2011).

³⁹ Concept that was developed by Joel Feinberg and then further by Dena Davis (Feinberg 1980; Davis 1997; Davis 2001).

‘development’ as freedom (Sen 1999). By applying this notion of ‘development’ to children it would mean that parents should not be entrusted to choose options that will limit the child’s autonomy and self-determination.

The genital alterations impair the child’s free development, as they - due to the irreversible nature of these practices - result in a limitation of future options. Male, female and intersex children that underwent without their consent to the permanent alteration and/or removal of healthy and functional tissue from their most intimate organs on the ground of their sex in order to adhere to the beliefs, values and norms of certain cultures, religions and societies, lose their right to decide autonomously over their bodies and identities. The children are prevented from the decision to keep their intimate organs intact but even to self-determine their identity that is constituted by several characteristics such as ‘sex, sexual orientation, national origin, religion beliefs, cultural identity and personality’ (Committee on the Rights of the Children 2013, 13). In all practices the children’s body is indeed marked permanently to stress the belonging to a certain community, religion or society, by preventing the free choice of the children and future adult to be part of it or not. Indeed in this globalized world based on internet and mobility ‘people encounter many different ways of life’ by enhancing the chance of ‘many to reconsider or even reject the cultural traditions or religious beliefs with which they were raised (The Brussels Collaboration on Bodily Integrity 2019, 22; Johnsdotter 2019; Pew Research 2018). In the case of intersex genital surgeries, furthermore the adherence and conformity to a binary sex and gender system may put the involved children at the risk of losing their right to freely choose their gender identity. The genital surgeries aim indeed to ‘fix’ the gender identity of the intersex child by surgically assigning it to the male and female sex/gender, without considering not only the short and long consequences of the interventions but even the great discomfort and long-term psychological and emotional stress (Kon 2015) that they may suffer, in particular if they do not self-identify with the gender that had assigned them at birth through the surgical intervention.

The impairment of the bodily integrity of the involved children put therefore at serious risk the involved children’s free development by limiting even their freedom to self-determine fundamental elements of their identity. The impairment is therefore difficult to legitimize in particular because as there are no evidence that any of these genital interventions are carried out on the grounds of necessary and urgent health measures these practices could be postponed to a later stage of the child’s life where the child could be included in the decision-making procedure (Svoboda 2010). Such postponement would not be only in line with art. 12 of the CRC as it would allow to the involved children to express their views but even the approach with the minimum

of risk, in that it avoids both the risks of the surgery, that are even difficult to consider compatible with the children's right to the highest attainable standard of health in line with art. 24 of the CRC, and the danger that as an adult the concerned person will resent the bodily impairment suffered when it was an infant.

Conclusion

The best interest and harm principle within the analysis of the different forms of unnecessary genital practices on non-consenting children present some limitations due to the fact that both concept have a relative nature as they are bounded to the different perception and understanding embedded into the different socio-cultural contexts. But what FGM, male circumcision and intersex genital surgeries have all in common is the unnecessary impairment of the children's bodily integrity through the alteration of healthy tissue.

The first step towards an inclusive approach was taken in 2013 by the Parliamentary Assembly of the Council of Europe with the PACE resolution. In this resolution, the concern about practices such as FGM, male circumcision, and intersex treatment was already expressed with reference to their conflict with 'the right to bodily integrity'. In the resolution there was no reference to the cultural factors that underpin such practices. Some would argue that the lack of such reference constitutes a flaw of this resolution, but if on the one hand this could indeed be seen as an important missing element in the description of these phenomena, on the other hand, such an approach is in line with the intent to question them apart from the cultural factors on which they are grounded. The aim is indeed to avoid any critic to any specific culture by just adopting in all cases the same human rights perspective. It would indeed be difficult to justify a different approach to genital alteration practices on the grounds of the child's sex in line with the prohibition of discrimination between sexes and the universality of human rights. If indeed male circumcision, female mutilation, and intersex treatments cause different degrees of physical harm that could in part be avoided through further medicalization, nevertheless they all irreversibly mark and alter the children's body by impairing their integrity and limiting their future choices.

Thereby, it seems interesting to consider the adoption of a gender-equity or, better, a gender-neutral approach in the protection of the rights of all children in line with what has been already recommended in relation to intersex children in the PACE resolution namely that member states should

‘ensure that no-one is subjected to unnecessary medical or surgical treatment during infancy or childhood, guarantee bodily integrity, autonomy and self-determination to children concerned’.

To achieve such goals and care standards for children, the first step - particularly with regard to male circumcision and intersex treatment - is to carry out more in-depth research, which analyzes the short- and long-term psychological and physical consequences of such practices.

Moreover, more research is also needed to assess the impact of broadening the campaign against FGM with other practices such as male circumcision and intersex treatment as done in Germany, where on 7th April 2019 the first campaign against all forms of genital alteration practices has been launched⁴⁰.

Meanwhile, considering the absence of demonstrated medical benefits, and where such practices lack any therapeutic justification and are thus neither necessary nor urgent, they should be postponed at least until the children could be personally involved, express their views, and finally grant their informed consent. Such postponement would not be only in line with art. 12 of the Convention on the Rights of the Child as it would allow to the involved children to express their views but even the approach with the minimum of risk, in that it avoids both the risks of the surgery and that a third party limits the range of choices available to them when they become adults through an irreversible intervention in order to secure an upbringing in accordance with certain religious, cultural, or social beliefs. The UN Committee on the Rights of the Child has indeed already affirmed that ‘cultural identity cannot excuse or justify the perpetuation by decision-makers and authorities of traditions and cultural values that deny the child or children the rights guaranteed by the Convention’ (Committee on the Rights of the Children 2013, 14).

It is indeed of great importance to protect the child’s right to an open future by sheltering those ‘rights in trust’ that, as Feinberg stated, should be saved for when the child will reach adulthood (Feinberg 1992). With this the intent is not to affirm that parents are not allowed to educate and raise their children in line with their beliefs and values, but rather that if the education includes irreversible bodily marks that impair the rights of children, then indeed parental authority should be questioned, as the parents’ own religious and cultural freedom is yet limited by the respect of the fundamental human rights of the children. Thereby, if the parents do not ensure protection of those rights, and if they instead abuse their ‘sovereign power’ of guardianship over vulnerable people (especially if such people, although holders of rights,

⁴⁰ <http://s783056778.online.de/> (accessed: 21/11/2019).

could not exercise the rights on their own), the states should intervene to avoid infringement. The fact that someone is unable to exercise one's rights implies that a greater protection is needed in order to preserve such rights, so that if and when the individuals will become able to exercise them, they will have the freedom to (Balocchi and Kehrer 2019).

In relation to the question which the best solution could eventually be to protect the right to the bodily integrity of the involved children the answer is still uncertain. There are three main options: apply in any case, as some courts have already done, the general provisions about bodily injury; open up the legislation about FGM to all form of genital alteration through a gender-neutral approach⁴¹; adopt specific legal provision for each practice.

It should therefore be analyzed which approach could guarantee a greater protection to the concerned children. Indeed, there is still criticism also with regard to FGM toward the adoption of specific legal provision because such an approach seems to lead to the condemnation of certain cultures or religions more than to the protection of the victims (Fornasari 2011). While others are concerned that the prohibition would increase the 'black market' of those procedures, in particular in the case of male circumcision, and that this is rendered even more dangerous by the fact that children do normally not denounce their caregivers as shown in the case of FGM. Furthermore, there would be the problem that maybe some procedures would be justified on medical grounds even if there aren't any therapeutic reasons. But there are some solutions that could be adopted to avoid such issues such as the introduction of a duty for every professional to report the modification of a child's genitalia as it is provided already by the dispositions of some States concerning FGM and that in any case where a modification of a child's genitalia are suggested an interdisciplinary ethical committee has to evaluate if the procedure is really medically necessary.

Law regulation would not be enough to eradicate all practices affecting the fundamental rights of children, as it has already been shown in the case of FGM. However, together with other measures such as education and outreach programs, it could significantly concur to change culturally established viewpoints. Indeed, culture is dynamic, and it continuously changes and absorbs influences from external factors. Undoubtedly, one of these factors is law, which has the power to increase awareness about the hazards and

⁴¹ Such a gender-neutral approach could be found within the Austrian penal code even if insofar it has been applied just to FGM. According to Art. 90 abs. 3 StGB it is not possible to consent to a genital mutilation or other injury of the genitals which is apt to lead to a lasting impairment of sexual sensitivity.

risks related, among others, to traditional practices that are often carried out in mere accordance with well-established customs and beliefs.

The regulation of such practices could play an important role, because by focusing on the impairment of children rights, the harmful nature and consequences of this practices could be exposed. It is however of vital importance, in our super diverse societies, that legal regulations do not condemn any religious, cultural, or social beliefs and values *per se*; indeed it is in the children's best interest to be included in a vibrant cultural community, and into the religious observances of the family. But there is a limit, and that is when children's fundamental rights are at stake.

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