**CONSENSUAL REINFIBULATION: IN SUPPORT OF A COMPROMISING POSITION BETWEEN AUTONOMY AND NONMALEFICENCE**

1. **Overview of paper:**

This paper examines ethical justifications for ‘consensual’ reinfibulation by African and Asian women who have migrated to Europe. Based on a non-systematic review of literature related to FGM/C, the paper addresses an issue that is relevant and important for a journal on bioethics/medical ethics. It is unlikely to influence practice or policy, (but if worked on and improved significantly) could possibly add to the current debate on female cutting practices by presenting a counterpoint to the current global activism against FGM/C.

1. **Originality:**

The views of the author are not new. Similar viewpoints have already been expressed in literature by various scholars (Richard Shweder, for example). However, the author refers to this body of work and builds his arguments around it. There is no suspicion of plagiarism – this seems to be the author’s own work.

1. **Content and conclusions:**

The author provides some logical arguments in favour of his position, namely:

* The issue of wellbeing, and the possibility that a deinfibulated woman may consider her genitals no longer ‘normal’ and may experience discomfort in her body.
* The parallels between consensual reinfibulation and cosmetic surgery, both of which involve alteration to the genitals at the request of the woman.
* A possible moral distinction between infibulation and reinfibulation, if the former is considered a potentially harmful and severe alteration to the genitals and the latter is considered a restoration of the pre-existing appearance and functioning of the genitals.
* The conception of autonomy as relational rather than individualistic, implying that a woman’s autonomy may not necessarily be expressed as opposition to cultural norms, but may equally have expression in her desire to *adhere* to those norms.

Having said that, the article suffers from poor English and a rather haphazard structure in which the author goes off on tangents and brings in arguments that are not applicable to reinfibulation (for instance his discussions of male circumcision as a parallel for female cutting practices or FGM/C as symbolic harm are irrelevant to infibulation). Therefore, all of the author’s conclusions are not warranted. Also, an important flaw in the author’s paper is that he appears to have grossly misinterpreted some of the referenced papers (see examples ahead in comments for author) and drawn extremely incorrect conclusions from them.

1. **Language and title:**

The author is evidently using English as a second language. To publish in the IJME, he would need to improve/get editorial help to improve the clarity of his writing. Also, the title needs to be reconsidered. The word ‘compromising’ in English generally means ‘embarrassing’. He could consider replacing ‘compromising position’ with either ‘a position of compromise between...’ a compromise between...”

1. **Recommendation:**

It is recommended that the paper should not be accepted in its current form. However, the author could be given the opportunity to make a fresh submission of his modified paper. Even though the topic does not connect to India (and is of relevance more in the European context), it relates to an ongoing global debate.

The author needs to make significant modifications to the paper before resubmitting it:

* Firstly, the style and language need improvement because the paper suffers from a lack of clarity at many points.
* Secondly, the author should omit irrelevant parts that do not connect to his specific focus on reinfibulation.
* Thirdly, and most importantly, the author’s review of literature is flawed. In a paper based on a non-systematic review of literature, it is a serious drawback if the author has misunderstood or misinterpreted many of the referenced papers.

After resubmission, the paper would need to go through a process of review again to assess readability and ensure that the referenced literature was appropriately interpreted.

1. **Separate comments for the author:**

This paper is on a relevant and important topic but needs significant improvement. The author provides some logical arguments in favour of his position, namely:

* The issue of wellbeing, and the possibility that a deinfibulated woman may consider her genitals no longer ‘normal’ and may experience discomfort in her body.
* The parallels between consensual reinfibulation and cosmetic surgery, both of which involve alteration to the genitals at the request of the woman.
* A possible moral distinction between infibulation and reinfibulation, if the former is considered a potentially harmful and severe alteration to the genitals and the latter is considered a restoration of the pre-existing appearance and functioning of the genitals.
* The conception of autonomy as relational rather than individualistic, implying that a woman’s autonomy may not necessarily be expressed as opposition to cultural norms, but may equally have expression in her desire to *adhere* to those norms.

Having said that, the author also brings in arguments that are not applicable to reinfibulation (for instance his discussions of male circumcision as a parallel for female cutting practices or FGM/C as symbolic harm are irrelevant to infibulation). Therefore, all of the author’s conclusions are not warranted. Also, an important flaw in the author’s paper is that he appears to have grossly misinterpreted some of the referenced papers and drawn incorrect conclusions from them. Finally, the English, while fluent, is at times unclear and confusing. Also, the title needs to be reconsidered. The word ‘compromising’ in English generally means ‘embarrassing’. The author could consider replacing ‘compromising position’ with either ‘a position of compromise between...’ a compromise between...”

Please see the reviewer’s critique of various sections ahead, which is intended to point out the strengths and weaknesses of the paper’s content and indicate places where the author has digressed from the focal point of the paper.

**Section heading: The WHO**

In this section, the author critiques the overarching term ‘FGM’ used by the WHO. Considering that his focus is reinfibulation, and not a broad overview of female cutting practices, this critique appears unnecessary.

**Section heading: Respect for the foreign culture**

The author references Meyers’ 2003 paper, “Feminism and Women's Autonomy: the Challenge of Female Genital Cutting”, <https://onlinelibrary.wiley.com/doi/abs/10.1111/1467-9973.00164>, in support of the argument that women who opt for FGM/C may do so autonomously. Meyers does argue that “women who resist cultural mandates for FGC do not necessarily enjoy greater autonomy than do those women who accommodate the practice,” but she goes on to say that “yet it is clear that some social contexts are more conducive to autonomy than others.” The author ignores the point that Meyers is talking about an autonomy that does not necessarily fit into the individualistic, Western construct, but is not *supporting* FGC.

In this section the author also brings in male circumcision. I quote, “In my opinion, there are no morally relevant differences between customary male circumcision and (minimal forms) of customary female circumcision.” While the argument he makes about male circumcision and female cutting practices is in itself worth reflecting upon, in the specific context of infibulation or reinfibulation, it becomes an unnecessary digression. His actual topic is not female cutting practices in a broad sense but is specifically focused on *reinfibulation* – and in this reviewer’s opinion, male circumcision cannot be considered a parallel for reinfibulation.

**Section heading: The harmfulness of reinfibulation**

In this section, the author references Johnsdotter and Essen’s 2015 paper “Cultural change after migration: Circumcision of girls in Western migrant communities,” <https://www.sciencedirect.com/science/article/pii/S1521693415001959>, and writes, “However the harms caused by infibulation are not always as significant as western societies believe.” Based on the same paper, he asserts that “Infibulated Somali immigrant women reported “overall best health.” These are problematic inferences drawn from Johnsdotter and Essen’s paper. They do mention that infibulated Somali women in Norway reported “best health,” but go on to discuss how immigration and exposure to Arab Muslims and new ideas has *changed* attitudes towards infibulation in Somali women. The same paper discusses a qualitative study that found that immigrant Somali women participants did not support infibulation, the majority calling it “barbaric, and un-Islamic.”

In the same section, based on Moxey and Jones’s 2016 paper, “A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England,” <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4716221/>, the author asserts that “One out of ten Somali women living in the UK reported that infibulation was a traumatic experience which, however, did not affect her life “afterwards”. This author seems to be using this finding in support of reinfibulation. However, this was a study done on ten women in which the one woman quoted above was an outlier because she did not experience complications. What the author ignores is that in a study with only ten participants, the other nine women had *significant* psychological and physical problems following infibulation.

Further on, the author references Knipscheer et al’s 2015 paper “Mental health problems associated with female genital mutilation,” (full text available at <https://www.researchgate.net/publication/285547821_Mental_health_problems_associated_with_female_genital_mutilation>), to assert that “Other women reported no impact (or even positive impact) of infibulations on their mental health [19].” This is a completely incorrect inference from a paper that says “A third of the respondents reported scores above the cut-off for affective or anxiety disorders; scores indicative for post-traumatic stress disorder were presented by 17.5% of women.”

Referencing Creighton and Hodes 2015 paper, “Female genital mutilation: what every paediatrician should know,” the author concludes rather obscurely, “However, these are not undoubtedly reliable studies [20].” Again, the author misunderstands the gist of the paper which argues that because of the secrecy surrounding FGC, paediatricians do not know enough about it, and there is a lack of rigorous, evidence based research.

**Section heading: Infibulation, Deinfibulation and Reinfibulation: Morally different practices**

The author sees infibulation and consensual reinfibulation as morally distinct practices. He writes that infibulation may be seriously harmful because it “is a permanent and perhaps severe alteration of female genital’s anatomy,” whereas reinfibulation “restores to a former condition.” The author makes a logically valid argument, though a counter position could be that something that is seen as *intrinsically* wrong cannot be considered acceptable if it is redone, even at the woman’s own request.

**Section heading: Potential benefits to health and well-being**

The author takes the viewpoint that health is more than physical and builds an argument in support of consensual reinfibulation based on this perspective of health as something that will bring overall benefit to the person. He then deduces that consequently, promoting well-being in a woman who desires reinfibulation can be considered medical treatment.

**Section heading: Relational well being**

The author posits that reinfibulation that may enhance relational well being and an existing sexual relationship between a woman and her partner/husband.

Based on Moxey and Jones’s paper “A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England,” the author asserts that “The vast majority of Somali women living in UK choose to undergo intrapartum deinfibulation in the belief that such an opening is her husband’s business only. “ This is a misinterpretation of Moxey and Jones’s study. “Intrapartum” means during birth and according to this study, women delayed deinfibulation because they wanted it to happen at the same time as childbirth when they were likely to undergo another procedure. In particular, women that anticipated needing an episiotomy delayed deinfibulation until labour in order to ensure that any surgical procedures were done at the same time: “I can't have two operations…so I chose it [deinfibulation] when I have a baby.”

**Section heading: The subjective/psychological well-being**

In this section, the author presents one a strong argument in favour of reinfibulation – the possibility that an infibulated woman accustomed to seeing her genitals in a particular way may perceive her deinfibulated genitals as no longer ‘normal’.

**Section heading: The sexuality**

The author reviews literature that shows that it is not established that infibulation necessarily decreases sexuality or affection sexual functioning in women. Again, this can be an important argument in favour of consensual reinfibulation.

**Section heading: Relational autonomy is a true autonomy**

The English needs improvement here as this section is unclear and confusing. The author wants to establish that women from non-Western cultures have autonomy – though their autonomy is more relational and differs from the Western construct of ‘individualistic autonomy’ through which a person necessarily opposes social custom. However, he needs to write it out with more clarity.

**Section heading: The autonomous desire for reinfibulation**

The author presents another strong argument by arguing that cosmetic genital surgery may be indistinguishable from some FGM/C practices. However, his discussion on “thin”, “thick enough” and “full thick” autonomy is unclear. If you add to that “second order” and “first order” autonomy, the section becomes a difficult, confusing read. It is suggested that he could lessen the jargon: while ‘thin’ and ‘thick’ may be appropriate indicators of the level of autonomy, “full thick” makes it confusing reading.

**Section heading: Symbolic harm**

The author discusses FGM/C as a symbolic harm, but this section appears irrelevant to the focus of this paper. The author needs to consider whether a symbolic prick or cut is analogous to reinfibulation, which is a major change in how a woman’s body functions.

**Section heading: Conclusion**

The author concludes that consensual reinfibulation should be medically available in carefully screened cases, and that discomfort in the body following deinfibulation should make a case for reinfibulation.

There are questions regarding some of his ending points, for instance, how is virtue ethics to be incorporated into principlism? He does not explain how he thinks two widely different approaches can be merged. Furthermore, the definition of ‘thick enough’ autonomy that appears here should come earlier.

I would prefer that my name remains unpublished.