

## REVIEW ARTICLE

# Might Reinfibulation be Medically Plausible in Carefully Screened Cases?

DOI: 10.29063/ajrh2020/v24i1.17

*Polychronis Voultzos*

Department of Legal Medicine & Toxicology, School of Medicine, Faculty of Health Sciences, Aristotle University of Thessaloniki, University Campus, 54124 Thessaloniki, Greece

\*For Correspondence: Email: [pvoultzos@auth.gr](mailto:pvoultzos@auth.gr); Phone: 00306932727580

## Abstract

In light of the relational account of autonomy and the modern (holistic and phenomenological) account of health, this paper examines ethical justifications for ‘consensual’ reinfibulation. Significant and constant discomfort in the body following deinfibulation might make a case for reinfibulation (considered as medical treatment in the traditional sense of the term). In any other case, the following requirements should be met for reinfibulation to be considered medically plausible: a) strong evidence that reinfibulation could help effectively improve woman’s relational well-being, b) insignificant complications are expected, c) congruence between first-order and second-order autonomy or -in the context of political liberalism- strong second-order autonomy, d) an “open door” for the woman to exit an oppressive context, e) rigorous scrutiny of woman’s psychology, and f) woman’s practical wisdom to organize her identity-related values, find a balance between her extreme emotions and realize her own goal of meaningful life in accordance with her own conception of the good. Conclusively, in carefully screened cases and individually judged requests for reinfibulation, it should not be ruled out that, after having been conducted a multi-disciplinary in-depth investigation at social, psychological and medical level may be met conditions that make a case for reinfibulation. (*Afr J Reprod Health* 2020; 24[1]: 165-181).

---

**Keywords:** Reinfibulation, deinfibulation, autonomy, sexuality, health, well-being

---

## Résumé

À la lumière du récit relationnel de l'autonomie et du récit moderne (holistique et phénoménologique) de la santé, cet article étudie les justifications éthiques d'une réinfibulation «consensuelle». Un gêne important et constant dans le corps après la désinfibulation pourrait justifier une réinfibulation (considérée comme un traitement médical au sens traditionnel du terme). Dans tout autre cas, les conditions suivantes doivent être remplies pour que la réinfibulation soit considérée comme médicalement plausible: a) des preuves solides que la réinfibulation pourrait aider à améliorer efficacement le bien-être relationnel de la femme, b) des complications insignifiantes sont attendues, c) la congruence entre le premier ordre et une autonomie de second ordre ou - dans le contexte du libéralisme politique - une forte autonomie de second ordre, d) une «porte ouverte» permettant à la femme de sortir d'un contexte oppressif, e) un examen rigoureux de la psychologie de la femme, et f) la sagesse pratique de la femme pour organiser ses valeurs identitaires, trouver un équilibre entre ses émotions extrêmes et réaliser son propre objectif de vie significative en accord avec sa propre conception du bien. En conclusion, dans les cas soigneusement examinés et les demandes de réinfibulation jugées individuellement, il ne faut pas exclure la possibilité de découvrir des conditions qui justifient une réinfibulation après avoir menée une enquête approfondie multidisciplinaire au niveau social, psychologique et médical. (*Afr J Reprod Health* 2020; 24[1]: 165-181).

---

**Mots-clés:** Réinfibulation, désinfibulation, autonomie, sexualité, santé, bien-être

---

## Introduction

The actual topic of this paper is specifically focused on *reinfibulation*. It 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 timely and important for health professionals working in the area of reproductive

and sexual health. As the number of African and Asian migrants in Western-type countries is at increase, reinfibulation is a subject about which there is increasing awareness among Western physicians. It is beyond the scope of this paper to explore the ethicality of infibulation. Regardless of its ethicality, infibulation is practised in several African and Asian countries. As migration flows from these countries to Europe increases, the rates of request for reinfibulation are at increase (after deinfibulation having been necessarily performed for obstetrician or other medical reasons, perhaps in a legal and medicalized way as has been encouraged in Norway)<sup>1</sup>, thus making its ethicality a topic of increasing concern. Reinfibulation is a topic of major controversy, around which there is legal uncertainty in many countries and many misconceptions prevail. In this paper, a provision of a more comprehensive and nuanced insight into the topic on the hypothesis that under certain circumstances reinfibulation may be medically plausible is attempted.

According to the WHO/UNICEF/UNFPA Joint Statement infibulation (type III of what is conflated under the term “Female Genital Mutilation”) is “narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris”<sup>2</sup>. It is an extensive (and most severe) form of “non-therapeutic female genital cutting/altering” (NTFGC/A) practices which vary considerably across cultures as is emphasized by the scholarship of the last 10-15 years<sup>3</sup>. Occasionally, it may be necessary for an infibulated woman that a reverse of infibulation (de-infibulation) be carried out on her body, for medical or other reasons (e.g. first intercourse). It is stated that de-infibulation “is the procedure used to reverse infibulation, to create a normal vaginal opening and to rebuild, medically speaking, a sort of “normal” anatomy of external mutilated genitals, respectful of their function also from the patient’s eyes”<sup>4</sup>. Re-infibulation is a (hygienic when performed by physician) procedure by which “the vulva is sutured to restore its infibulated appearance”<sup>5</sup>. Recently Addulcadir et al state that reinfibulation is an operation that opens the infibulations scar, exposing the vulvar vestibule, vaginal orifice,

external urethral meatus, and eventually the clitoris”<sup>6</sup>. It is a roughly reversible genital alteration that does not involve removal of healthy tissue, except in the cases of the medical indications. It is subtly different than “infibulation”. Anatomic deformations resulted from repeated re-infibulations should be treated during a reinfibulation procedure<sup>7</sup>.

Although infibulation and reinfibulation are ontologically similar practices, between these practices there are morally relevant differences. First, infibulation is a permanent and perhaps severe alteration of female genital’s anatomy. It is a radical (potentially painful and harmful) intervention to a highly valuable part of female body. Infibulation is a potentially harmful and severe alteration to the genitals whereas reinfibulation may be seen as restoration of the pre-existing appearance and functioning of the genitals. Reinfibulation is restoring to a former condition. It is a medicalized, (hygienic), roughly reversible major genital alteration. Second, infibulation is mostly performed on girls. Reinfibulation is mostly performed on adults capable of making autonomous decisions. Third, women that seek reinfibulation have already had their personal experience of living in and through their infibulated body.

Despite legal prohibition reinfibulation is performed by health professionals in many countries of the world<sup>8</sup>. In many countries there is legal uncertainty with regard to reinfibulation. In Belgium gynecologists reportedly feel confused about the admissibility of reinfibulation<sup>5</sup>. Moreover, physicians may have compelling reasons to perform (partial) reinfibulation to prevent infections or fusion between the tissues although it remains unclear to what extent it is permitted<sup>7</sup>.

This paper views reinfibulation as consensual ‘medical’ (in the broad sense of the term) treatment and thus goes beyond the conflict between autonomy and non-maleficence or between relativism and universalism. The here supported position is not respectful of the woman’s minority culture in itself. However, environmental factors that reflect cultural values slip into what is meant to be “health/well-being status” (valuable for all cultures) and “autonomous

choice”, thus determining the relative weight of each principle when the principles of beneficence and non-maleficence enter into conflict, and thus determining which principle will be the overriding one. Furthermore, the paper reflects on autonomy of a woman who seeks to undergo reinfibulation. Medically plausible reinfibulation no way means ethically acceptable infibulation. Besides, tolerance of a practice is not always recognition of it<sup>9</sup>. Overarching goal of a here considered permissible reinfibulation is to preserve the woman’s already existing health/well-being status. In contrary, the overarching goal of infibulation is to cause the woman’s body to become valuable in her culture and society. Tolerance for requested reinfibulation is no way recognition of the values of the foreign culture but respect for the woman’s autonomy.

## **Discussion**

### ***The request for reinfibulation***

Women’s request to be reinfibulated after being deinfibulated seems to be a request that may be profoundly shaped by either internal pressures (i.e. resulted from maladaptation to the changes in the body post deinfibulation or internalized gender oppression) or external pressures (i.e. social and cultural pressures). Request for reinfibulation seems to be a strong request. Bello et al. (2017) argue that there is no evidence to conclude that counselling before deinfibulation influences rates of request for reinfibulation<sup>10</sup>. Notwithstanding, Abdulcadir et al found that ‘specific care and counseling for women with FGM/C type III can improve the acceptability of defibulation without reinfibulation’<sup>11</sup>.

Monitoring rates of request of reinfibulation would be important given the so little research that has been done in this area which is considered taboo among most of the communities and illegal in many countries. In a Greek study which was carried out in 2009 by the 2<sup>nd</sup> Department of Obstetrics and Gynecology of Aretaieion Hospital in Athens, 3 out of 7 women answered positively to the hypothetical question whether they would like to undergo reinfibulation after vaginal delivery<sup>12</sup>.

### **Might Reinfibulation be Medically Plausible?**

#### ***Reinfibulation as a (traditional) medical treatment: Maladaptation to bodily changes post defibulation***

Maladaptation to the changes in the body post deinfibulation may be viewed as medical reason in the strict (traditional) sense of the term, from both an objective and subjective standpoint. If maladaptation to the changes in the body post deinfibulation is intended by the psychiatrist the operant reason for requesting reinfibulation, this might make a case for reinfibulation. I go into details.

A woman may develop over time an empowered and well-established *already existing* relationship with her own infibulated genitals (her own self) especially if underwent infibulation in childhood. Genitals represent a most particular and valuable part of a human body which holds considerable symbolic value. The symbolic value that a woman places on her genitals is greatly influenced by environmental factors that reflect the values of her own culture of origin to which she is attached. According to phenomenologists, the higher the symbolic value of a part of the human body the more likely that it assumes greater internal “visibility” and therefore plays an important role in the way that one perceives oneself<sup>13</sup>.

Moreover, if the constructive theories of gender identity are true, the woman’s sense of femininity results from interaction between biological body (as essentialism argues) and social body (as constructivism argues)<sup>14</sup>.

Furthermore, defibulation does not restore emotional normality. It may cause a woman to feel embarrassed about her body and experience unpleasant sensations arising from the edges of the incision (perhaps due to free nerve endings cutting). Deinfibulated women reported feeling “openness” and embarrassment about some bodily functions (e.g. urination) related to genitals. Besides, they are reported feeling “naked” and “ugly” as if they have a “cow pussy” or a masculine-type protrusion<sup>3,15-18</sup>. The anthropologist Gruenbaum states that “women conceive of the uninfibulated body as lacking in both propriety and beauty, as well as making a woman less able to please a husband sexually”<sup>19</sup>.

Deinfibulation may cause low sense of self-worth. On the other hand, infibulated women who are attached to the values of their culture of origin when considering the “normalcy” of their body (genitals) describe themselves as “neat”, “smooth”, “clean”, “virgin” and having child-type genitals<sup>3,15-18,20</sup>. However, this is not always an unchangeable attitude. The positive attitude of a migrant woman towards values of her culture of origin can be changed if a “critical mass” of the population of her community abandons the infibulation (for instance the men accept deinfibulated women as their wives) or she assumes a positive attitude towards values of in the host country (“acculturation”)<sup>21</sup>. Therefore, she may feel like she has lost something important<sup>3</sup>, thus resulting in “mental/psychological infibulation”<sup>4</sup>.

As deinfibulation and delivery may constitute repetition of women’s traumatic experience of infibulations<sup>22</sup>, in all likelihood, the same holds for reinfibulation. That remains to be proved through empirical studies.

Significant and constant discomfort in the body following deinfibulation might make a case for reinfibulation since it may be considered medical treatment in the traditional sense of the term. For this is sufficient informed critical reflection and a balance between side-effects of deinfibulation and reinfibulation. If maladaptation to the changes in the body post deinfibulation is intended by the psychiatrist as the operant reason for requesting reinfibulation, this may make a case for reinfibulation. For doing so, it is not required a robust philosophically conceived autonomy but is enough a typical informed consent. In this case, maladaptation to the post-deinfibulation changes in woman’s body should outweigh the negative side-effects of (re)infibulation (regarding physical, mental, reproductive or sexual aspect of health) that are (eventually) expected by both physician and woman’s perspective.

Because of her own pre-deinfibulation experience the woman can make evaluative judgments on the issue even if her physician reserves such judgments. At any rate, such a balance of maladaptation against negative side-effects is morally plausible as both maladaptation and reinfibulation complications are harms to

woman’s health in the strict/traditional sense of the term. Embarrassment or other maladaptation-related disorders would be classified as mental health-related disorders rather than well-being reducing factors. Nevertheless, research questions as to whether reinfibulation might be perceived as repetition of woman’s traumatic experience of infibulation or whether maladaptation to changes of the body post defibulation persists over time would move further towards the goal of making appropriate evaluation in a given case.

### ***Reinfibulation as medical treatment (in the broad sense of the term)***

By analogy with a traditional medical treatment that is instrumental to preserving health in the strict sense of the term, reinfibulation may under certain circumstances be instrumental to fostering the woman’s happiness based on functioning or succeed relationships, namely, her health (in the broad sense of the term) and well-being. As such, reinfibulation may be considered a “medical treatment” in the modern broad sense of the term, either using the holistic concept of health or conceiving the notion health through the lens of phenomenology along with the principle of beneficence (understood as enhanced).

### ***The holistic-positive concept of health***

Nordenfelt’s theory of holistic health focuses upon the typical (in the social/cultural context) abilities to reach the set goals under ‘acceptable circumstances’ (environment), rather than upon the mere (implicit) goals. Health is the one’s ability to strive for or reach the ‘vital goals’ that she set<sup>23</sup>. Venkatapuram gives a far broader definition considering as health the one’s capability to achieve ‘a cluster of basic human activities’ in a communal / cultural/global context<sup>24</sup>. According to Nussbaum and Sen , ‘vital goals’ are those securing ‘minimally happy and decent life’<sup>25,26</sup>. In our social/cultural context, for some persons such a “human activity” or “vital goal” may be to have a strong and well-functioning family or at least a happy and healthy relationship. However, such relationships (in or out of marriage) need intimacy to survive. Although intimacy goes beyond the physical

connection you can get through sexy time in the bedroom, in principle, intimacy involves it.

The holistic theories of health significantly blur the distinction between health and well-being. This distinction is further blurred in light of Richman's theory of health. According to Richman's theory of "embedded instrumentalism", health is a matching between one's abilities "*qua organism*" and goals "*qua person*",<sup>27</sup>.

Well-being is a considerably broad concept including subjective/psychological/mental and relational/social well-being, two overlapping and interacting dimensions of it. The subjective/psychological well-being goes beyond the individual. It is informed by the individual's relations. The relational well-being is a multi-dimensional dynamic interactive process that goes clearly beyond the individual and concerns the net of interpersonal relationships wherein the individual is embedded.

### ***The relational well-being***

Consider the case where an infibulated woman ends up with a partner (or a husband) to whom she feels emotionally and (second-order) autonomously strongly attached. Regardless of whether the woman's choice to get into this relationship was initially autonomous, a deep, well-functioning, lasting and happy pair bond may develop over time as the partners share experiences and emotions. Nevertheless, the concept of intimacy may be based on community-specific cultural values. The woman may actually be involved in such a pair bond autonomously. It is in her best interest this *already established* relationship to be continued. Between the woman and her partner (or husband) may have been established an authentic, affective and interactive relationship that over time may shift far beyond sexuality

However, sexuality (e.g. sexual pleasure of the woman's partner) may be instrumental in fostering the well-functioning happy relationship, all things considered. In this context, being the woman infibulated may be in all likelihood instrumental in enhancing the sexual pleasure of her male counterpart, all else being equal. Besides, because of deeply held cultural convictions the partners, the symbolic values that both place on female

genitals may be significant part of the values that underpin their pair bond. Main values are woman's 'virginity' (vaginal tightness) and man's virility and sexual pleasure. 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<sup>28</sup>. In the same belief both Somali and Sudanese women living in Norway valued (as emerged from a recent study) vaginal tightness as necessary for male sexual pleasure and thus marital stability<sup>1</sup>. Prohibition of reinfibulation might be grossly disproportionate intervention of the state insofar as reinfibulation is instrumental, all else being equal, in maintaining the *already existing* and *valuable for all culture's* status of woman's relational well-being. From a moral point of view, there is a considerable difference between posing a threat to an *already existing situation* and hopes for a future one. Besides, it is to be noted that happy pair relations are healthy not only in the broad but also in the strict sense of the term<sup>29</sup>. People with *intimate* relationships have fewer stress-related symptoms.

### ***Through the lens of phenomenology***

Further, reinfibulation might be viewed from another standpoint as being encompassed within the scope of medicine, when considering the woman's body as being-in-the-world lived body (phenomenology), the total good of which goes far beyond its medical good (enhanced principle of beneficence).

Consider women who seek reinfibulation (patients in the broad sense of the term) as persons (conceived as 'lived bodies') which pursue their total well-being (total good), of which their medical good (meant as homelike being-in-the-world) is only a component. Svenaeus uses the Heidegger's phenomenology based on his pivotal work 'Being and Time' (more specifically the phenomenological hermeneutics as a form of Gadamer's philosophical hermeneutics) as a platform of his health theory. In this perspective, Svenaeus considers that illness has an alienating character and is conceptualized as frustrating 'unhomelike being-in-the-world'<sup>30</sup>. Human-being is viewed as 'lived body'. When physician's and patient's pattern of values are merely reflections of

different attitudes toward the body related to different cultural settings there may be a morally relevant difference between the patient's more or less direct experience and understanding of his being-in-the-world and the physician's understanding of this being-in-the-world. A physician's task is to eliminate this difference. For Pellegino and Thomasma medicine is "a relation of mutual consent to effect individualized well-being by working in, with and through the body"<sup>31</sup>. In the authors' opinion medicine is a tradition of wisdom and practices through which physicians acquire the responsibility to pass on the skills of learning to live with (in and through) a body<sup>31</sup>. As body is meant 'not simply a physical body but a "lived body" which organizes a whole field of perception in addition to being the subject of a history of experiences', '...a complex human interaction in which a mutually satisfactory state of well-being is sought...'<sup>31</sup>. The end of the medicine is a moral one: the good of a person seeking help. 'Medical good is only one of the components of the complex notion of patient good. The key concept is beneficence in trust. If the physician is to heal in any true sense, he must place the medical good in the context of patient's assessment of his total good'<sup>32</sup>.

### ***Requirements to make a case for reinfibulation***

Reinfibulation may prevent the status of a woman's health (broadly understood) and well-being from getting worse through de-infibulation. Reinfibulation may be beneficial for woman's total health (understood broadly) and (sense of) well-being when, all things considered, it is expected to be instrumental in fostering her relational well-being. However, in addition to this requirement, the fulfillment of the following two major requirements may make a case for reinfibulation: a) No more than insignificant (or at least minor) complications of reinfibulation to be expected from both physician's and woman's perspective, and b) Robust autonomy (philosophically conceived) of the woman who seeks reinfibulation. Informed critical reflection (the legal model of the doctrine of informed consent that focuses entirely on the woman's actual understanding) would not be enough to

### **Might Reinfibulation be Medically Plausible?**

justify such an -in the broad sense of the term- "medical" treatment that, in addition, might -to a lesser or greater extent -be harmful to woman's physical, mental or sexual health (traditionally understood). The holistic concepts of health as well as the woman's assessment of his own total good involve (to a lesser or greater extent) some kind of subjectivity. Therefore, a "thick" philosophical account of autonomy is needed to protect individuals from their own themselves when deciding what is in their best interest in light of the holistic conception of their health.

### ***Insignificant or minor reinfibulation complications***

To make a case for reinfibulation it should not be expected that more than insignificant or minor (from the prospective of the woman) complications would be caused by the reinfibulation in question. The woman due to her previous experience as infibulated woman can from her own prospective make evaluative judgments as to whether a prospective reinfibulation would expectedly be harmful to her health (traditionally understood). However, the prospective of more than insignificant harms to health (traditionally understood) cannot be balanced against the prospective of effective improvement of the woman's overall health (broadly understood) and well-being. More than insignificant negative side-effects of reinfibulation cannot be balanced against the prospective of effective improvement of the woman's health (broadly understood) and well-being. Whilst the negative side-effects concern the woman's health in the strict sense of the term (namely, traditionally understood), the improvement of her health is conceived in the broad sense of the term health. Therefore, in effect, the principle of non-maleficence conflicts with the principle of beneficence and finally overweighs because of the following reasons: In principle, the presumed harm to health in the traditional sense of the term is more closely allied to one's identity and as such it would be expected to be much greater than the presumed harm to health in the broad (holistic-positive) sense of the term, whether it is caused directly or indirectly by violating the principle of beneficence. Besides, the principle of beneficence

is a never satisfied principle as opposed to the principle of non-maleficence.

Below are presented requirements the fulfillment of which –in author’s opinion-might make a case for reinfibulation to effectively improve the woman’s relational well-being, on the condition that from both the woman’s and physician’s perspective the possible complications of reinfibulation (concerning physical and mental health as well as sexuality) are expected to be no more than minimal. This is something that cannot be ruled out. Although inferences from the available literature that reinfibulation may not be harmful would be in principle misleading, there are some points that might give rise to assumptions that in particular and isolated cases it cannot be completely rule out that reinfibulation may be practically innocuous or minimally harmful to physical, mental or sexual aspect of health.

### ***Might (re)infibulation be minimally harmful?***

Infibulation may be harmful to physical and mental health as it may be responsible for significant obstetrical, uro-gynecological and psychosexual complications. It may cause long-term medical complications<sup>7</sup>. In this prospective, reinfibulation cannot be considered beneficial for health/well-being. However, the harms caused by infibulation may not always be as significant as western societies believe<sup>33</sup>. According to Johnsdotter and Essen’s paper infibulated Somali immigrant women reported “overall best health”<sup>33</sup>. Of course, this does not mean that these women supported infibulations. 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”.

Other studies reported no causal relationship between infibulation and obstetric complications<sup>33</sup>. 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”<sup>28</sup>. Of course, in a study with only ten participants, the other nine women had *significant* psychological and physical problems following infibulation. The particular

### **Might Reinfibulation be Medically Plausible?**

woman may be the exception to the rule that, however, is to be reckoned with.

From other paper emerges that their women reported no impact (or even positive impact) of infibulations on their mental health<sup>34</sup>. However, the same paper says: “A third of the respondents reported scores above the cut-off for affective or anxiety disorders; scores indicative for post-traumatic stress disorders were presented by 17.5% of women.” At any rate, it is to be stressed that because of the secrecy surrounding FGC there is a lack of rigorous, evidence-based research<sup>35</sup>. The observations that, in principle, infibulation may not be harmful or may be to lesser extent harmful practice would be a strong claim and lacking of serious supporters. From a very recent paper emerges that Kenyan nurses-midwives were found to be unwilling to perform reinfibulation although their knowledge “was poor to moderate on the importance of the need to leave the woman deinfibulated”<sup>36</sup>. However, exceptions seem to be not excluded in consistency with what emerges from empirical studies.

### ***Might a woman retain her sexuality post reinfibulation?***

The assumption that infibulation eliminates the female sexuality is one of the western-type false perceptions towards NTFGC/A. Infibulation does not always eliminate the woman’s capability for having sexual desire, arousal, pleasure and even achieving orgasm<sup>3,4,16-18,20</sup>. Besides, it is doubtful whether deinfibulation can enhance the existing sexuality (for reasons mentioned below) of a certain woman or even reduce it (for reasons mentioned above).

It is important that in many cases of infibulation clitoris remains intact (because of the fear of bleeding) or partially cut (having lost the “tip of the iceberg”) under the scar<sup>3,18</sup>. Even after the external part of clitoris has been removed the woman may maintain her capability for achieving orgasm. Clitoral tissue and its abundant sensory nerve endings are well-embedded in vulva pervading it and arriving beneath the surface, thus blurring the distinction between clitoral and vaginal orgasm<sup>3,15,18</sup>. Moreover, erogenous tissues may be enhanced to compensate for the absent (partially or totally) clitoris<sup>18</sup>.

Furthermore, sexuality is argued to be a highly (if not entirely) subjective issue<sup>3</sup>. The scientific assessment of sexuality as well as the overemphasized role attributed to genitals in reaching sexual satisfaction (“genital determinism”) is reliably argued to be oversimplification<sup>16-18,22</sup>. Sexuality is a multi-dimensional and complicated issue which is mentioned in the literature as interaction between mental process, relational dynamics, neurophysiological and biochemical mechanisms. These factors may interact between them and be profoundly affected by other psycho-biological and/or socio-cultural factors (perhaps overlapping)<sup>4,20</sup>.

The sexuality of a woman is argued to be strongly or entirely determined by culture<sup>3,4,22</sup>. In any case, environmental factors that reflect cultural values strongly affect the way a woman enacts her sexuality, the value that a woman places on her genitals, the meaning that she attributes to her sexual experiences as well as her own concept of the good.

A (Western-centric) study of African communities in the EU showed “the contradictory nature of women’s sexual experiences”<sup>37</sup>. In the literature the brain is said to be the most important female sexual organ<sup>38</sup>. Besides, a fulfilling pair relation full of tenderness and affection in the context of which the husband holds his wife dear and devotes plenty time to making love may determine the woman’s sexual pleasure and satisfaction<sup>4</sup>. As mentioned above, the fact that the woman is infibulated may be instrumental to developing such a pair relation, all else being equal.

In the interesting study of Florence infibulated women reported “vivid” orgasm though it is not clear whether an infibulated woman perceive the accurate meaning of orgasm<sup>3</sup>, or if there is sexual pleasure without orgasm<sup>4</sup>.

### ***Autonomy that might justify reinfibulation***

When reinfibulation is expected to improve the overall health (understood broadly) of the woman who request it, the answer to the question as to whether reinfibulation might be medically plausible is a matter of agency. Robust moral agency (relationally conceived) and congruence

### **Might Reinfibulation be Medically Plausible?**

between first-order and second-order autonomy are necessary to be established for a woman to be considered able to make autonomous choice to undergo reinfibulation. Importantly, relational models of personal autonomy provide powerful theoretical frameworks for understanding the many ways in which women might make choices under the circumstances of gender oppression. Besides, as it is presented below, in the context of political liberalism strong second-order autonomous desire of a woman with robust moral agency may be enough to make a case for reinfibulation, all other things being considered (i.e. expectedly *de minimis* harmfulness, adequate information).

### ***Relational autonomy is a true autonomy***

Autonomy is a variously conceived concept. There are several accounts of autonomy between of which there is not any evidence of superiority. Multiple perspectives about the nature of autonomy have been represented in literature. In a world of interdependence and human vulnerability the notion of autonomy is better advanced in relational terms, thus involving emphasizing ‘the social nature of the self and the social relations and conditions that are necessary for the realization of autonomy’<sup>39</sup>. A completely individualistic account of autonomy is an “illusion”<sup>40</sup>. Self-sufficient or ‘self-made’ person is an illusion<sup>41</sup>. Not only in light of Kantian approach of autonomy but also according to purely proceduralist accounts of autonomy agent’s reflection is suitably independent. However, in a world where individuals are embedded in an interactive and inter-relational complex net of dependence, intra-dependence, care and duties, self can only be conceptualized as relational self. Persons make sense in relational frameworks. Relational theories of autonomy explore how internalized oppression and oppressive social conditions undermine or erode agents’ capacity for autonomy to the point that invalidate autonomy and prevent agents from making autonomous choices. In light of relational autonomy there are connections between autonomy and other aspects of the agent, including self-conception, self-trust, self-acceptance and self-worth. In a relational analysis of autonomy, it is argued that autonomy is



a multidimensional and context-sensitive concept, 'with three distinct but causally interdependent axes: self-determination, self-governance, and self-authorization<sup>41</sup>. Self-authorization is conceptualized as an individual's *normative authority* to be self-determining and self-governing with respect to their motivational structure, to endorse their desires resulted from self-reflection<sup>41</sup>.

Relational theories of autonomy explore how internalized oppression and oppressive social conditions undermine or erode agents' capacity for autonomy to the point that invalidate autonomy and prevent agents from making autonomous choices.

### ***Robust moral agency***

It is unacceptable paternalism to impose your own cultural values to others. Within the framework of Western-type liberal democracies it would be necessary to draw a sharp line of demarcation *between* respect for the foreign culture in the sense of recognizing a woman's unlimited or unconditioned right to cultural self-determination, and unreflective acceptance of the foreign culture in the sense of allowing her to be subjected to a traditional practice that might have seriously harmful effects on her health. Tolerance of a practice does not always mean recognition of it<sup>9</sup>. For doing so, I urge the need to highlight the "Western" overlapping values of autonomy and freedom. An expression of cultural-based discrimination (perhaps cultural imperialism) towards nonwestern-type cultures is the assumption that women is no way capable of making choice to undergo infibulation (a nonwestern-type choice)<sup>20</sup>. This is wrong. The weight should be placed on determining whether there is robust moral agency. Robust enough moral agency to make 'authentic' and 'independent', namely, autonomous choice for reinfibulation could be considered established when the woman's *mechanisms and skills* of autonomy are robust and well-functioning, and she is a *strong-willed agent*, as well.

### ***Influences by external and internal factors***

Women are said to be faced with strong pressures by her family or their cultural/social environment

### **Might Reinfibulation be Medically Plausible?**

in coming to their decision on reinfibulation, though it is not a well-established association<sup>20</sup>. In fact, deinfibulated women may face pressures by midwives, family or female relatives<sup>8</sup>. Uninfibulated women are strongly threatened by stigma, ostracism, sexual and social rejection<sup>3</sup>.

Defibulated women may resist the state of defibulation because it is seen to challenge the cultural values that underlie the practice of infibulation. These values—women's virginity and virtue and men's virility and sexual pleasure — as long as are significant in the community can hinder the abandonment of reinfibulation. Besides, defibulated women may seek reinfibulation because doing so is the norm<sup>21</sup>. At any rate, as long as cultural underpinnings of infibulation are still significant in the community and, hence, within the community men proceed in not accepting "uncut" women as marriage partners, the number of requests for reinfibulation is not expected to decrease. The question is raised whether these requests are autonomous. In light of the relational account of autonomy only strong external oppressions (i.e. threat involving physical or psychological violence) or strong internalized oppression that enormously erodes the woman's skill of self/trust or self-acceptance (a basic mechanism for authenticity) would be considered influences that could invalidate the woman's choice. Below, I explain why.

Not surprisingly, in the world where we live in, people make choices that although they are profoundly influenced by both external coercions or internal impulses and compulsions, we consider them autonomous. As we in our everyday life do not make choices in a vacuum with unlimited options, ideal autonomy does not make sense. Therefore, in a world where people construct their own understanding and knowledge of the world through experiencing things and reflecting on those experiences, pursuing ideal autonomy would make a nihilistic constructivism unavoidable. Our "autonomous" decisions and choices fall short of ideal autonomy. There are hidden or overt social forces, strong or mild, that undermine the extent to which an agent's choices are ones that she has decided upon for herself. For instance, there are (sometimes strong) environmental influences regarding lifestyle, fashion, beautification, dieting,

tattooing, accepted medical treatment, hymen reconstruction surgery, breast implantation or cosmetic genital surgery (western-type NTFGC/A) that profoundly shape our 'autonomous' choices<sup>42</sup>. More particularly, there are practices of cosmetic genital surgery (as well as breast implantation surgery) that involve autonomous choice of the woman although between these practices and certain forms of NTFGC/A practices there are similarities to the extent that they are anatomically indistinguishable<sup>43</sup>. In both cases the choice of the woman may be shaped by cultural or social factors. It is stated that 30-50% of women with (Western-type) genital piercing reported abuse or forced sexual assault against their will<sup>43</sup>. There is 'patriarchy' of the 'beauty industry' that is stressed by feminists. It is reasonably argued that between the 'beauty industry' and the sexualization there is a merger with consequences for all of us<sup>44</sup>. Therefore, under strong universalism should both be practices of either permitting or banning. If not, a double standard has been applied (based on culture or even on professional interests). As Johnsdotter and Essen state, "even the pricking of the African clitoral hood is condemned, while reduction of the clitoral tissue in a European woman is legal and accepted"<sup>45</sup>. Abdulcadir et al state that "in general, in diaspora countries adult women who have undergone defibulation will be denied reinfibulation after giving birth, but the same women can access "genital cosmetic surgery", which may even be covered through social security or insurance"<sup>46</sup>.

On internalist accounts, a person's psychology should meet certain standards in order to be considered autonomous. On externalist accounts, however, a person's psychology can meet certain standards while she nonetheless fails to be autonomous. External coercion deprives an agent of the ability to make autonomous choices if and only if it amounts beyond a certain threshold so that agent's ability to make autonomous choices be profoundly manipulated. In a given case it is difficult to give a definitive answer to questions as to whether a particular external pressure is coercive to the extent that invalidates or compromises the autonomous consent (request) of the woman for reinfibulation. In this perspective, it

would serve as a piece of evidence for a robust agency the establishment of an "open door" for the woman to exit an oppressive context. If considerable external obstacles (physical or psychological) stand in the woman's *way of opting* to stay defibulated, the request for reinfibulation should not be considered autonomous. The same should hold if there is enormous internalized oppression. As in fact both internalist and externalist factors are relevant to determinations of autonomy, the autonomy accounts would be viewed as placed on an internalist/externalist spectrum<sup>47</sup>. However, in order for agents to make autonomous choices they should be able to fight external coercions and internal impulses or compulsions. As Jecker and Ko put it "a person's power over their thoughts" may be thought of as falling along a continuum in the between "the ordinary authority people exercise" and the "internal and external constraints" that adversely affect such authority<sup>48</sup>. A robust full-fledged agency may produce effectively autonomous choices. Nevertheless, the psychological mechanisms and skills that underlie autonomy may be eroded by social and cultural oppressions (external or internalized). Indeed, robust, smooth-functioning mechanisms and skills are necessary for autonomy, such as a) critical reflection (so that even seemingly irrational decisions, e.g. to undergo reinfibulation, may be reflectively endorsed), b) self-trust/regard/worth/esteem/confidence, and c) normative consciousness are required<sup>49</sup>. However, in effect, such constraints do not corrupt decision-making processes equally because of the fact that such a process is a matter of agency.

### ***The role of agent's will***

On the account of autonomy as self-governance (if not on any account of it) the *will* of the agent has crucial role. In light of the self-governing capacity-based account of autonomy, Fischer states that "the more robust notion of autonomy is inconsistent with weakness of the will"<sup>50</sup>. As regards to autonomy, a key determinant factor is whether an agent is a strong-willed agent, in the sense that she has the ability to do otherwise. An agent may be unable to do otherwise for external or internal countervailing reasons. Strong-willed

agents may be behaviorally characterized by their ability to fight against external (i.e. social) pressures to obtain their goal, as in the case of individuals seeking gender reassignment surgery. Not surprisingly, it is most likely that women who seek reinfibulation have already internalized external oppressions. This is a topic which feminist ethics is concerned with. According to feminist's authenticity conditions presuppose a "transparent and unified self"<sup>47</sup>. Due to our unconscious brain we are not always able to know ourselves. Indeed, internalized oppression is an internal stressor that acts as predisposing factor in reducing self-trust, a mechanism essential for authenticity. Women who have internalized oppression may be merely weak-willed and as such not self-governing agents. Women without infibulations are likely to display low self-competence and self-esteem for the sole reason that they feel unable to satisfy their husbands sexually. Women may have to fight against their internal pressures (impulses) that are motivated either by internalized strong oppression or by strict commitment to the cultural values of their own community. A strong woman will enable her to deal with and overcome these internal pressures. At the other end of the spectrum is the case of woman whose will (regarding genital alteration) has never been cultivated because of her internal pressures motivated by internalized oppression, strong commitment to her cultural values, or unquestioned acceptance of conformity ('doing so is the norm'). In this case, she may in fact be a passive bystander of her own pro-reinfibulation motives whose power cannot really be attributed to the woman herself.

A rigorous scrutiny must necessarily be conducted to decide whether a particular woman who seeks reinfibulation is well placed to possess freedom of will (as regards to her genital alteration) based on her capability of rational evaluation. If this is the case, she might have autonomously chosen to undergo reinfibulation.

### ***The adaptive preferences***

According to certain theorists, women *could* (to some extent) remain autonomous under oppressive circumstances and autonomously accept oppressive norms and comply with them<sup>51-53</sup>. This

is the case especially in light of a weak substantive account of autonomy<sup>54</sup>. Meyers writes that "there are women [participating in the practice of female genital cutting] who conclude that cultural tradition or cohesion or getting married and bearing children are more important than bodily integrity" and that therefore "we would need far more consensus than we presently have (or are likely to get)...before we could conclude that women who opt for compliance with female genital cutting norms never do so autonomously"<sup>53</sup>. 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". Meyers is talking about an autonomy that does not necessarily fit into the individualistic, Western construct.

This assumption that a woman who chooses to act in congruency with oppressive gender norms may be autonomous seems counterintuitive given that the feminist intuition is that "preferences influenced by oppressive norms of femininity cannot be autonomous"<sup>55</sup>. However, a closer look reveals that it is not counterintuitive. The Stoljar's claim that a woman loses autonomy only when oppressive feminine norms carry excessive weight in her life (thereby bringing into play the motivations of the woman) might receive such interpretation. As Vilman and Piper state "the fealty to oppressive gender norms built into the agent's motivational system would need to be assessed" and "a preponderance of individualized motivations in a woman's volitional amalgam would count as insufficiently influenced by oppressive feminine norms to run afoul of Stoljar's feminist intuition"<sup>41</sup>. A woman who chooses to act in congruency with oppressive gender norms for distinctive personal reasons and these reasons are the operant reasons for her choice, she may be autonomous<sup>41</sup>. In the context of gender oppression-based female genital alteration, the strength of woman's *will* would play a *particularly* dominant role in constructing a robust agency (on any account of autonomy) in retaining her autonomy. This is due to the fact that both external and internal (motives, internalized

oppression, impulses) pressures are likely to be particularly strong.

Further on, some scholars focusing on psychology rather than on philosophical (relational) accounts of autonomy argue that “blind” and “unconscious” processes of (adaptive) preferences formation are not always incompatible with autonomy<sup>56-58</sup>. Given the truth of that assumption, woman’s practical wisdom (= *phronesis* in ancient Greek) might be viewed as criteria for her capability of making autonomous choices even under gender-based oppressive conditions.

### ***Second-order autonomy***

Congruence between second-order autonomy and first-order autonomy is a condition that should be in principle met for choice to be considered autonomous<sup>42,49,59</sup>. “Second-order” autonomous person is one who forms, revises and pursues her own life on her own values, beliefs, motives, goals and desires being free from external influences or internal coercions. According to Rawls this is one’s ability to frame, revise and pursue their conception of good<sup>60</sup>. Second-order autonomous individuals are those who “actively and willingly” have chosen their *way of life*<sup>42</sup>. A woman may make second-order autonomous choice to keep her marriage functioning and strong. First-order autonomous are those who consider and endorse or reject the rules that determine their way of life<sup>42</sup>. First-order autonomous individuals are those who have “considered, questioned and adopted wholeheartedly” for themselves the rules and norms, which are part of a way of life<sup>42</sup>. When women seek reinfibulation what in reality want (their second-order autonomous desire) is to keep her marriage or intimate relationship strong whereas they reject reinfibulation on its own sake, namely, they do not make such a first-order autonomous choice. It is arguably stated that “reinfibulation is not what women really want when autonomously concluding that “cultural tradition or cohesion or getting married and bearing children are more important than bodily integrity”<sup>53</sup>. Women are likely to seek reinfibulation with second-order autonomy (because it furthers her goal of keeping her marriage) but without first-order autonomy

(because she does not endorse the practice of reinfibulation for its own sake). She is not first-order autonomous as regards the practice of reinfibulation. Agents are second-order autonomous, on Frankfurt’s account, only when are wholeheartedly identified with their second-order desires. The “wholehearted identification” of the women with her second-order desire for keeping her marriage strong is necessary condition and ensures that her desire is truly hers. However, it is unclear to what notion this vague ‘identification’ bears witness. On Frankfurt’s account “wholehearted identification” means that an agent’s “volitions derive from the essential character of his will”<sup>59</sup>, so that her choices are central to her identity. Second-order autonomy may be coercively denied, as in the case of strong gender oppression, or may be absent because it has never been cultivated, as in the case of a woman who follows norms without questioning them, in the belief that ‘doing so is the norm’. The salience of cultural values that are specific to a woman’s community or internalized gender oppression may cause a kind of “pro-social impulse” at the expense of her true wills and motivations.

Although congruence between second-order autonomy and first-order autonomy is a condition that should be in principle met to make a case for reinfibulation, in the context of political liberalism a strong second-order autonomous decision may be enough to make a case for this practice. Put generally, political liberalism prioritizes second-order autonomy over first-order autonomy<sup>25</sup>. Second-order autonomous choice may involve alienating of first-order autonomy. Not surprisingly, in case that reinfibulation represents an essential ingredient in keeping the particular marriage alive, for instance because from her husband’s prospective the particular marriage does not make sense without it, the woman’s choice to get married with the particular husband involves alienating of her first-order autonomy. Political liberalism ought to give the citizens considerable leeway to create their own concept of good and choose their own *ways of life*. One could counterclaim that political liberalism focuses on citizens not on moral agents as such. Nevertheless, in author’s opinion, political autonomy (liberally conceptualized) cannot be

separated from personal autonomy (relationally conceptualized).

### ***Informed consent (request)***

Respect for the woman's autonomy can practically be shown through commitment to her *informed consent (request)*. Therefore, *adequate information* should have been provided. Further, her physician should go far in helping reinfibulation-seekers to be aware of their values. Her physician should go beyond information and help the reinfibulation-seeker to insight her situation and be *actively* engaged in her decision-making process with her *values, preferences and emotions*, so that her informed consent effectively promote her autonomy. Given the physician's enhanced responsibility towards a patient (traditionally understood, whose best interest is self-evident) to go beyond providing adequate information<sup>61</sup>, this responsibility would be considered much more enhanced when it comes to patient in the broad sense of the term (i.e. a woman who seeks reinfibulation to improve or preserve her well-being), whose best interest is questionable.

A valid informed consent process should be established before reinfibulation. It should be evaluated by a psychiatrist. The woman should receive clear, concise and unbiased information. Many women seeking reinfibulation are inadequately informed or are not included in their decision-making process<sup>8</sup>.

A woman may request (consent to) reinfibulation with the idea that it will bridge her to happiness related to intimacy, given that reinfibulation is expected to be instrumental in promoting both physical and emotional intimacy. Nevertheless, this intimacy-related happiness may in reality be unrealistic optimism. As in the case of traditional patients who are unrealistically optimistic<sup>62</sup>, her eventual self-deception (perhaps motivated by internalized gender oppression) may (create barriers to or) distort her understanding about the risks, benefits and consequences of reinfibulation. However, the distinction between realistic and unrealistic hopes (self-deception) may be blurred given that within communities of women who seek reinfibulation the decision-making process is reported to be "complex" and "dynamic"<sup>19</sup>. These communities have the key to

### **Might Reinfibulation be Medically Plausible?**

nudging her toward the option of reinfibulation, thus undermining the extent to which her choice to undergo reinfibulation is one that she has decided upon for herself. This is adaptive preference formation<sup>57</sup>. Therefore, we should be more permissive in our approach to them unless they are apparently living in a state of self-deception and thus in all likelihood their choice to undergo reinfibulation would be clearly bad for them in light of their own values, beliefs and goals. At any rate, a discussion between her physician and her husband seems useful before going to reinfibulation.

### ***Practical wisdom as criteria for decision-making capacity***

As is anticipated above it is argued that "blind" and "unconscious" processes of (adaptive) preferences formation are not always incompatible with autonomy. Although not intentional or under the woman's control, her choices to decide in favor of oppressive conditions could not automatically count as non-autonomous. Bruckner claims (and employs empirical evidence for this claim) that adaptive preferences that cannot be reflectively endorsed can be conducive to subjective well-being, thereby promoting a valuable life<sup>56</sup>. In this perspective, one can see possible relevance of practical wisdom as criteria for determining a woman's capacity to make autonomous choices even though under circumstances of gender oppression. Practical wisdom is a (perhaps *the*) fundamental virtue and represents the excellence of practical thought that is an essential element of decision-making process. Recently scholars have argued that practical wisdom might be viewed as criteria for decision-making capacity of individuals with mental disorders and, hence, with limited cognitive functions. Widdershoven *et al.* argue that practical wisdom might be a criteria for decision-making capacity and consider the following as conditions for practical wisdom to be established in a given case: Agent's ability to organize her pattern of values that are closely allied to her (narrative) self, agent's ability to find a balance between extreme emotions (not pathogenic in author's opinion) and define a goal of meaningful life according to *her own*

*conception of the good*<sup>63</sup>. As it is anticipated above, political liberalism has to be by definition respectful of one's own conception of good. However, such a conception may reflect the cultural values that are strictly related to a particular community. As in analogy to a mental disorder gender oppression may erode a woman's psychological autonomy-underling mechanisms such as critical reflection, one could find similarities between decision-making capacity in mental illness and under gender oppressive circumstances. Hence, if practical wisdom might be criteria for decision-making capacity of an agent with mental illness it would also be criteria in the instance that a woman makes choices under gender oppression.

## **Conclusion**

After having conducted a non-systematic review of the relative literature, the paper addresses the issue in light of the relational account of autonomy as well as the modern (holistic and phenomenological) account of health. Significant and constant discomfort in the body following defibulation might make a case for reinfibulation (considered as medical treatment in the traditional sense of the term). The following requirements should be met for reinfibulation to be considered medically plausible: a) strong evidence that reinfibulation could help effectively improve woman's relational well-being, b) insignificant complications are expected, c) congruence between first-order and second-order autonomy or -in the context of political liberalism - strong second-order autonomy, d) an "open door" for the woman to exit an oppressive context, e) rigorous scrutiny of woman's psychology (to establish robust autonomy-underling mechanisms and skills, strong will and motivations, lack of strong internalized oppression), and f) woman's practical wisdom to organize her identity-related values, find a balance between her extreme emotions and realize her own goal of meaningful life in accordance with her own conception of the good.

Ending up: In carefully screened cases and individually judged requests for reinfibulation, it should not be ruled out that, after having been conducted a multi-disciplinary in-depth investigation at social, psychological and medical

## **Might Reinfibulation be Medically Plausible?**

level, may be met conditions that make a case for reinfibulation. However, such investigation is a difficult task that requires a multi-personal and multi-disciplinary committee to conduct it under the individual circumstances in a given case. I stress the crucial role of virtue ethics, especially of practical wisdom (= *phronesis*), in making sensitive and difficult assessments regarding the particularities of each individual case. Principlism does not suffice to solve extremely complex dilemmas, particularly when the solution is influenced by a multiplicity of factors.

Finally, it is to be highlighted that given the truth of the assumption I defend in this paper, all the stakeholders involved in the case of reinfibulation should get together and share data and experience to strike an appropriate balance between the principle of non-maleficence and the principle of respect for the foreign culture in Western democracies where pluralism and bodily integrity should, in principle, be respected equally.

## **Funding**

This research received no specific grant from any funding agency in the public, commercial or not-for-profit sectors.

## **Availability of Data and Materials**

This paper is based on publicly available data and materials. For this paper I made use of articles published in international journals, to be found on, for example PubMed.

## **Competing Interests**

The author declares that he has no competing interest.

## **Contribution of Authors**

Dr Polychronis Voultzos is the author who conceived and designed the study as well as the person who collected and analysed the data and the person who prepared and approved the manuscript.

## References

1. Johansen RE. Virility, pleasure and female genital mutilation/cutting. A qualitative study of perceptions and experiences of medicalized defibulation among Somali and Sudanese migrants in Norway. *Reprod Health*. 2017 Feb 10;14(1):25.
2. World Health Organization. Eliminating female genital mutilation. An interagency statement. Geneva: WHO, 2008.
3. Earp BD. Between moral relativism and moral hypocrisy: Reframing the debate on “FGM.” *Kennedy Institute of Ethics Journal* 2016; 26(2):105-44.
4. Catania L, Abdulcadir O, Puppo V, Verde JB, Abdulcadir J and Abdulcadir D. Pleasure and orgasm in women with female genital mutilation/cutting (FGM/C). *The Journal of Sexual Medicine* 2007; 4(6): 1666-78.
5. Leye E, Ysebaert I, Deblonde J, Claeys P, Vermeulen G, Jacquemyn Y and Temmerman M. Female genital mutilation: Knowledge attitudes and practices of Flemish gynaecologists. *The European Journal of Contraception and Reproductive Health Care* 2008; 13(2):182-90.
6. Abdulcadir J, Marras S, Catania L, Abdulcadir O and Petignat P. Defibulation: A Visual Reference and Learning Tool. *J Sex Med*. 2018;15(4):601-11.
7. Toubia N. Female Circumcision as a Public Health Issue. *The N Engl J Med* 1994; 331 (11): 712-6.
8. Serour GI. The issue of reinfibulation. *International Journal of Gynaecology and Obstetrics* 2010; 109(2): 93-6.
9. Galeotti AE. Relativism, universalism, and applied ethics: the case of female circumcision. *Constellations* 2007;14(1):91-111.
10. Bello S, Ougbue M, Chibuzor M, Okomo U and Meremikwu MM. Counselling for deinfibulation among women with type III female genital mutilation: A systematic review. *Int J Gynaecol Obstet*. 2017;136 Suppl 1:47-50.
11. Abdulcadir J, McLaren S, Boulvain M and Irion O. Health education and clinical care of immigrant women with female genital mutilation/cutting who request postpartum reinfibulation. *Int J Gynaecol Obstet*. 2016;135(1):69-72.
12. Vrachnis N, Salakos N, Iavazzo C, Iliodromiti Z, Bakalianou K, Kouiroukidou P and Creasas G. Female genital mutilation in Greece. *Clin Exp Obstet Gynecol* 2012; 39(3): 346-50.
13. Svenaeus F. Organ transplantation and personal identity: how does loss and change of organs affect the self? *J Med Philos*. 2012;37(2):139-58.
14. Elson J. Hormonal Hierarchy. Hysterectomy and Stratified Stigma. *Gender & Society* 2003; 17(5): 750-70.
15. Shweder RA. The goose and the gander: The genital wars. *Global Discourse* 2013; 3(2): 348-66.
16. Obermeyer C. The consequences of female circumcision for health and sexuality: an update on the evidence. *Culture, Health & Sexuality* 2005;7(5): 443-61.
17. Obermeyer CM. The health consequences of female circumcision: science, advocacy, and standards of evidence. *Medical anthropology quarterly* 2003; 17(3): 394-412.
18. Obermeyer CM. Female genital surgeries: The known, the unknown, and the unknowable. *Medical anthropology quarterly* 1999; 13(1): 79-106.
19. Gruenbaum E. The cultural debate over female circumcision: the Sudanese are arguing this one out for themselves. *Med Anthropol Q*. 1996;10(4): 455-75.
20. Public Policy Advisory Network on Female Genital Surgeries in Africa. Collaborators: Abdulcadir J, Ahmadu FS, Catania L, Essen B, Gruenbaum E, Johnsdotter S, Johnson MC, Johnson-Agbakwu C, Kratz C, Sulkin CL, McKinley M, Njambi W, Rogers J, Shell-Duncan B, and Shweder RA. Seven things to know about female genital surgeries in Africa. *The Hastings Center Report* 2012; 42(6): 19-27.
21. Mackie G and LeJeune J. Social dynamics of abandonment of harmful practices: a new look at the theory. *Special Series on Social Norms and Harmful Practices, Innocenti Working Paper No. 2009-06, UNICED Innocenti Research Centre, Florence, 2009.*
22. Johnsdotter S. Discourses on sexual pleasure after genital modifications: the fallacy of genital determinism (a response to J. Steven Svoboda). *Global Discourse* 2013; 3(2): 256-65.
23. Nordenfelt L. *On the nature of health: an action-theoretic approach*. 2<sup>nd</sup> revised & enlarged edn. Dordrecht: Kluwer Academic. 1995.
24. Venkatapuram S. Health, vital goals, and central human capabilities. *Bioethics*. 2013; 27(5):271-9.
25. Nussbaum MC. *Frontiers of justice: disability, nationality, species membership*. Cambridge, MA: The Belknap Press of Harvard University Press. 2006.
26. Sen A. *The Idea of Justice*. London: Allen Lane. 2009.
27. Richman KA. *Ethics and the Metaphysics of Medicine. Reflections on Health and Beneficence*. Cambridge, MA: The MIT Press, 2004.
28. Moxey JM and Jones LL. A qualitative study exploring how Somali women exposed to female genital mutilation experience and perceive antenatal and intrapartum care in England. *BMJ Open*. 2016; 6(1):e009846. doi: 10.1136/bmjopen-2015-009846
29. Savulescu J and Sandberg A. Neuroenhancement of love and marriage: The chemicals between us. *Neuroethics* 2008;1(1):31-44.
30. Svenaeus F. Illness as unhomelike being-in-the-world: Heidegger and the phenomenology of medicine. *Med Health Care Philos*. 2011; 14(3):333-43.
31. Pellegrino ED and Thomasma DC. *A philosophical basis of medical practice*. New York: Oxford University Press. 1981: pp: 69, 73-4, 80, 147.

32. Pellegrino ED and Thomasma DC. *The Virtues in Medical Practice*. New York, Oxford: Oxford University Press. 1993: pp. 73-4.
33. Johnsdotter S and Essén B. Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Pract Res Clin Obstet Gynaecol*. 2015 Oct 24. pii: S1521-6934(15)00195-9.
34. Knipscheer J, Vloeberghs E, van der Kwaak A and van den Muijsenbergh M. Mental health problems associated with female genital mutilation. *BJPsych Bull*. 2015;39(6):273-7.
35. Creighton SM and Hodes D. Female genital mutilation: what every paediatrician should know. *Arch Dis Child*. 2016;101(3):267-71
36. Kimani S, Esho T, Kimani V, Muniu S, Kamau J, Kigundu C, Karanja J and Guyo J. Female Genital Mutilation/Cutting: Innovative Training Approach for Nurse-Midwives in High Prevalent Settings. *Obstet Gynecol Int*. 2018 Mar 15;2018:5043512.
37. Brown K, Beecham D and Barrett H. The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches. *Obstetrics and Gynecology International Article ID 324362*, 12 pages, 2013. doi:10.1155/2013/324362
38. Heiman JR. Orgasmic disorders in women. In: Leiblum SR, ed. *Principles and Practice of Sex Therapy*. New York: Guilford, 2007: 84
39. MacKenzie C and Stoljar N. (Ed.). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. New York: Oxford University Press. 2000. pp: 4.
40. Nedelsky J. *Law's Relations: A Relational Theory of Self, Autonomy, and Law*. New York: Oxford University Press. 2011.
41. Veltman A and Piper M. (Ed.). *Autonomy, Oppression and Gender*. New York: Oxford University Press. 2014. pp: 15-41, 118.
42. Chambers C. Are breast implants better than female genital mutilation? Autonomy, gender equality and Nussbaum's political liberalism. *Critical Review of International Social and Political Philosophy* 2004; 7(3): 1-33.
43. Nelius T, Armstrong ML, Rinard K, Young C, Hogan L and Angel E. Genital piercings: diagnostic and therapeutic implications for Urologists. *Urology* 2011;78:998–1008.
44. Johannsdottir NK. Patriarchy and the subordination of women from a radical feminist point of view. *Universitatis Islandiae Sigillum. Hugvísindasvið*. 2009. p. 20. Available from: [https://skemman.is/bitstream/1946/3017/1/Nina\\_Ka\\_trin\\_Johannsdottir\\_fixed.pdf](https://skemman.is/bitstream/1946/3017/1/Nina_Ka_trin_Johannsdottir_fixed.pdf) (Last accessed: 15 June 2018).
45. Johnsdotter S and Essen B. Genitals and ethnicity: the politics of genital modifications, *Reproductive Health Matters* 2010; 18(35): 29-37.
46. Abdulcadir J, Alexander S, Dubuc E, Pallitto C, Petignat P and Say L. Female genital mutilation/cutting: sharing data and experiences to accelerate eradication and improve care. *Reprod Health*. 2017 Sep 15;14(Suppl 1):96.
47. McGill-Rutherford E. *Feminism, Liberalism, and Relational Autonomy*. Dissertation Submitted to the Faculty of the Graduate School of Vanderbilt University. In partial fulfillment of the requirement for the degree of Doctor of Philosophy. In *Philosophy* August, 2015 Nashville, Tennessee. Available from: <https://etd.library.vanderbilt.edu/available/etd-06052015-104052/unrestricted/McGill-Rutherford.pdf> (Last accessed: 15 June 2018).
48. Jecker NS and Ko AL. Is that the Same Person? The Problem of Identity Following Neurosurgical Interventions. *AJOB Neuroscience* 2017 [Ahead of Print].
49. *Stanford Encyclopedia of Philosophy*. *Feminist Perspectives on Autonomy*. (First published Thu May 2, 2013). Available from: <http://plato.stanford.edu/entries/feminism-autonomy/> (Last accessed: 15 June 2018).
50. Fischer JM. Responsibility and autonomy: The problem of mission creep. *Philosophical Issues* 2012a; 22: 165–84.
51. Christman J. Relational Autonomy, Liberal Individualism, and the Social Constitution of Selves. *Philosophical Studies*, 2004; 117: 143–64 (152).
52. Westlund A. Rethinking Relational Autonomy. *Hypatia* 2009; 24: 26–49 (29).
53. Meyers DT. Feminism and Women's Autonomy: The Challenge of Female Genital Cutting. *Metaphilosophy*, 2000a; 31: 469–91 (479).
54. Benson P. Feminist Intuitions and the Normative Substance of Autonomy. In: Taylor JS (Ed.). *Personal Autonomy*. Cambridge, UK: Cambridge University Press, 2005, 128–30, 136.
55. Stoljar N. Autonomy and the Feminist Intuition. In: Mackenzie C and Stoljar N (Ed.). *Relational Autonomy: Feminist Perspectives on Autonomy, Agency, and the Social Self*. New York: Oxford University Press, 2000, 95.
56. Bruckner DW. In defense of adaptive preferences. *Philosophical Studies* 2009; 142 (3):307 – 24.
57. Colburn B. Autonomy and Adaptive Preferences. *Utilitas* 2011; 23(1): 52-71 (57).
58. Elster J. Sour Grapes - Utilitarianism and the Genesis of Wants. In: Sen AK and Williams BAO (Ed.). *Utilitarianism and Beyond*. New York: Cambridge University Press, 1982, 219—38 (225).
59. Frankfurt, HG. Reply to Gary Watson. In: Buss S and Overton L (Ed.). *Contours of Agency: Essays on Themes from Harry Frankfurt*. Cambridge, Massachusetts: MIT Press, 2002, 160-64.
60. Rawls J. *Justice as Fairness: A Restatement*. Cambridge, MA: Harvard University Press. 2001.p: 19.



*Polychronis Voultzos*

61. Ubel PA, Scherr KA and Fagerlin A. Empowerment Failure: How Shortcomings in Physician Communication Unwittingly Undermine Patient Autonomy. *Am J Bioeth.* 2017;17(11):31-9.
62. Blumenthal-Barby JS and Ubel P. In Defense of “Denial”: Difficulty Knowing When Beliefs Are

Might Reinfibulation be Medically Plausible?

- Unrealistic and Whether Unrealistic Beliefs Are Bad. *Am J Bioeth* 2018 [Ahead of Print].
63. Widdershoven GAM, Ruissen A, van Balkom AJLM and Meynen G. Competence in chronic mental illness: the relevance of practical wisdom. *J Med Ethics.* 2017 Jun;43(6):374-78.