EMPOWERING HEALTHCARE PROFESSIONALS:
Unveiling the Harms of Female Circumcision in Malaysia

ACKNOWLEDGEMENTS

MALAYSIAN DOCTORS FOR WOMEN & CHILDREN

The Malaysian Doctors for Women & Children (MDWC) is an academic forum by Malaysian doctors who are passionate about the scientific discourse of non-medical cultural practices that impact women and children.

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AIM OF THE LEAFLET

This leaflet aims to provide accurate information on the practice of female circumcision in Malaysia to healthcare professionals, with the ultimate objective of bringing about the cessation of this practice within Malaysia.

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WHAT IS FEMALE CIRCUMCISION?

Female circumcision in Malaysia and several other Southeast Asian countries is commonly performed on female infants as young as one-month-old.[1–4] This practice involves nicking or pricking the clitoral prepuce/hood with the requirement of drawing a drop of blood to complete the ritual[1–4] and is classified as Type 4 female genital cutting (FGC) according to the WHO classification. Arguably, the nicking of the clitoral hood by a *Mak Bidan* (traditional birth attendant), producing a small piece of teased-out tissue typically given to the mother for burial, should be classified as Type 1 FGC.[4] A report on the medicalisation of this practice in Malaysia has revealed that 36% of the 20.5% of doctors who practised FGC would cut the tip of the visible part of the clitoris with surgical scissors.[2] This also meets the classification for Type 1 FGC.

TABLE 1: THE UPDATED 2007 WHO CLASSIFICATION OF FGC:[5]

Type	Description
TYPE 1 CLITORIDECTOMY	Partial or total removal of the clitoral glans and/or the prepuce/clitoral hood. ▸ **Type 1a:** Removal of the prepuce/clitoral hood only. ▸ **Type 1b:** Removal of the clitoral glans with the prepuce/clitoral hood.
TYPE 2 EXCISION	Partial or total removal of the clitoral glans and the labia minora, with or without removal of the labia majora ▸ **Type 2a:** Removal of the labia minora only. ▸ **Type 2b:** Partial or total removal of the clitoral glans and the labia minora (prepuce/clitoral hood may be affected). ▸ **Type 2c:** Partial or total removal of the clitoral glans, the labia minora and the labia majora (prepuce/clitoral hood may be affected).
TYPE 3 INFIBULATION	Narrowing of the vaginal opening with the creation of a covering seal. The seal is formed by utting and repositioning the labia minora, or labia majora. The covering of the vaginal opening is done with or without removal of the clitoral prepuce/clitoral hood and glans. ▸ **Type 3a:** Removal and repositioning of the labia minora. ▸ **Type 3b:** Removal and repositioning of the labia majora.
TYPE 4 OTHERS	Any other harmful procedures including piercing, incising, scraping, cauterising, and pricking the female genitalia for non-medical reasons.

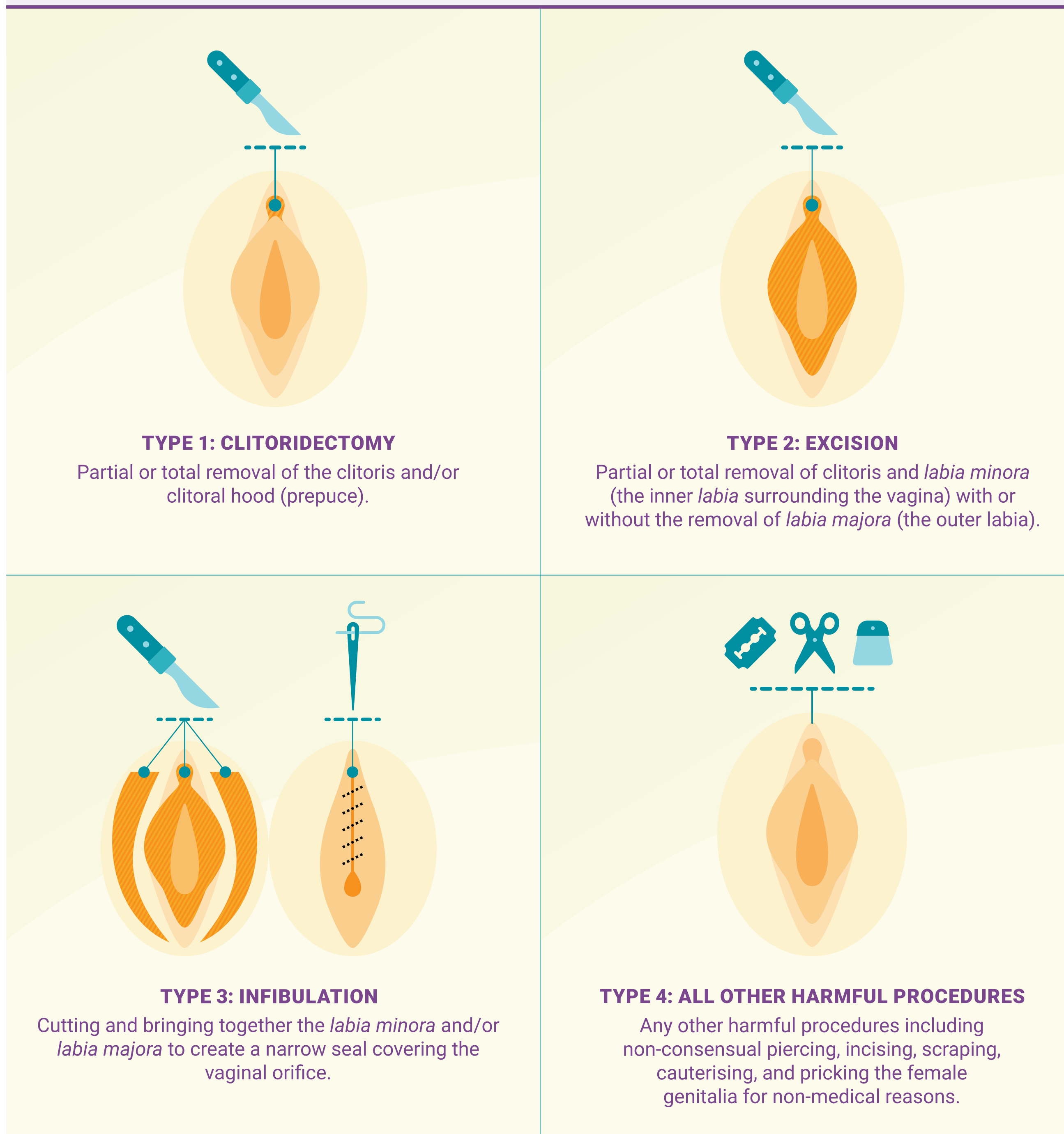
THE CORRECT TERMINOLOGY

The term "circumcision" finds its etymological roots in Latin, from *circum* "around" and *caedere* "to cut." This definition raises the question of whether the Malaysian practice of nicking or pricking the clitoral prepuce/hood should be characterised as female circumcision.

Furthermore, a pertinent inquiry arises regarding the suitability of applying the term "female genital mutilation" (FGM) to the Malaysian practice of "female circumcision." According to the Oxford Advanced Learner's Dictionary, the definition of mutilation is "to damage someone's body very severely, especially by cutting or tearing off part of it" which is not an accurate description of the Malaysian practice. Thus, the term "mutilation" is based on subjective value judgement, contingent on the perspective of the observer, rather than an impartial and accurate description of the Malaysian practice. This could also explain the decision adopted by the Office of the Mufti of the Federal Territory of Malaysia (Islamic directorate)[6] to distance the Malaysian practice from FGM. Granted, it may be argued that the act of using a sharp instrument on the genitalia of a female infant carries connotations that invoke the term "mutilation." However, it is important to note that in the context of the Malaysian practice, no visible alteration or disfigurement of the female genitalia is evident[3] although conclusions cannot be made on the impact of FGC on sexual pleasure. Consequently, it is more appropriate to define the Malaysian practice as female genital cutting (FGC) rather than female circumcision or FGM, notwithstanding the frequent interchangeability of these terms within the international advocacy context.

We hope to enlighten our readers on the potential harms of FGC as practised in Malaysia by understanding the

FIGURE 1: WHO CLASSIFICATION OF FGC TYPES 1 TO 4



SOURCE: WHO Classification of Female Genital Mutilation (FGM/C), taken from "Ending FGC: A Toolkit for Engaging Practitioners" by the Asia Network to End FGM/C.[7]

female genitalia which may prompt readers to question the categorisation of the Malaysian practice as female circumcision, FGC or FGM. The usage of terminology and definitions may in course influence the attention given to this practice, for example, usage of the term FGC instead of FGM may reduce the seriousness and severity of harm potentially inflicted on female infants.

It is also important to reiterate, that all parties involved in the development of this leaflet **do not endorse** the Malaysian female circumcision or any other form of FGC or FGM.

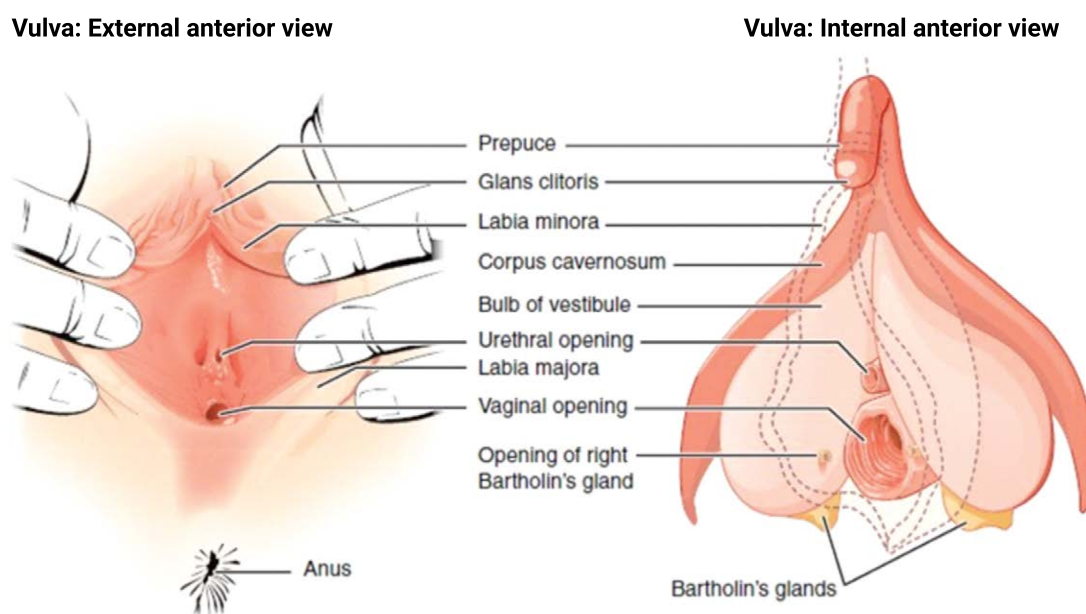
In this leaflet, the terms female circumcision and FGC will be used interchangeably as the Malaysian public is more familiar with the term female circumcision.

THE FEMALE EXTERNAL GENITALIA

The female external genitalia are commonly called the vulva (Figure 2). This area consists of the mons pubis, labia majora, labia minora, the opening of the vagina, the opening of the urinary tract, and the external part of the clitoris.

This booklet by the British Society of Paediatric and Adolescent Gynaecology on normal vulval variations can be sourced and downloaded at: http://legacy.brook.org.uk/data/Sowhatisavulvaanyway.april12.18-2.pdf, and shared with patients. You may refer to their website at: https://britspag.org/.

FIGURE 2: THE FEMALE EXTERNAL GENITALIA AND THE CLITORIS[8]



SOURCE: Lumen Learning. Anatomy and Physiology of the Female Reproductive System. https://courses.lumenlearning.com/suny-ap2/chapter/anatomy-and-physiology-of-the-female-reproductive-system/.

The Clitoris

The clitoris, a majority of which is internal, is essential for sexual pleasure (Figure 3). This internal part consists of paired crura and vestibular bulbs. The vestibular bulbs surround the vaginal vestibule posteriorly and anterior of the paired crura, which arises from the clitoral body. The vestibular bulbs swell and become bigger when aroused.

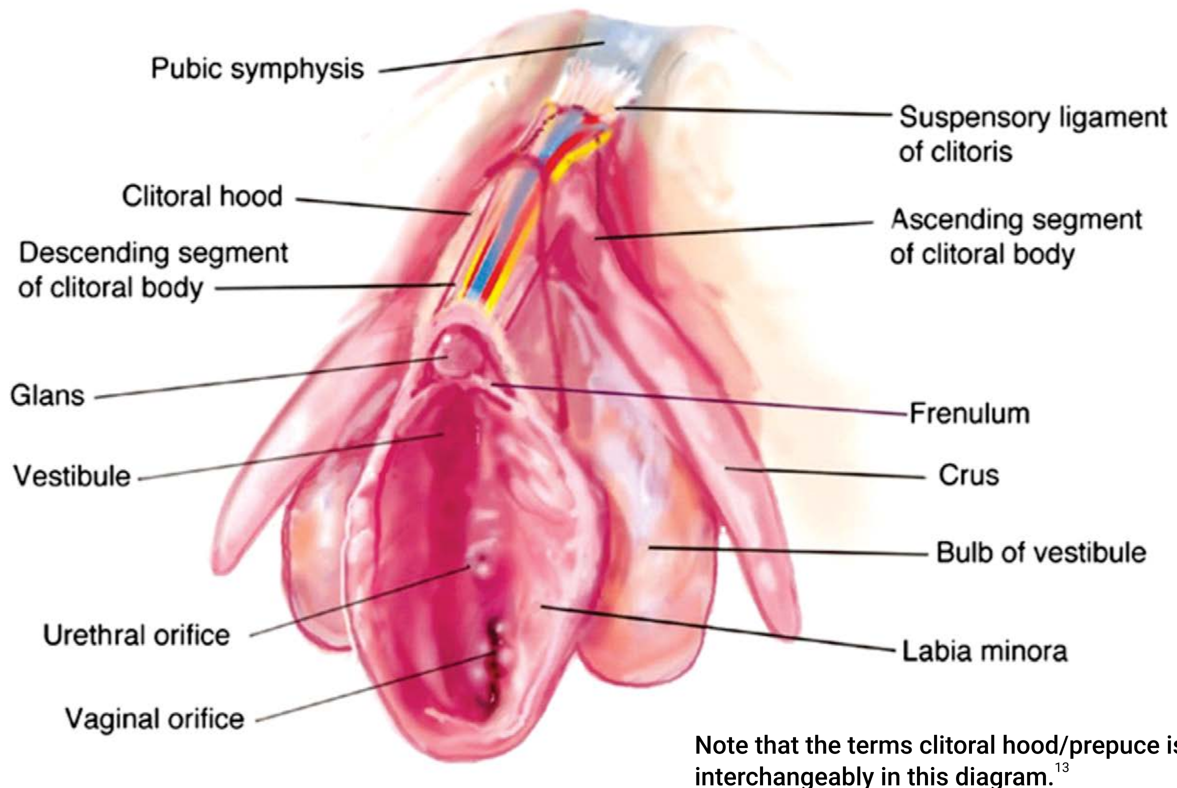
The external clitoris consists of the descending part of the clitoral body (clitoral shaft) which continues to the clitoral glans (tip of the external clitoris). Covering the descending part of the clitoral body is the clitoral prepuce, which is connected to the clitoral hood, the loose end of the clitoral prepuce which covers the clitoral glans.[9, 10] Therefore, the clitoral prepuce is formed of three parts: (i) the base, which is connected to the mons pubis and which covers the ascending part of the clitoris, (ii) the prepucial body, which covers the descending part of the clitoral body (clitoral shaft), and (iii) the clitoral hood, which covers the clitoral glans.[9, 10] However, the terms clitoral hood and prepuce are used interchangeably in many textbooks.

The mean length of clitoral glans/prepuce in female newborns was 0.67 ± 1.6mm in a study.[11] In another study looking at 85 zero- to three-year-old girls, the mean clitoral hood length was 0.87mm.[12] Brodie *et al*. (2016) also noted that the clitoral hood becomes more retractile with age.[12] Thus, the clitoral hood is highly adherent or connected to the body in female infants. Additionally, there are blood vessels and dorsal nerves mere millimetres underneath the clitoral prepuce. In a study of ten adult female cadavers,[13] the mean length of the descending clitoral body (clitoral shaft) was 37.0mm (Figure 4). The clitoral dorsal nerves are within 6mm of the clitoral glans. The mean number of nerve fibres in these dorsal nerves in adults is 10, 281.[14] Compared to the human hand (18, 288 median nerve fibres and 16,412 ulnar nerve fibres), the density of nerve fibres in the dorsal nerve of the clitoris is higher, despite the human hand being larger.[14] Additionally, a large part of

the descending part of the clitoral body is external, with some studies suggesting up to two-thirds[13] or even three-quarters of it.[10]

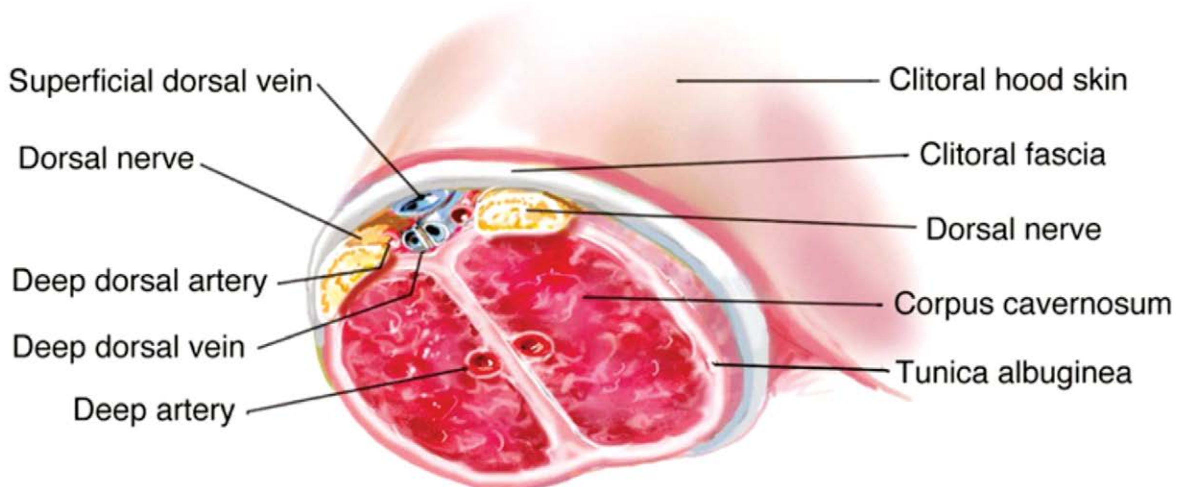
Therefore, any nicking, pricking, or cutting of the clitoral glans/prepuce in female infants causes immense pain and damages growing tissue with potentially serious repercussions in adulthood.

FIGURE 3: THE CLITORIS



Note that the terms clitoral hood/prepuce is used interchangeably in this diagram.[13]

FIGURE 4: BLOOD VESSELS AND THE PAIRED DORSAL NERVES



Blood vessels and the paired dorsal nerves are mere millimetres underneath the clitoral hood/prepuce.[13]

SOURCE FOR FIGURES 3 and 4: Kelling JA, Erickson CR, Pin J, Pin PG. Anatomical dissection of the dorsal nerve of the clitoris. doi:10.1093/asj/sjz330.

WHAT GOVERNS SEXUAL DRIVE AND MOTIVATIONS

Considering the information in the previous section on nerve endings and sensations, we can argue that female circumcision may impact sexual drive and motivations.

Sexual motivation, arousal, and desire are important concepts that play a crucial role in understanding human sexual behaviour. Sexual desire is often viewed as a multi-dimensional construct, consisting of three distinct components that interact with each other: drive, motivation, and wish.[15] The drive component is influenced by neurochemical and neuroendocrine conditions in an individual, which can affect their level of sexual desire. Motivation, the psychological interest to engage in sexual behaviour, is influenced by interpersonal relationships and personal emotions, such as love and attachment, that can either enhance or inhibit sexual desire. The third component, wish, is influenced by cultural values and previous sexual experiences that shape an individual's sexual desires.

These three components combine to shape sexual desire that can increase the likelihood of responding to sexual stimuli. Sexual arousal is defined as the physiological response of the genitals to sexual stimuli and is distinct from sexual motivation.[15] It is important to note that sexual motivation and arousal can be influenced by a variety of factors, including age, gender, sexual orientation, and cultural background. In addition, the relationship between sexual motivation and arousal is complex and dynamic, with each component reciprocally affecting the other.[15] Understanding these concepts is essential in developing a comprehensive understanding of human sexual behaviour, and to shape effective interventions to address sexual dysfunction and other related issues.

Some *Mak Bidans* have stated that female circumcision is performed to prevent girls from becoming promiscuous.[16] However, it is unlikely that female circumcision will curb their sexual desire and there is no evidence that uncircumcised girls are 'wilder' than circumcised girls. Female circumcision may however impair their sexual motivation and ability to enjoy sexual intercourse due to the damage to the clitoral tissue.

THE IMPACT OF FGC

The Physical Impact of FGC

The Malaysian practice of Type 4 FGC, that is, nicking or pricking,[1–4] causes immediate and severe pain and distress in female infants. Infants feel the same intensity of pain as adults, as proven in a functional magnetic resonance imaging (MRI) imaging, where brain regions that correspond to pain light up in infants in a similar way to adult brains.[17] It is thus unethical to subject female infants to a noxious stimulus to their clitoris, a highly dense area of nerve fibres, for no benefit. However, the practice continues as there were no short- and[2] long-term effects reported.[3]

However, the nicking of the clitoral prepuce/hood produced a small teased-out tissue and therefore should be classified as Type 1 FGC.[4] *Mak Bidans* who carried out this practice showed a lack of anatomical knowledge as they believed that if female circumcisions were not performed, the clitoris will expand and occlude the vaginal orifice making penetration difficult and sexual intercourse not pleasurable.[4] Increasingly, parents were concerned that *Mak Bidans* use unsterilised instruments, are not medically trained, and are not informed or equipped enough to prevent infection.[2]

This has led to parents choosing doctors over *Mak Bidans* to perform the procedure, perceiving that having doctors perform female circumcision would reduce complications. Doctors (20.5% of the total respondents in a study) also believe that this procedure should be done by them to reduce the risk of infection. These doctors believe that FGC was necessary due to religious requirements and health reasons.[2]

Even more worryingly, a substantial number of doctors implied that they may not have sufficient knowledge on clitoral anatomy and physiology, and the practice varies between doctors (Table 2).[2] Malaysian Muslim doctors also prefer to perform FGC on much younger female infants – between four to six months old (34.7%) versus at seven to twelve months old (32.0%).[2] Unfortunately, more damage could be done to younger infants, as they could be removing too much growing tissue. It is extremely difficult to not injure or damage nerves and blood vessels which are mere millimetres underneath the clitoral prepuce/hood,[13] and retraction of the clitoral hood is more difficult in infants.[12] Where FGC was done in older girls such as five to seven year olds, such as in Sri Lanka among the

Muslim Bohra community, girls who had Type 1 FGC done remembered the procedure to be extremely painful to the point of momentarily “losing the ability to speak, hear, or see” (Anonymous, personal communication with Dr Hannah Nazri).

BOX 1: QUOTED REMARKS FROM DOCTORS PRACTISING FGC, OBTAINED FROM IN-DEPTH INTERVIEWS[2]

“We prick the prepuce…Just nick…just prick”
- Respondent 9

“Somebody teach [taught] me just to prick with the needle but I think it is not proper”
- Respondent 16

“There is nothing to be remove[d] except for the clitoris…you do like aaa…you remove small part but not actually small part…”
- Respondent 11

“…The tip of the clitoris, I cut it with the scissors”
- Respondent 20

“We cut…we try to get the small part of the clitoris. [asked again whether the clitoris is cut and not the prepuce over the clitoris]…No, no…ya [yes] clitoris is cut”
- Respondent 17

“…Then I cut a very small, very little piece of clitoris”
- Respondent 16

Female circumcision is not taught in medical schools and most doctors learn to perform female circumcision from more senior colleagues, while others learn it from traditional healers.[2] Additionally, 86.7% of doctors do not use any form of anaesthetic and 62.7% do not screen for bleeding or infectious disorders before performing the procedure. Those who screened for bleeding or infectious disorders only do so via patient history taking.[2] Though rare in female infants, bleeding disorders such as Haemophilia A may present itself as prolonged bleeding following female circumcision, if this or other disorders are not ascertained during the heel prick tests. 69.3% of these doctors reported bleeding in patients following the procedure with 98.1% reporting a single drop of blood. This could mean that the remaining 1.9% had experienced more bleeding than a single drop of blood in their patients.[2]

Alarmingly, 36% of the 20.5% of doctors who admitted to performing female circumcision used surgical scissors to cut a small piece of the external clitoris, hence they had performed Type 1 FGC (Table 1).[2] This could lead to severe consequences (see Table 3). Therefore, the medicalisation of FGC to reduce harm is ineffective, as there remains the risk of mutilating the genitalia even when doctors performed FGC.

Table 3: Physical complications of Type 1 FGC. Adapted from *“Ending FGC: A Toolkit for Engaging Practitioners”* by Asia Network to End FGC. The physical impact of all types of FGC including other Type 4 FGC subtypes is also summarised in this toolkit.

TABLE 3:
PHYSICAL COMPLICATIONS OF TYPE 1 FGC

IMMEDIATE COMPLICATIONS[18, 19]

- Severe pain.
- Genital swelling.
- Haemorrhage.
- Wound infections (including tetanus) can lead to septicaemia and death.

LONG TERM COMPLICATIONS

- Chronic pain can be due to trapped or exposed nerve endings.
- Keloid scarring: Excessive growth of scar tissue over the cut area and is a source of anxiety and shame for the women.[20]
- Neuroma: Growth of nerve tissues causing pain during intercourse.[21]
- Cysts which could become infected.[22]
- Sexual dysfunction.[23]

A different subtype of Type 4 FGC had been reported by a Malaysian Muslim participant of an informal group discussion organised in December 2022 by a Malaysian-based child protection non-profit called Monsters Among Us, which the Malaysian Doctors for Women & Children (MDWC) had participated in. This subtype involves “cutting to loosen the vaginal orifice so that penile penetration would not be as satisfactory” which sounded similar to a *Gurya* or *Gishiri* cut which can cause vesicovaginal

fistulas.[24] It was unclear to the participant of the focus group discussion as to what was being cut. Further research to validate this finding is necessary.

However, previous studies reported no long-term complications resulting from the female circumcision performed in Malaysia.[2, 3] Isa, Shuib and Othman (1999) reported no clinical signs of damage to the clitoris or labia, or any physical symptoms of excised tissue.[3] The study also purported that 100% of the women were enjoying their sex life. However, the study relied on the women's ability to recall a procedure they had as infants, which meant that they were possibly only describing what they had heard from their mothers, which may be inaccurate or does not depict their own experiences.[3] This study also implied poor knowledge of clitoral anatomy among the women. Women who were circumcised as infants would not be aware of any loss of sensation or decrease in orgasm quality as they could not compare their experiences before and after the circumcision.

Type 1 FGC can cause sexual dysfunction, especially with extensive tissue removal. Extensive tissue removal is a genuine and serious concern, given that the medicalisation of FGC in Malaysia had transformed the practices of 20.5% of doctors from Type 4 FGC of needling or pricking to Type 1 FGC of cutting tissue.[2] Type 1 FGC could cause discomfort during sexual intercourse, difficulty achieving orgasm, and subsequently decreased sexual desire.[23]

Additionally, it is imperative to acknowledge that sexual dysfunction (characterised by persistent issues with sexual desire, arousal, or arising pain) may be the result of a multitude of complex factors, encompassing not only the physical implications of FGC but also the intricate interplay of emotional facets such as anxiety, depression, and interpersonal challenges.[15] Further research endeavours are vital in comprehending the extent of effects of FGC on the dimensions of sexual desire and pleasure in women who have been subjected to this practice within the Malaysian context.

It is worth noting that discussions concerning matters related to the vulva remain encumbered by societal taboos within Malaysia.[25] Regrettably, there is a dearth of studies or surveys conducted to explore the comprehension levels of female external genital anatomy among Malaysians, largely due to the perception that such discourse may be regarded as inappropriate or superfluous. Women who experience vulvodynia, vaginismus, dyspareunia, or chronic pelvic pain may not know to associate their pain with FGC as they may not be aware of normal variations of female external genitalia anatomy or did not know that they were subjected to FGC. It is also possible that women who are unaware of normal variations of the female external genitalia may incorrectly believe that they have been subjected to FGC. Some women may also erroneously believe that being uncircumcised is the cause of their sexual dysfunction and/or marital issues (survey from Sisters in Islam).

In a contrasting scenario, women who unexpectedly discover that they underwent FGC as infants may mistakenly connect this revelation with their ongoing chronic pelvic pain or sexual dysfunction especially when no obvious gynaecological or surgical causes are found (Anonymous, obtained from personal communication with Dr Hannah Nazri). These observations, while anecdotal, underscore the imperative need to investigate and research the secondary and long-term repercussions of FGC and to ensure that affected women receive the requisite support and care.

The Psychological Impact of FGC

Whether or not women and girls have undergone FGC or think they may have undergone FGC as infants, one may feel shame and stigma for belonging to a culture that practises FGC as they are associated with a practice that is scrutinised within the international discourse. Condescension and judgemental caustic remarks by healthcare professionals have been directed at women who have undergone FGC, in a study that investigated the maternity experiences of Somali women in Canada.[26]

There was a lack of international focus on FGC practices in Southeast Asia in terms of research and advocacy[27] until recently, and this highlights the lack of knowledge of many researchers and activists in the region who mostly derived their assumptions from FGC practices in the African context. This may not be as effective or applicable in the effort to end FGC in Malaysia.

It must be understood that FGC in Malaysia does not exert a significant transformative influence on the lives of women, at least from the external perspective, in terms of their marriage prospects or their long-term obstetric health.[3] Nevertheless, it remains crucial to address and

discontinue this practice due to its potential adverse effects stemming from the medicalisation of FGC in Malaysia and to promote the recognition of sexual pleasure as a one of the pivotal markers of women's health. Women who experience sexual dysfunction may avoid intimate relationships or feel ashamed of their bodies, potentially leading to sexual phobia.[28] The inability to engage in sexual intercourse may prevent a woman from childbearing, which may be important to the woman and holds significant importance in certain communities in Asia especially. While we recognise that women are more than just birthing vessels and they are not merely an extension of the men in their lives, we must acknowledge the unfortunate reality that when a woman faces challenges in conceiving, she is frequently saddled with unwarranted blame by the community around her.

The pervasive myths surrounding FGC in Malaysia may also cause distress among women and girls who did not undergo FGC, as illustrated in the previous section. These negative emotions can further worsen anxiety and depression, significantly impacting a person's overall mental health and well-being.

Crucially, it is incumbent on healthcare professionals to recognise that women and parents possess the ability to make informed, ethical decisions. In other words, in educating women and parents, we must not be patronising. Not all Malaysian Muslim women who experienced FGC would call themselves survivors, and this should be respected and supported.

HISTORY

ORIGINS OF FGC

Many have hypothesised that FGC originated from Ancient Egypt (present-day Sudan and Egypt) as there has been evidence that it was widely practised there.[29, 30] However, opinions on the origins of the practice are divided. Some have speculated it to be an old African puberty rite which infiltrated Egyptian culture with time.[29] It is believed to date back to at least 2,000 years ago, predating the origins of Christianity and Islam, and was widely practised in Egypt, the Arabian Peninsula, and the Red Sea coasts.[29] Although religious justification of FGC was developed subsequently, it is a fact that it was practised by Christians, Muslims, Jews, and animists, thus supporting the idea that FGC predates Christianity and Islam.[31] The reasons behind carrying out the practice are also inconclusive, as expounded below.

The practice may have evolved to control sexual behaviour in women. The first mention of male and female circumcision appeared in the writings of Greek geographer Strabo in his work Geographica. He wrote that "One of the customs most zealously observed among the Egyptians is this, that they rear every child that is born, and circumcise the males, and excise the females."[32] Circumcised and infibulated mummies have been found in Egypt,[30] though the markings on the mummies to symbolise excision had been contested.[32] A Greek papyrus dated 163 BC recorded that circumcision was performed on girls in Memphis, Egypt at the age when they received their dowries. Therefore, it was speculated to be an initiation rite for girls.[33, 34] The Romans also slid fibulae through the labia majora of female slaves to ensure chastity.[29, 31, 34] Female slaves in Egypt, Arabia, and around the Red Sea coasts were infibulated to prevent pregnancy, thus increasing their value in the slave market. It was hypothesised that this practice had spread to Africa via slave routes and by Arab traders, which coincided with the expansion of Islam across the region.[35] The practice of FGC in Southeast Asia arrived with the introduction of *Shafi'i* Islam by Arab traders and missionaries.[36] It is assumed that 'milder' forms of FGC are practised in Southeast Asia as locals felt discouraged from accepting Islam if infibulation was compulsory practice (Prof Abdul Rashid Khan, obtained from conference proceedings).

Elizabeth Boyle[37] however speculated a different reason and origin for the practice. She expounded that during the Pharaonic era, the Egyptians believed in gods having bisexual features, with a woman's clitoris representing the masculine soul and a man's prepuce representing the feminine soul. These features were reflected upon mortals thus for a female body, circumcision was considered a way to detach from her masculine soul and vice versa.

In her work as an anthropologist, Dr Sada Mire speculated that FGC began as an act of sacrifice from humans to the gods and ancestors, and it was part of a cycle of rituals that children must undergo, to avoid being cursed.[38] The curse was thought to be in the form of lack of rain, failed crops, and illness. These beliefs then became assimilated into Christianity and Islam, and from then the practice evolved to become a symbol of safeguarding chastity in women.

Arguably, FGC was practised during the Middle Ages in Europe in the form of chastity belts (mechanical infibulation) as opposed to the Roman practice of directly infibulating women.[29, 31, 34] In the 1860s, clitoridectomies[39] were first promoted by Dr Isaac Brown who had set up a clinic in Notting Hill, London for women diagnosed with 'hysteria', epilepsy, depression, masturbation, and distaste of their spouse. It was banned after the Obstetric Society of London debated the ethics of it, however, this ban was not based on the harm it caused women, but because they could not resolve whether it was the husband or the father of the woman who could provide consent. It completely ceased from being practised in the UK during the 1870s.

However, the practice continued in the USA into the mid-20th century (1933-1967) for two contradictory medical reasons:[40] (i) to prevent masturbation, and (ii) to enable women to achieve sexual orgasm. Recently, genital surgeries for intersex babies have been branded as "genital mutilation" by campaigners as these unnecessary genital surgeries carry the implication of stigmatising intersex individuals as being abnormal.[31] This classification arises due to the fact that these surgeries are frequently performed on infants and toddlers who are incapable of comprehending or granting consent for these permanent procedures, which could lead to substantial risks including loss of sexual sensation, infertility, and pain.

Could female genital cosmetic surgery (FGCS) be a socially acceptable form of FGC?[41] When juxtaposing FGCS and FGC, the element of consent assumes paramount significance. It is undeniable that a 3-month-old female infant lacks the capacity to provide consent for female circumcision, whereas an adult woman can grant consent to undergo FGCS. However, the question of whether this consent is genuinely informed (Table 5) arises when societal pressures to conform to an idealised notion of vulva aesthetics loom large.[42] It is crucial to underscore that there is no universally defined standard for an aesthetically-perfect vulva, and many women subject themselves to unwarranted physical risks and psychological distress when opting for FGCS, which often necessitates general anaesthesia. It is important to acknowledge that any surgical procedure, FGCS included, carries inherent risks and potential complications.

In addition, Kelly and Foster (2012)[41] raised the issue of White saviourism and its connection to FGC, which could lead to racial biases and ethnocentrism. Kelly and Foster (2012) presented the case of a 19-year-old woman of British and Eritrean heritage, who expressed a desire to have her labia minora shortened and sewn together, and contrasted this with a 21-year-old presumably White woman, who visited a gynaecology clinic with a request for labiaplasty. Which of these two women would be defined as seeking FGC?

Currently, the reasons for FGC vary according to the communities in which it is practised.[1] In certain communities in the African continent, it is a rite of passage to womanhood, and a woman could not marry until it is done. This is not the case with female circumcision in Malaysia. FGC is not a pre-requisite for marriage for Malaysian Muslim women, yet the practice continues. In Malaysia, most believe female circumcision is compulsory in Islam though this is heavily disputed[1] (see Islamic Jurisprudence section below). Others consider the vulva dirty, thus female circumcision was performed for hygiene purposes,[3] a reasoning not backed by medicine.

Debates persist regarding the origins of Malaysian FGC and its ties to patriarchal traditions. In the Malaysian context, it is worth noting that men are not actively engaged in the practice of FGC on female infants.[43] Nonetheless, the underlying motive, which revolves around diminishing women's sexual drive and increasing men's sexual drive[3] and control, could be predicated upon a problematic belief of "women have nine parts of lust and one part of intellect" while "men have one part of lust, and nine parts of intellect." This problematic myth has been a serious subject of discussion, with even the Office of the Mufti of the Federal Territory of Malaysia stepping in to debunk it on their website.[44] In any case, type 4 FGC of needling and pricking has no recorded impact on sexual drive, though it may impact sexual arousal (physical changes that occur in response to a sexual stimulus). As stated previously, sexual drive can impact sexual desire as sexual desire is a complex interplay between drive (neurochemical changes in the brain), motivation (influenced by interpersonal relationships), and wish (cultural values/previous sexual experiences). Therefore, it is essential to recognise and honour women's agency in managing their own sexual desires rather than resorting to extreme and invasive measures.

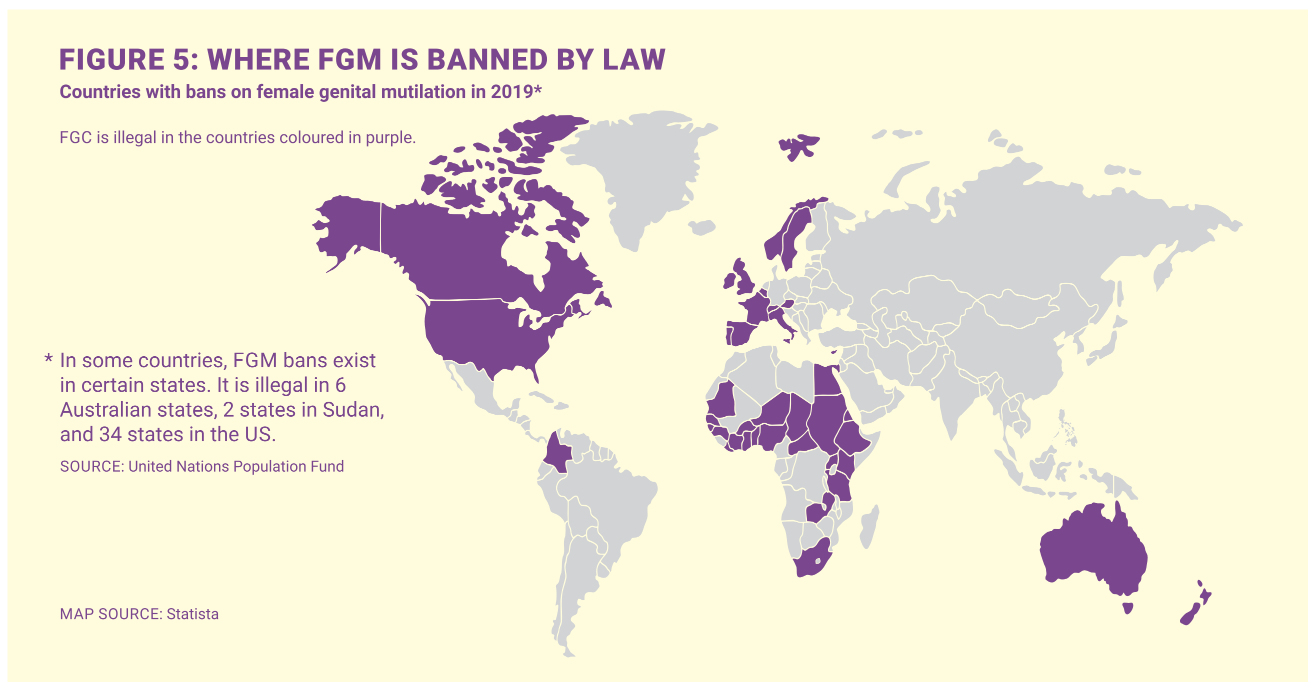
LEGAL IMPLICATIONS, ISLAMIC JURISPRUDENCE, AND MEDICAL ETHICS

LEGAL IMPLICATIONS

There is no Malaysian law that deems FGC illegal, therefore there are no legal or career repercussions for parents who consent to or doctors who perform FGC or female circumcision. 68.3% of doctors who practice FGC believed that female circumcision was legal.[2]

In the UK, FGC is illegal and parents who take their children out of the country to undergo female circumcision can be prosecuted.[46]

In the international context, FGC is banned in the following countries (Figure 5):[45]



ISLAMIC JURISPRUDENCE

Adapted from "One Cut Too Many: Islamic Relief Policy Brief on Female Genital Mutilation/Cutting"

Rights in Islam[47]

The primary objective of the *Shari'ah* is to ensure the welfare of humanity and uphold the rights of all individuals. It specifically strives to enhance human well-being by safeguarding interests related to religion, life, intellect, progeny, and wealth. In Islam, any endeavour is considered "religious" if it aligns with the teachings of the Qur'an or the *sunnah*, which encompasses the practices exemplified or approved of by the Prophet Muhammad (peace be upon him) as recorded in *hadith*. Additionally, many Muslims attach great importance to sources of guidance such as *ijma* (scholarly consensus) and *qiyaas* (analogical deduction).

The Qur'an and FGC[47, 48]

The Qur'an does not explicitly mention female circumcision. Instead, it provides guidance against causing harm to oneself or others intentionally, and it emphasises avoiding alterations to the natural human anatomy design created by Allah SWT.

The *Sunnah* and FGC[47, 48]

There are variations of validity for the *hadith*, which are narrations or descriptions of actions attributed to the Prophet Muhammad (peace be upon him). Out of the few *hadiths* which may be relevant to FGC, most are considered insufficient or unreliable.

The most frequently cited *hadith* concerning FGC revolves around a woman named Umm Attia, who was known to have practiced female circumcision in Medina. It is claimed

that the Prophet told her, “Umm Attia, restrict yourself to a sniff and do not overstrain; (this way) it is more pleasant in appearance and more satisfactory to the husband.” However, scholars of *hadith*, including Zein al-Din al-Iraqi in his commentary on Al-Ghazali's *Ihya ulum al-din*, have identified this *hadith* as unreliable due to questionable chains of transmission.

It is important to note that even if this Umm Attia *hadith* was considered authentic, it should only be taken as an explanation of how to perform FGC if it were to be done. In some interpretations, scholars restricted it to a 'sniff,' implying only minimal removal of the external skin fold known as the prepuce. However, modern knowledge reveals that the clitoral hood of female infants is connected to the clitoral glans,[12] with delicate nerves and blood vessels located just beneath.[13] Therefore, the notion of a 'sniff' becomes ambiguous.

In addition, the stronger and more authentic hadith do not directly address female circumcision, let alone endorse it. They may allude to circumcised organs but often use the term for male circumcision *(khitan)* rather than female circumcision *(khifaadh)* in Arabic. Interpretations tend to differ when linguistic ambiguity exists in this context. Additionally, the practice of female circumcision is not documented among the female family members in the Prophet's household, nor among early Muslim communities.

Islamic Scholars on FGC[47]

In Islamic jurisprudence, the views of scholars hold significant weight, but when it comes to the matter of FGC, there is a lack of *ijma* (consensus) among the four principal schools of thought. While scholars within these four main schools may differ in their perspectives on the practice, the general positions can be summarised as follows:

- **Hanafi school:** Circumcision is *sunnah* (optional) for males and females.
- **Maliki school:** Circumcision is *wajib* (obligatory) for males and *sunnah* for females.
- **Shafi'i school:** Circumcision is *wajib* for both males and females.
- **Hanbali school:** (i) Circumcision is *wajib* for both (ii) Circumcision is *wajib* for males and *makrumah* (honourable) for females.

It is important to highlight that according to the perspective of early classical Islamic scholars, their *ijmaa* (consensus) on female circumcision was based on references from *hadith* literature. They approved of it based on the belief that it could enhance sexual pleasure for women during marital intimacy and facilitate sexual relations for both men and women. However, there were varying opinions among scholars regarding the reliability of the hadith references.

The procedure permitted in this context involved the removal of the skin covering the descending part of the clitoral body, known as the clitoral hood. Differing views exist, with some asserting that it also included excess skin from the labia minora.

Unfortunately, a minority viewpoint outside of the traditional schools of jurisprudence has emerged over time, suggesting that the clitoris should be partially or entirely removed. This shift in discourse has been detrimental to women's well-being. It is essential to emphasise that none of the four major schools of thought advocates for the removal of the clitoris or mutilation of any other female genitalia, and FGC is not considered a means to diminish female sexual pleasure. This is because it directly infringes upon a woman's human rights within the framework of Islam.

Even the small group of scholars who consider it a religious requirement insist that the procedure should be carried out under the supervision of a medical professional and never without the consent of the female involved. However, most contemporary scholars are hesitant to revisit the subject, let alone prohibit it, due to the lack of unanimous agreement declaring FGC as *haraam* (forbidden) in all its forms across all schools of thought.

Furthermore, Islam places a profound emphasis on the dignity and preservation of the human body. Each individual bears the responsibility to safeguard, nurture, and show reverence for the sanctity of their body in the eyes of Allah SWT. In Islam, one's duty extends beyond moral accountability to include the physical well-being of the body, as the body is considered a sacred trust from Allah SWT. This care for the body in Islam includes both a legal obligation and a religious duty, with corresponding rewards and consequences.

A significant aspect of this perspective of dignity and preservation of the human body is that illnesses and adversities that afflict the human body are viewed through a moral lens, and closely tied to divine will. This moral dimension forms the bedrock for both physical and moral integrity. Consequently, devout Muslims who may be ill, injured, or have experienced physical loss are encouraged to not feel deficient. They believe that these trials are a part of Allah's will. In the words of the Prophet Muhammad (peace be upon him), "No fatigue, disease, sorrow, sadness, hurt, or distress befalls a Muslim, not even the prick of a thorn, without Allah expiating some of their sins through it."[49]

Islam is very invested in honouring and safeguarding the human body, in both the Qur'an and the *hadith*. Interventions done to the body are allowed only according to certain juristic rules. However, female circumcision may violate bodily integrity or even lead to a biological deficiency or a feeling of a lack of wholeness, and as such, some scholars such as the Grand Mufti of Al Azhar, Sheikh Dr Sayed Muhamad Al Tantawi was of the view that it is prohibited.

Malaysian Islamic Ruling on Female Circumcision

Muzakarah of the *Fatwa* Committee of the National Council for Islamic Religious Affairs of Malaysia (MKI *Muzakarah* Committee) decreed that the practice of female circumcision is part of Islamic teachings that must be implemented by Muslims. However, Islam is also very concerned about the safety of its people and provides flexibility if a practice or act can cause harm to oneself. Accordingly, in line with the views of *Jumhur Ulama'*, *Muzakarah* decided that the law of circumcision for women is obligatory. However, if it can bring harm, then it should be avoided.

However, the Perlis State *Fatwa* Committee had published this ruling on the 9th December 2019.[50] After considering the arguments discussed by scholars and medical experts in this regard, the Perlis State Fatwa Committee opined the following:

"The law of circumcision for women varies according to the state of a woman's private parts. It is based on the condition of each woman after her needs have been determined by an expert. If a woman finds herself needing to be circumcised and is approved by an expert, then it is a *makrumah* (respect) as in the *hadith* of Umm Attia which is considered *Hasan* by some scholars. If it is found that there is no need to perform circumcision, then circumcision does not need to be performed for her."

As for the circumcision of female babies that is done by some of the community without referring the need to an expert, it is a practice that does not have any foundation in *Shariah* and may even expose the baby to harm if done incorrectly.

MEDICAL ETHICS AND HUMAN RIGHTS

Medical ethics is a subfield of ethics that deals with issues and dilemmas that arise in the field of healthcare. It is a set of principles, values, and guidelines that are to be applied by healthcare professionals, researchers, and policymakers in making morally sound medical decisions and judgments.

Medical ethics has its roots in ancient civilisations, where early codes of conduct, such as the Hippocratic Oath, provided moral guidance for physicians. However, the formal discipline of medical ethics as we know it today emerged in the mid-twentieth century. The atrocities committed during WWII, particularly in the context of medical experiments and the Holocaust, highlighted the importance of ethical standards in medical research and practice. These events sparked widespread international concern, leading to the establishment of ethical principles to protect patients, while also upholding their dignity and rights.

Beauchamp and Childress' Principles of Biomedical Ethics

Tom Beauchamp and James Childress' principles of biomedical ethics are a widely used framework for analysing ethical situations in medicine. The four principles of medical ethics can be found in Table 4.

TABLE 4: BEAUCHAMP AND CHILDRESS' PRINCIPLES OF BIOMEDICAL ETHICS
Respect for **autonomy**, this principle considers the patient's perspectives on their treatment. Autonomy is not an all-or-nothing concept, and it is critical to consider the patient's level of autonomy when making care decisions.
Non-maleficence is the principle of not causing harm to the patient. Before beginning treatment, it is critical to weigh the risks and benefits of any medical intervention.
Beneficence is the principle of promoting the well-being of the patient. Before beginning treatment, it is critical to consider the potential benefits of any medical intervention.
The principle of **justice** entails distributing. Justice is the equitable distribution of benefits, risks, and costs. It is critical to consider how medical decisions may affect different groups of people and to ensure that everyone is treated fairly.

These principles serve as a bridge between moral theory and common morality. They have become the bedrock of biomedical ethics in clinical practice. While the principles are general guidelines, they leave plenty of room for discretion in specific cases. The principles have been criticised for failing to distinguish between moral rules and moral ideals, as well as for failing to guide on resolving conflict between two or more of the principles. Nonetheless, the principles have had a significant impact on medical ethics, and its practical application in ethical decision-making is obvious.

Medical Ethics and FGC

Autonomy

The philosophical basis for autonomy, as interpreted by philosophers Immanuel Kant (1724-1804) and John Stuart Mill (1806-1873) and accepted as an ethical principle, is that all persons have intrinsic and unconditional worth and, as such, should have the ability to make rational decisions and moral choices, and each individual should be allowed to exercise their capacity for self-determination. Over the years, the principle of respect for patient autonomy has had a huge impact on changing attitudes in doctor-patient relationships. It has been used as a basis to criticise medical paternalism and has helped shape the development of patient-centred medicine. It has resulted in ever-increasing standards for the provision of information to patients, as well as the development of the concept of **informed consent** (Box 2).[52] Respecting patient autonomy is important for two reasons. First, knowing the patient's preferences can help in determining what is best for them. The second reason is the value placed on individual freedom, and how it correlates with respecting patient autonomy. This could be expressed as the right to make medical decisions. If we value autonomy in this way, it may sometimes conflict with the best interests of the patient, since there is a possibility that some people may not always make the best decisions. Nonetheless, it may be necessary to still respect their choices.

However, there are conditions that should be met for one to be autonomous. According to German philosopher Immanuel Kant[53] a person is only autonomous if their choices and actions are unaffected by external, or inessential factors to himself. Thus, a person lacks autonomy or is heteronomous if their choices or actions are influenced by factors such as conventions, peer pressure, legal or religious authority, or even their own desires.

BOX 2: DEFINITION OF INFORMED CONSENT[52]

Informed consent: A patient has given informed consent if he or she is agrees verbally or in writing (depending on the complexity of a medical procedure and situation), after the patient is explained to all known benefits, risk, and complications of a medical procedure and is able to ***understand, retain, reflect and relay back** to their healthcare professionals the benefits, risks, and complications of a medical procedure. Every effort must be made to ensure that patients understand a medical procedure including using translator services if there is a language barrier.

* This means the patient has the **capacity** to provide informed consent.

In the context of FGC, it is essential to promote the autonomy of women and girls by ensuring that they have the freedom to choose whether to undergo the procedure or not. The autonomy principle recognises a person's right to make decisions about their own body and health. However, with FGC, the issue of autonomy becomes more complicated due to a variety of factors such as cultural norms, societal pressure, and the potential for coercion or inability to provide informed consent such as in the case of infants. Thus, should parents have the right to provide consent on behalf of their infants in this case?

Beneficence

FGC provides no health benefits to girls or women. Beneficence entails two complementary intentions, (i) to do no harm and (ii) to maximise potential benefits while minimising potential harm.[54] Beneficence requires healthcare professionals to act in their patient's best interests and promote their overall well-being. In the context of FGC, this entails taking steps to protect individuals' rights and promote their health.

To fulfil the principle of beneficence, healthcare professionals must acknowledge that FGC is a harmful practice with no medical benefits. Healthcare professionals should practice evidence-based medicine and recognise that FGC poses significant physical and psychological risks to patients. When we examine FGC from the standpoint of principles, we can argue that it violates the principle of beneficence. When considering FGC, healthcare professionals should consider the patient's physical, mental, and social health, as well as the deep cultural significance of the practice. FGC is recognised internationally as a violation of girls' and women's human rights and an extreme form of discrimination against them.[54] Similarly, the medicalisation of FGC should also be considered a violation of the ethical principle of beneficence.

Non-Maleficence

The principle of non-maleficence requires healthcare professionals to avoid causing harm to their patients and, if harm cannot be avoided, to minimise it.[52] Non-maleficence in the context of FGC in Malaysian types means that healthcare professionals should not perform or support FGC because of its potential harms to women and girls. This is especially so since latest evidence has shown that medicalisation of FGC leads to further harm, contrary to the popular belief of harm reduction as discussed in earlier sections.[2]

Justice

In the context of healthcare, justice[55] necessitates the distribution of healthcare resources in a fair, equitable, and appropriate manner. Healthcare professionals must consider how to distribute limited resources in the most effective and equitable manner as possible. Justice also requires that healthcare institutions, their staff, as well as patients be treated fairly. In situations where resources are limited or scarce, the principle of justice may conflict with other ethical principles such as autonomy, non-maleficence, and beneficence.

FGC stems from gender inequality and harmful social norms that perpetuate discrimination against women and girls. This practice is frequently associated with the control of female sexuality, the maintenance of patriarchal power structures, and the reinforcement of traditional gender roles. FGC violates girls' and women's autonomy, bodily integrity, and reproductive rights, perpetuating a cycle of gender-based violence and oppression. Compared to male circumcision, the most prominent basis for FGC is not hygiene. While the Malaysian FGC practice does not prevent women from entering marriage, the practice is connected to controlling women's bodies and sexual drives, implying that extreme measures need to be taken to regulate women's sexual drives. A better way to help girls and women to self-regulate their bodies and sexual drives is through education.

Addressing these issues is inextricably linked to the principle of justice. Fairness, equality, and the abolition of discrimination are all demands of justice. In the case of FGC, justice necessitates addressing the underlying gender inequality as well as deconstructing the social norms that support and perpetuate the practice. Justice demands concrete actions taken to recognise FGC as a violation of human rights, including the rights to equality, non-discrimination, and freedom from violence.

This includes putting in place legal frameworks and policies that explicitly prohibit FGC, holding perpetrators accountable, and ensuring survivors have access to justice and support services. This also entails community education and empowerment to confront harmful practices and promote gender equality. It also involves promoting women's rights, providing women and girls with access to healthcare, education, and economic opportunities, as well as cultivating a society that values and upholds justice and equality for all.

FGC: A HUMAN RIGHTS VIOLATION

FGC constitutes a violation of human rights, given that it entails the deliberate harm or removal of healthy tissue without any medical necessity. This contravenes the fundamental human rights to health and bodily integrity, as outlined in Article 25 of the Universal Declaration of Human Rights. FGC also infringes upon the principles established by the Convention on the Rights of the Child as they are predominantly performed on girls below the legal age of consent.

Additionally, FGC qualifies as a form of gender-based violence, thereby constituting a breach of the UN Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). Malaysia's ratification of CEDAW, despite the absence of legal repercussions for practitioners of FGC, raises concerns about its compliance with the Convention. This situation could potentially be interpreted as Malaysia being in violation of its obligations under CEDAW, as the Convention explicitly prohibits practices such as FGC and calls for measures to eliminate gender-based violence and discrimination against women. However, it is important to note that the assessment of a country's compliance with international treaties like CEDAW often involves complex legal and diplomatic considerations, and any determination of non-compliance would typically require a formal evaluation by relevant international bodies or organisations.

Indeed, the notion that human rights are a western invention is a misconception. Human rights are not tied to any specific culture, region, or ideology; they are universal principles that should be applicable to all individuals, regardless of their background or nationality. Human rights have deep historical roots that can be found in various cultures and civilisations throughout history.

The Universal Declaration of Human Rights (UDHR), adopted by the United Nations in 1948, was a global effort that drew on contributions from diverse cultures and nations. It reflects a consensus on the fundamental rights and freedoms to which all people are entitled, regardless of their cultural or geographical background.

Hansa Mehta[56] from India and Begum Shaista Ikramullah[56] from Pakistan both played a significant role in shaping the Universal Declaration of Human Rights. Hansa Mehta is renowned for her pivotal contribution in amending the language of the declaration, transforming the phrase from "all men are born free and equal" to the more inclusive "all human beings are born free and equal."

Begum Shaista Ikramullah,[56] was a staunch advocate for Article 16 of the UDHR, which addresses issues related to child and forced marriages. Article 16 emphasises the rights of both men and women of full age to marry and establish families without any restrictions based on factors such as race, nationality, or religion. Moreover, it underscores that marriage should only be entered into with the free and full consent of both parties, ensuring that they have equal rights within the partnership.

In essence, human rights are a shared and universal framework for promoting dignity, equality, and justice for all individuals, and they are not limited to any part of the world. It is hoped that information in this leaflet and other studies on FGC are shared widely for better public advocacy.

RECOMMENDATIONS

Female circumcision or FGC is not a medical procedure. It is not taught in medical schools. It is not safe and can cause physical and psychological harm on girls and women. We propose the following recommendations to healthcare professionals:

- **Adopt a strong stance against FGC**, recognising that it violates human rights and causes significant harm. Refuse to perform or support the procedure in any way, even if patients or our families request it.
- **Education and counselling:** We can play an important role in informing families and communities about the dangers of FGC. We can help parents make informed decisions and understand the risks associated with the practice by providing accurate information.
- **Survivor support:** Not all women who experienced FGC can call themselves survivors, but some women do. Healthcare professionals should support women, no matter how they choose to identify, and provide them with appropriate medical and psychological support.
- **Advocacy and collaboration:**
  - Engage with religious leaders to foster an exchange of knowledge and understanding concerning FGC from the medical perspective. This harmonious engagement not only empowers the religious leaders with more accurate information but also serves as a platform for the dissemination

of comprehensive knowledge regarding women's anatomy and autonomy, so they too could formulate a comprehensive deduction on FGC.

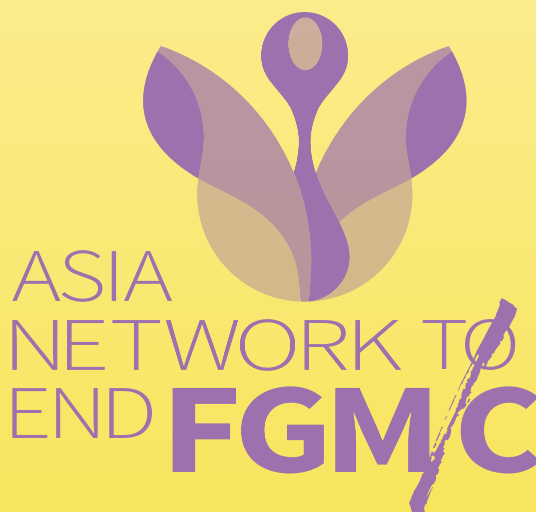
> Participate in academic research to build the body of evidence on the practice of FGC in Malaysia and Southeast Asia.

> Advocate for policies and legal measures to protect girls and women from FGC and promote its abolition. Work together with organisations, and policymakers to raise awareness, influence policy changes, and contribute to the broader elimination of FGC. Please share this leaflet with colleagues to create awareness.

ENDNOTES

1. Rashid, Abdul, and Yufu Iguchi. "Female Genital Cutting in Malaysia: A Mixed-Methods Study." *BMJ Open* 9, no. 4 (2019). https://doi.org/10.1136/bmjopen-2018-025078.
2. Rashid, Abdul, Yufu Iguchi, and Siti Nur Afiqah. "Medicalization of Female Genital Cutting in Malaysia: A Mixed Methods Study." *PLOS Medicine* 17, no. 10 (2020). https://doi.org/10.1371/journal.pmed.1003303.
3. Isa, Ab.Rahman, Rashidah Shuib, and M.Shukri Othman. "The Practice of Female Circumcision among Muslims in Kelantan, Malaysia." *Reproductive Health Matters* 7, no. 13 (1999): 137–44. https://doi.org/10.1016/s0968-8080(99)90125-8.
4. Rashid, Abdul, Patil SS, and Valimalar AS. "The Practice of Female Genital Mutilation among the Rural Malays in North Malaysia." *The Internet Journal of Third World Medicine* 9, no. 1 (2010). https://doi.org/10.5580/a23.
5. OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, and WHO. "Eliminating Female Genital Mutilation: An Interagency Statement." United Nations Population Fund, (2008). https://www.unfpa.org/publications/eliminating-female-genital-mutilation-interagency-statement.
6. Pejabat Mufti Wilayah Persekutuan. "Al-Kafi #419: Hukum Berkhatan Bagi Kaum Wanita." Pejabat Mufti Wilayah Persekutuan, (2016). https://muftiwp.gov.my/artikel/al-kafi-li-al-fatawi/1336-al-kafi-419-hukum-berkhatan-bagi-kaum-wanita.
7. Nazri, Hannah. "Ending FGM/c: A Toolkit On Engaging Medical Practitioners." ARROW, (2022). https://arrow.org.my/publication/a-medical-practitioners-toolkit-to-ending-fgm-c/.
8. Lumen Learning. "Anatomy and Physiology II: Anatomy And Physiology Of The Female Reproductive System." Accessed February 22, 2023. https://courses.lumenlearning.com/suny-ap2/chapter/anatomy-and-physiology-of-the-female-reproductive-system/.
9. Baky, Fahmy Mohamed A. "Normal female prepuce." In *Normal and Abnormal Prepuce*, 279-289. Switzerland: Springer, 2020.
10. Di Marino, Vincent and Lepid, Hubert. *Anatomic Study Of The Clitoris And The Bulbo-Clitoral Organ*. Springer International, 2016.
11. Adekoya, Adesola Olubunmi, Musili Bolanle Fetuga, Olumide Olatokunbo Jarrett, Tinuade Adetutu Ogunlesi, Jean-Pierre Chanoine, and Abiola Omobonike Adekoya. "Clitoral Sizes and Anogenital Distances in Term Newborns in Nigeria." *International Journal of Pediatric Endocrinology* 2019, no. 1 (2019). https://doi.org/10.1186/s13633-019-0069-6.
12. Brodie, K.E., E.C. Grantham, P.S. Huguelet, B.T. Caldwell, N.J. Westfall, and D.T. Wilcox. "Study of Clitoral Hood Anatomy in the Pediatric Population." *Journal of Pediatric Urology* 12, no. 3 (2016). https://doi.org/10.1016/j.jpurol.2015.12.006.
13. Kelling, Joseph A, Cameron R Erickson, Jessica Pin, and Paul G Pin. "Anatomical Dissection of the Dorsal Nerve of the Clitoris." *Aesthetic Surgery Journal* 40, no. 5 (2019): 541–47. https://doi.org/10.1093/asj/sjz330.
14. Uloko, Maria, Erika P Isabey, and Blair R Peters. "How Many Nerve Fibers Innervate the Human Glans Clitoris: A Histomorphometric Evaluation of the Dorsal Nerve of the Clitoris." *The Journal of Sexual Medicine* 20, no. 3 (2023): 247–52. https://doi.org/10.1093/jsxmed/qdac027.
15. Bancroft, John. "Sexual Desire and the Brain Revisited." *Sexual and Relationship Therapy* 25, no. 2 (2010): 166–71. https://doi.org/10.1080/14681991003604680.
16. R.AGE. "How Female Circumcision Is Still Practised in Malaysia | The Hidden Cut." YouTube, November 2, 2018. Accessed September 21, 2023. https://www.youtube.com/watch?v=4Q4_q8n45Ys&t=9s.
17. Goksan, Sezgi, Caroline Hartley, Faith Emery, Naomi Cockrill, Ravi Poorun, Fiona Moultrie, Richard Rogers, et al. "FMRI Reveals Neural Activity Overlap between Adult and Infant Pain." *eLife* 4 (2015). https://doi.org/10.7554/elife.06356.
18. El Dareer, Asma. "Complications of Female Circumcision in the Sudan." *Tropical Doctor* 13, no. 3 (1983): 131–33. https://doi.org/10.1177/004947558301300313.
19. Berg, Rigmor C, Vigdis Underland, Jan Odgaard-Jensen, Atle Fretheim, and Gunn E Vist. "Effects of Female Genital Cutting on Physical Health Outcomes: A Systematic Review and Meta-Analysis." *BMJ Open* 4, no. 11 (2014). https://doi.org/10.1136/bmjopen-2014-006316.
20. Toubia, Nahid. "Female Circumcision as a Public Health Issue." *New England Journal of Medicine* 331, no. 11 (1994): 712–16. https://doi.org/10.1056/nejm199409153311106.
21. Lightfoot-Klein, Hanny. "The Sexual Experience and Marital Adjustment of Genitally Circumcised and Infibulated Females in the Sudan." *Journal of Sex Research* 26, no. 3 (1989): 375–92. https://doi.org/10.1080/00224498909551521.
22. Dave, Amish J., Aisha Sethi, and Aldo Morrone. "Female Genital Mutilation: What Every American Dermatologist Needs to Know." *Dermatologic Clinics* 29, no. 1 (2011): 103–9. https://doi.org/10.1016/j.det.2010.09.002.
23. Berg, Rigmor C., and Eva Denison. "Does Female Genital Mutilation/Cutting (FGM/c) Affect Women's Sexual Functioning? A Systematic Review of the Sexual Consequences of FGM/C." *Sexuality Research and Social Policy* 9, no. 1 (2011): 41–56. https://doi.org/10.1007/s13178-011-0048-z.
24. Ouedraogo, Itengre, Regina McConley, Christopher Payne, Alison Heller, and L. Lewis Wall. "Gurya Cutting and Female Genital Fistulas in Niger: Ten Cases." *International Urogynecology Journal* 29, no. 3 (2017): 363–68. https://doi.org/10.1007/s00192-017-3370-z.
25. Ragavan, Surekha. "Libresse Pulls Campaign with Vulva Imagery Following Backlash: Advertising." Campaign Asia, September 21, 2021. https://www.campaignasia.com/article/libresse-pulls-campaign-with-vulva-imagery-following-backlash/472740.
26. Chalmers, Beverley, and Kowser Omer Hashi. "432 Somali Women's Birth Experiences in Canada after Earlier Female Genital Mutilation." *Birth* 27, no. 4 (2000): 227–34. https://doi.org/10.1046/j.1523-536x.2000.00227.x.
27. Dawson, Angela, Abdul Rashid, Rashidah Shuib, Kolitha Wickramage, Meiwita Budiharsana, Irwan Martua Hidayana, and Gabriele Marranci. "Addressing Female Genital Mutilation in the Asia Pacific: The Neglected Sustainable Development Target." *Australian and New Zealand Journal of Public Health* 44, no. 1 (2020): 8–10. https://doi.org/10.1111/1753-6405.12956.
28. Mohammed H. El-Defrawi, Galal Lotfy, Khadiga F. Dandash, Amany H. Refaat and Moustafa Eyada. "Female Genital Mutilation and its Psychosexual Impact," *Journal of Sex & Marital Therapy* 27. No. 5 (2001): 465-473. https://www.tandfonline.com/doi/abs/10.1080/713846810.
29. Jawad, Haifa. "Female Circumcision: Religious Obligation or Cultural Deviation?" In *The Rights of Women in Islam*, 52-60. London: Palgrave Macmillan, 1998. https://doi.org/10.1057/9780230503311_5.
30. Hosken, Fran P. *The Hosken Report: Genital and sexual mutilation of females*. Lexington, MA: WIN, 1994.
31. Andro, Armelle, and Marie Lesclingand. "Female Genital Mutilation. Overview and Current Knowledge." *Population* (English Edition, 2002-) 71, no. 2 (2016): 216–96. http://www.jstor.org/stable/44135271.
32. Knight, Mary. "Curing Cut or Ritual Mutilation?: Some Remarks on the Practice of Female and Male Circumcision in Graeco-Roman Egypt." *Isis* 92, no. 2 (2001): 317–38. https://doi.org/10.1086/385184.
33. Skaine, Rosemarie. *Female genital mutilation: Legal, cultural and medical issues*. Jefferson (N.C.): McFarland, 2005.
34. Hosken, Fran. *The Hosken report: genital and sexual mutilation of females, 3rd Edition*. Women's International Network News, 1982.

35. Ross, Cody T., Pontus Strimling, Karen Paige Ericksen, Patrik Lindenfors, and Monique Borgerhoff Mulder. "The Origins and Maintenance of Female Genital Modification across Africa." *Human Nature* 27, no. 2 (2016): 173–200. https://doi.org/10.1007/s12110-015-9244-5.
36. Clarence-Smith, William. "Islam and Female Genital Cutting in Southeast Asia: The Weight of the Past." *Finnish Journal of Ethnicity & Migration* 3. no. 2 (2008): 14-22.
37. Robertson, Claire. "Female Genital Cutting: Cultural Conflict in the Global Community." *Contemporary Sociology: A Journal of Reviews* 34, no. 2 (2005): 184–86. https://doi.org/10.1177/009430610503400248.
38. Mire, Sada. *Divine fertility: The continuity in transformation of sacred kinship in Northeast Africa*. London: Routledge, 2020.
39. Black, John. "Female Genital Mutilation: A Contemporary Issue, and a Victorian Obsession." *Journal of the Royal Society of Medicine* 90, no. 7 (1997): 402–5. https://doi.org/10.1177/014107689709000712.
40. Rodriguez, Sarah B. *Female Circumcision and Clitoridectomy in the United States: A History of a Medical Treatment*. NED-New edition. Boydell & Brewer, 2014. http://www.jstor.org/stable/10.7722/j.ctt6wp8c1.
41. Kelly, B, and C Foster. "Should Female Genital Cosmetic Surgery and Genital Piercing Be Regarded Ethically and Legally as Female Genital Mutilation?" *BJOG: An International Journal of Obstetrics & Gynaecology* 119, no. 4 (2012): 389–92. https://doi.org/10.1111/j.1471-0528.2011.03260.x.
42. Sharp, Gemma, Marika Tiggemann, and Julie Mattiske. "Predictors of Consideration of Labiaplasty." *Psychology of Women Quarterly* 39, no. 2 (2014): 182–93. https://doi.org/10.1177/0361684314549949.
43. Nakamura, Kyoko, Kaori Miyachi, Yukio Miyawaki, and Makiko Toda. Essay. In *Female Genital Mutilation/Cutting: Global Zero Tolerance Policy and Diverse Responses from African and Asian Local Communities*. Singapore, Singapore: Springer, 2023.
44. Tarmizi, Luqman. "Irsyad Al-Fatwa Siri ke-293: Benarkah Wanita Mempunyai 9 Nafsu dan 1 Akal?" Pejabat Mufti Wilayah Persekutuan. Accessed June 27, 2021. https://muftiwp.gov.my/artikel/irsyad-fatwa/irsyad-fatwa-umum/3157-irsyad-al-fatwa-293-benarkah-wanita-mempunyai-9-nafsu-dan-satu-akal.
45. McCarthy, Niall, and Felix Richter. "Infographic: Where FGM Is Banned by Law." Statista Daily Data, January 28, 2020. https://www.statista.com/chart/4952/which-countries-ban-fgm-by-law/.
46. "Female Genital Mutilation." Crown Prosecution Service. Accessed August 13, 2022. https://www.cps.gov.uk/legal-guidance/female-genital-mutilation.
47. "One Cut Too Many: Islamic Relief Policy Brief on Female Genital Mutilation/Cutting (FGM/c)." Islamic Relief Worldwide. Accessed August 3, 2023. https://islamic-relief.org/publications/one-cut-too-many-islamic-relief-policy-brief-on-female-genital-mutilation-cutting-fgm-c/#.
48. "Islamic Ruling on Male and Female Circumcision." World Health Organization, January 1, 1996. https://apps.who.int/iris/handle/10665/119559.
49. "al-Bukhārī Ṣaḥīḥ, al-libās Kitāb, al-aẓfār Bāb taqlīm. Hadith no.5552." Available from muhaddith.org.
50. "Hukum Khitan Anak Perempuan." Jabatan Mufti Negeri Perlis, December 9, 2019. https://muftiperlis.gov.my/index.php/himpunan-fatwa-negeri/136-hukum-khitan-anak-perempuan#:~:text=Setelah%20melihat%20dalil-dalil%20yang,keadaan%20alat%20sulit%20seseorang%20wanita.
51. Wilkinson, Dominic, Jonathan Herring, and Julian Savulescu. *Medical ethics and law: A curriculum for the 21st Century*. Edinburgh: Elsevier, 2020.
52. Taylor, Robert S. "Kantian Personal Autonomy." *Political Theory* 33, no. 5 (2005): 602–28. https://doi.org/10.1177/0090591705278397.
53. "Ethical Considerations in Research on Female Genital Mutilation." World Health Organization. Accessed August 3, 2023. https://www.who.int/publications/i/item/9789240040731.
54. Cookson, Richard. "Justice and the Nice Approach." *Journal of Medical Ethics* 41, no. 1 (2014): 99–102. https://doi.org/10.1136/medethics-2014-102386.
55. "The role of women in shaping the Universal Declaration of Human Rights." Office of the United Nations High Commissioner for Human Rights. Accessed August 15, 2022. https://www.ohchr.org/en/stories/2018/03/role-women-shaping-universal-declaration-human-rights.



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