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A Review of Female Genital Cutting (FGC) in the Dawoodi Bohra Community:

Part 1—FGC Terminology, Western Genital Cutting Practices, Southeast Asian Type Ia and Type IV FGC Practices

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Abstract

Purpose of Review The aim of this first review out of a three-part series is to provide an overview of the practices of genital cutting including male circumcision, genital alteration of children with ambiguous genitalia, and clitoral hood reduction in Western societies; and type IV FGC in Southeast Asia. Examination of these procedures provides context for the practice of Khafd, female genital cutting (FGC), in the Dawoodi Bohra community.

Recent Findings In 2018, a Sri Lankan Parliamentary Sectoral Oversight Committee on Women and Gender (PSOCWG) heard the confidential testimonies of 15 women. Subsequently, a circular to medical professionals advised them to refrain from FGC. In September 2018, there was a call by multiple Islamic organizations to medicalize the practice and remove the circular that doctors should refrain from FGC.

Summary In this review, the WHO terminology for FGC classification is evaluated, and criticisms published online from the Dawoodi Bohra perspective are underscored. Practices pertinent to Khafd are scrutinized. Western practices, male circumcision, genital surgeries for children with ambiguous genitalia, and clitoral hood reduction, are described to further contextualize Khafd. Position statements from professional medical societies on male circumcision are reviewed. Type IV genital cutting is widely practiced in Southeast Asian Muslims and is largely medicalized. The review paper highlights two studies. Interviews with 262 Malay women from Malaysia comprise the first study. The second is a qualitative study conducted by Islamic Relief Canada, an advocacy organization aimed to end the practice, with data collected from Indonesian women in 2013. Interestingly, all of the above practices of genital cutting adhere to social norms and are largely accepted within the communities that practice these different forms of genital cutting.

Keywords Female genital cutting · Khafd · Dawoodi Bohra · Islam

Preface

This review is a series of three articles. There is a significant paucity of data with regards to FGC (Khafd) in the Dawoodi Bohra community. In order to contextualize Khafd, part 1 reviews language including WHO terminology, genital cutting in Western societies; male circumcision, surgery on children with ambiguous genitalia, and clitoral hood reduction; and finally FGC in Southeastern Asia. In part 2, there is an overview of Bohra culture, marriage, and sexuality in Bohra women, review of studies and testimonies on the practice of Khafd in Dawoodi Bohras, and a review of the pertinent legal cases involving FGC. In part 3, the history, cultural anthropology, and geography of FGC in the Islamic context and the religious motivation among Dawoodi Bohras for practicing Khafd are reviewed.

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Introduction and Background

Before considering the practice of genital cutting, frequency and timing of routine physical exams is extremely important.

These practices vary across cultures and nations and between genders. To appreciate changes in genital anatomy, clinicians need to be familiar with the range of normal genitalia.

In the USA, the American Academy of Pediatrics (AAP) recommends multiple exams from the newborn period to age 2, and then annually. The AAP details that children and adolescents should be undressed and draped appropriately for the exam and recommend the use of chaperones for sensitive exams including anorectal, genital, and female breast exams [1, 2]. Exams are only directed towards grading sexual maturity, except for infancy when the provider should directly assess for labial or genital abnormalities [3]. In the USA, routine gynecologic exam of a female child/adolescent requires counseling before the exam, most commonly frog-leg positioning, followed by inspection and palpation of inguinal area, labia majora, minora, and the clitoris. The clitoral hood should be retracted to inspect the clitoris. With retraction of the prepuce, in a prepubertal girl, the average clitoris glans size is 5 mm length and 3 mm transverse diameter; there is a very slight increase in size with the peripubertal effect of estrogen [4].

Although the AAP has published Preventative Pediatric Health Care recommendations, in practice, genital exams for pediatric males are routine, whereas external genital exams for pediatric females are not reliably performed [1]. This is a barrier to identifying FGC in females.

WHO terminology for FGC classification is described in Table 1. Type Ia and type IV do not involve excision of the clitoris.

Female genital cutting (FGC) is the terminology that will be used in this paper to refer to the WHO classification of FGM types I–IV. The connotation of the word mutilation is culturally insensitive. Many also use the term female circumcision but this implies sanctioning the practice. FGC encompasses the wide range of practices without accusation and without support. Western genital cutting practices include male circumcision, genital surgeries for children with ambiguous genitalia, and clitoral hood reduction. These are profoundly pertinent with regard to the controversy surrounding FGC and specifically to further contextualize Khafd.

Type IV FGC is widely practiced among Southeast Asian Muslims [5]. This review paper highlights two studies. Interviews with 262 Malay women from Malaysia comprise the first study [6••]. The second is a qualitative study conducted by Islamic Relief Canada, an advocacy organization aimed to end the practice, with data collected from Indonesian women in 2013 [7••]. Interestingly, all of the above practices of genital cutting adhere to social norms and are largely accepted within the communities that practice these different forms of genital cutting. The medicalization of FGC is prevalent in Southeast Asia, specifically in Indonesia, Malaysia, and Sri Lanka [6••, 7••, 8••]. The effect of medicalization of the practice is readily explored in these countries.

Reviewing FGC terminology, Western genital cutting practices and Southeastern Asian type IV FGC will inform the study of Khafd in the Dawoodi Bohra population.

Methods

The author reviewed two websites: femalecircumcision.org and dbwrf.org, reflecting Dawoodi Bohra opinion with regard to WHO terminology regarding FGC. The American Academy of Pediatrics (AAP), Centers for Disease Control (CDC), and World Health Organization (WHO) position on male circumcision was reviewed in light of the position of multiple international pediatric and medical societies [9–11]. A pediatric urologist's perspective published in the *Journal of Urology* is reviewed with regard to children with ambiguous genitalia [12]. Earp's work on the bioethical principle of a child's right to bodily integrity and the concept of social harm is reviewed [13]. The website clitoralunhooding.com and the medical and scientific assertions made by Asiff Hussein in an online newspaper called the *Daily Mirror* regarding the benefits of FGC are reviewed [14, 15]. FGC in Southeastern Asian countries of Malaysia and Indonesia was studied. They perform type IV or type Ia similar to the Dawoodi Bohra community. This review paper highlights two studies. Interviews with 262 Malay women from Malaysia comprise

Table 1 WHO Classification of female genital mutilation (FGM) [5]

FGM Type	Anatomic Changes of Female Genitalia
Type I	*1a) excision of prepuce of clitoris*
	Ib) excision clitoral glans
Type II	IIa) excision of labia minora only
	IIb) partial or total clitorodectomy and excision of labia minora,
	IIc) partial or total clitorodectomy and excision of labia minora and majora.
Type III	IIIa) apposition of cut labia minora ± clitorodectomy,
	IIIb) apposition of cut labia majora ± clitorodectomy.
Type IV	*All other harmful procedures to the female genitalia for nonmedical purposes, for example pricking, piercing, incising, scraping and cauterization.*

the first study. The second is a qualitative study conducted by Islamic Relief Canada, an advocacy organization aimed to end the practice, with data collected from Indonesian women in 2013 [5, 6••, 7••].

Results

WHO Terminology

The World Health Organization (WHO) uses the term female genital mutilation (FGM). WHO chooses this language intentionally to highlight their position that the practice is a serious violation of girls' and women's rights. They also want to maintain "a clear distinction from male circumcision and emphasize the gravity and harmfulness of the act." [16]

WHO does not acknowledge the harmful effect the word mutilation can and does have on women who have undergone FGC. Community-based interventions show that the term "mutilation" evokes negative feelings within many of the girls and women who have been cut. They report feeling "offended, stigmatized, or victimized by the term." Unfortunately, even if they are willing to abandon the practice of FGC, this terminology can jeopardize their willingness to collaborate or commit to ending FGC [17, 18].

Zakir specifically contests the WHO's stance on FGC type IV. In the first portion of the paper, he compares and contrasts male circumcision, clitoral hood reduction, and FGC type IV. Notably for FGC type IV, there is no data with regard to the benefits and risks of the procedure. He cites that there is no known benefit collectively for the practice of FGC. Collectively for the practice of all types of FGC, he cites the health risks, reproductive risks, and psychological risks [19]. He justly highlights the 2012 Hastings Center public advisory report "Seven Things to Know About Female Genital Surgery in Africa," which expresses concern on the media coverage of female genital surgeries being biased by global activist and advocacy movements, and it calls for greater accuracy in cultural representations [20]. WHO does not cite the 2012 Hastings Center Report in their 458-page publication Care of Girls and Women Living with Female Genital Mutilation: A Clinical Handbook [16, 19].

The second half of Zakir's paper asserts that WHO's definition of genital cutting as mutilation is a violation of the religious rights of Dawoodi Bohras. He highlights the Dawoodi Bohra philosophy is rooted in doing no harm and prohibits the mutilation of the human body. He cites the religious texts driving the practice of Khafd within the community [19].

Male Circumcision

When examining the practice of FGC, it mandates attention to the practice of male circumcision. One in three men is circumcised globally [21]. It is a social norm in the USA strongly supported by the AAP and the CDC and WHO. The 2012 AAP statement highlights the benefits of better hygiene, lower incidence of UTI in males, and decreased incidence of HIV based on trials performed in Africa [9, 21, 22]. International peer organizations, by contrast, have emphasized that these African data may not directly translate to newborn circumcision in Western countries, that the purported health benefits of circumcision can generally be achieved through nonsurgical means, and that the risks of circumcision therefore do not justify the benefits [10]. Among the organizations that have failed to support the view of the AAP and CDC are the Canadian Pediatric Society, the Royal Dutch Medical Association, The Royal Australasian College of Physicians, the British Medical Association, and the German Association of Pediatricians [11].

Children with Ambiguous Genitalia

In the USA, when considering ambiguous genitalia due to disorders of sexual differentiation, historically, the baby was assigned a gender and radical surgery was performed to align the infant's anatomy to the prescribed gender. This trend has shifted over the last decade to allow for delaying nonessential, cosmetic, invasive surgery until the child has the opportunity to form gender identity, at which point, they can participate in the conversation to inform surgical interventions [23]. An interdisciplinary team comprised of a pediatrician, endocrinologist, pediatric urologist, and psychologist/psychiatrist is needed to provide optimal medical and psychosocial support to the family and child given the delicate nature of genital surgery and the long-term impact on gender and sexuality [12].

Earp highlights the concept of a child's right to bodily integrity and raises the issue of sexual harm [13]. He aptly delineates the difference between a medically necessary procedure compared with a nonessential medical procedure in a person who is able to consent compared with a person who is temporarily nonautonomous [13]. This ethical principle of the right to bodily integrity directly applies to the dialog surrounding FGC, male circumcision, and surgery on children with ambiguous genitalia.

Clitoral Hood Reduction

In contrast to neonatal male circumcision and surgery on children with ambiguous genitalia, clitoral hood reduction is an elective surgical procedure to remove excess prepuce skin from around the clitoris, usually performed for sexual dysfunction thought to be caused by clitoral phimosis. Usually, this is performed on consenting adult women [14]. Asiff Hussein is an Islamic scholar from Sri Lanka who draws comparisons between type Ia FGC (he describes as female circumcision) and clitoral hood

reduction. He has also published on the purported health benefits of type Ia FGC [15, 24].

ClitoralUnhooding.com has a disclaimer located at the top of their homepage that reads: "This website does not condone any form of Female Genital Mutilation—specifically those procedures that involve partial or total removal of external female genitalia for nonmedical reasons. Sadly, many societal and religious beliefs condone these procedures, wrongly so, and violate the rights of children (including infants) and women. No physicians on this website perform Female Genital Mutilation."

The website also emphasizes the need for a surgeon to have experience (they describe as at least 12 procedures) to avoid damage to the clitoris. They emphasize that the clitoris is methodically protected throughout the procedure, and not too much preputial skin is removed to prevent overexposure of the clitoris [14].

Hussein's references, presented as scientific/medical evidence to support the practice of FGC type Ia, are weak. He asserts the space between the clitoris and the prepuce is a haven for bacteria. He quotes a study based on an abstract from 1922 and reports 74% of women in the study had gonorrhea in the prepuce and reports this as a risk for reinfection with gonorrhea. In reality, there are only 11% (4 out of 35 women) that had gonorrhea in the prepuce alone. The 74% refers to women who had gonorrhea in the prepuce as well as other areas such as the vagina, the urethra, or the vagina and the urethra [25]. This study has not been reproduced and presents no strong relationship for risks of gonorrhea reinfection directly related to the prepuce. There is no statistical analysis presented in the abstract. This study does not support any form of surgical intervention; the author recommends retracting the prepuce and cleaning. Edwin Walter Hirsch MD wrote the book *Sexual Fear* in 1962 about frigidity and suggests that retracting and cleaning the prepuce of the clitoris can resolve frigidity. This is not further studied and there is no mention of surgical intervention.

Hussein also highlights a number of Western studies on type Ia FGC which were reviewed by the author. An infectious disease study from 1923 analyzed the preputial smegma of 36 asymptomatic women late in their pregnancy [26]. None of these women were ill nor symptomatic; therefore, the significance of any bacteria found in preputial smegma cannot be implicated in any type of pathology. There is no data to show clitoral hood reduction reduces the incidence of urinary tract infections, as claimed by Hussein.

McDonald was a general practitioner, who performed type Ia FGC. His recommendations for type Ia FGC patient selection were based on anecdotal experiences and speculation. In detailing the procedure, McDonald states "general anesthesia should be used to avoid making an enemy for life" [27]. This contradicts Hussein's position that no harm comes from the procedure. It endorses the trauma an awake child experiences during a genital surgery, for which they have not consented.

A *New England Journal of Medicine* study by D'Souza G et al. showed that oral HPV is a major risk factor for oropharyngeal cancers [28]. HPV vaccination in girls is recommended to prevent cervical cancer, which is a recognized sequelae of HPV infection. Similarly, the authors suggest HPV vaccination in boys and girls could lead to reduction in oropharyngeal cancer, but further studies need to corroborate their data. The article demonstrates a statistically significant relationship between the number of vaginal sex partners and oral sex partners with the development of oropharyngeal cancers. Importantly, the preputial skin of the clitoris, foreskin of the penis, and circumcision are not mentioned once. There is no data on HPV in the prepuce of the clitoris and no data demonstrating the benefit of clitoral hood reduction in the prevention of HPV acquisition or transmission. Cunnilingus could be the means of transmission of HPV from women's genitalia to men's oral cavity. Hussein makes an unsupported assertion that the prepuce is a sanctuary for HPV, which is not proven, nor even mentioned or explored in this study [28, 29].

The practices of genital cutting in Western societies, and type IV FGC in Southeast Asia, provide a lens through which Khafd in the Dawoodi Bohra community can be studied. It is a largely medicalized practice in Southeast Asia. There is a representative survey data from Indonesia and small-scale research studies or anecdotal evidence of the practice in Malaysia, Singapore, Thailand, and the Philippines [5]. Type Ia or type IV FGC is described in Malaysia and Indonesia and largely medicalized. Type Ia or type IV FGC is also described among the Dawoodi Bohra community [5].

Malaysia

In 2009, the National Council of Islamic Religious Affairs (JAKIM) in Malaysia introduced a controversial fatwa declaring female circumcision to be obligatory (wajib) for all Muslim women [30]. Regarding terminology, female circumcision has been used to reference both genital pricking and incision of the prepuce of the clitoris without reduction (type IV FGC) as well as reduction of the prepuce of the clitoris (type Ia).

Isa et. al studied FGC in Kelantan Muslims in Malaysia. Islam is the state religion; the Malaysian Constitution guarantees freedom of religion. Malays comprise 60% of Malaysian society. Ninety-five percent of the population of Kelantan are Malays, with the majority of them Sunni Muslims [6••].

Isa et. al's study captured pregnant Malay women who came to the labor ward. Two hundred sixty-two women from that group reported FGC and agreed to examination and questionnaires. Ninety-seven percent pointed to the clitoris as the site of their procedure. Ninety-four percent reported that a pen-knife was used for the procedure. Ninety-seven percent reported

nicking as descriptive of the procedure. Ninety-nine percent of women reported it as a customary practice and 100% considered it a religious requirement. When asked about what would happen if women did not have type IV FGC, one-third believed it would result in a woman acting immorally, such as having sex outside of marriage or acting promiscuously. About one-third thought it promoted fertility. All respondents were in complete agreement with the desirability of FGC type IV. They saw no harm in the procedure [6••]. Respondents described minimal infant pain, such as a short cry or slight bleeding akin to a drop of blood [6••].

Authors highlight that there is no word for prepuce in Malay and suggests that the true anatomic location of the nicking is the prepuce of the clitoris, not the clitoral head. Participants viewed illustrations and pointed to the clitoris, not the prepuce when completing questionnaires [6••]. The practice was accepted across all age groups and educational levels and not more common in conservative or less educated realms [31]. A small focus group in women outside of Kelantan revealed that the practice may be performed on girls age 4 to 5. Also, people who live away from their elders more readily abandoned the practice [6••].

Indonesia

In 2006 in Indonesia, the Ministry of Health circulated a letter prohibiting FGC. In response, in 2008, the Indonesian Ulema Council (Majelis Ulama Indonesia – MUI) issued a fatwa recommending females undergo FGC. From 2010 to 2014, the Indonesian Ministry of Health authorized medical professionals to scratch the skin that covers the front of the clitoris, without injuring the clitoris [32]. After conducting its own research, the Muhammadiyah, the second largest Muslim organization in Indonesia, discourages its followers from partaking in FGC, but the largest Muslim organization in the country still favors the practice [33].

Islamic Relief Canada 2016 performed a qualitative study on women in Indonesia in 2013. Focus group discussions with men, women, and girls, as well as in-depth interviews with cultural and religious leaders, were conducted in Padang and Lombok. Additionally, in Jakarta, 12 interviews were conducted with key stakeholders, such as women's organizations, NGOs, civil servants, activists, and medical practitioners. (See Table 2) Notably, 60% of interviewees had limited knowledge of female genitalia and reproductive organs. They reported no major physical complications due to FGC, but did report incidences of pain, fever, and bleeding [7••]. One respondent felt she may have had better sexual enjoyment if she had not been circumcised. Perceived health benefits described by those in favor of the practice included: "enhanced sexual relations between a man and woman as part of the intimacy of marriage; minimizing sexual behavior prior to marriage; and a clean and healthy genital area."

This study intriguingly revealed a generational change in the timing of the procedure moving from an older age in older women to a younger age in the girls in the focus groups. In Padang and Lombok, all the girl respondents were cut between 0 to 24 months of age except for one. In contrast, in the women's focus groups, the cutting age ranged from 1 to 16 years of age. The change in cutting age could be secondary to the 2010 Ministry of Health government legislation, which led to medicalization of the FGC practice in Indonesia. FGC is offered as part of birth packages that include vaccinations and routine medical check-ups, although the government legislation was repealed in 2014 [7••]. This field study lacks sufficient data to determine how the legislation from 2010 to 2014 impacted how and by whom the procedure is carried out.

Of the respondents who agreed with FGC, they all believed that if a girl was not circumcised, then her Islamic duties (i.e., prayers, fasting, charity) were not accepted [7••]. Interviewees in all three provinces described FGC as a religious event that begins with a cold bath followed by recitation of the Shehada (Islamic declaration of faith) while the procedure is performed. The most common practice reported is type Ia or type IV FGC, but there are reports on the island of Madura that type II or type III is performed between ages of 5 to 18 [7••].

Fifteen respondents from Lombok had witnessed FGC and described tools ranging from penknives, surgical knives, and scissors to coins or fingernails and bamboo sticks. The technique described by the "2010 Regulation on Female Circumcision; Article 4" describes sterile technique, fixation of knees of the child, removal of smegma between "frenulum clitoris" and glans of the clitoris, followed by making "a small cut …using … needle of size 20G-22G …without harming the

Table 2 Key findings from Indonesian field study [7••]

Indonesian city	Percentage in favor of FGC (women in favor of FGC/total interviewees)	Motivators for FGC	Traditions surrounding FGC
Padang	77.5% (24/31)	Stabilize sexual libido, ensure healthy, clean genitals	Performed secretly sometimes with only mother's knowledge
Lombok	89.5% (34/38)	Religious obligation to purify girl and become better Muslim	Celebrated with a party to mark girl becoming more complete Muslim
Jakarta	1.5% (unclear as these 12 interviews were not with individual people)		

clitoris." Interestingly, while this regulation was in effect, most interviewees were not aware of it. Traditional midwives called "dukun" were interviewed and they continued to perform the procedure with equipment such as bamboo sticks, even during the 2010 to 2014 Regulation on Female Circumcision, although this was forbidden [7••].

The stigma attached to uncut Indonesian girls varies by region. They are seen as unclean but do not have difficulty with getting married or finding employment. However, in some rural communities in Padang, if there is uncertainty as to whether a female is cut, she will be cut again before marriage. Ninety-nine percent of interviewees reported a government ban on FGC would be ineffective because the primary driver of the practice is religious [7••]. A women's rights crisis center emphasized that any interventions must engage local scholars and religious organizations. Indonesians receive campaigning against the practice of FGC on the basis of gender rights, as "secular" and "pro-western," rendering it ineffective [7••]. Women in the focus groups would consider abandoning FGC if it was found to be medically and or psychologically harmful. However, 40% of the interviewees felt if FGC was found to be medically harmful but it was a recommended Islamic practice, they would still perform it. Also noteworthy, 50% of those against the practice of FGC would espouse type IV symbolic FGC [7••].

Further research is needed to explore the effects of FGC in Indonesia, specifically pain, fevers, and possible long-term trauma and impact on sexual satisfaction. Indonesian society and Indonesian women do not openly discuss FGC or sex, which might contribute to the current absence of evidence with regard to sexual impact. Sexual satisfaction within marriage is an Islamic right for women; therefore, it is a critical topic of research from both a religious and a health perspective, and highly pertinent to FGC practice patterns.

Discussion and Conclusion

Religious fatwas, or mandates, have been passed in favor of and against FGC. In 2008, the All Ceylon Jamiyyathul Ulama (ACJU), a religious association with widespread influence in Sri Lanka's Muslim community, which is largely the Shafi'i subsect, issued a fatwa declaring FGC mandatory after the 40th day of birth [8••, 34]. In 2018, a Sri Lankan Parliamentary Sectoral Oversight Committee on Women and Gender (PSOCWG) heard the confidential testimonies of 15 women. Subsequently, a circular to medical professionals advised them to refrain from FGC. In September 2018, there was a call by multiple Islamic organizations to medicalize the practice and remove the circular that doctors should refrain from FGC [8••]. Egypt's Dar al-Iftaa, a highly ranking Muslim institution, confirmed that FGC is a cultural practice and has no link whatsoever with Islam and its teachings. He cited that the Prophet Muhammad had not had his own daughters circumcised as evidence that it is not a religious duty for women [35]. Leading international Islamic scholars delineate that all forms of FGC are forbidden (haraam), including the Sheikh of Al-Azhar University, Grand Imam Muhammad Sayyid Tantawy [7••].

Many supporters of Khafd compare the practice with clitoral hood reduction. Clitoral hood reduction is a similar surgical procedure purportedly for women with sexual dysfunction secondary to clitoral phimosis, but the circumstances of Khafd and clitoral hood reduction are dramatically different. A 7-year-old girl who has Khafd, historically has had no counseling nor consent, and is possibly subjected to force to keep her still. She may or may not practice that religion as an adult and she may or may not be affected traumatically by irreversible alteration of her genitalia. Different individuals are affected differently by the same procedure. Clitoral hood reduction is electively performed under anesthesia in a sterile environment by a trained surgeon, after obtaining full informed consent from an adult individual who has identified sexual dysfunction as a problem. Clitoral hood reduction poses much less risk of negative sexual and emotional impact given the age of the individual, the voluntary consent, and the use of anesthesia [14].

In looking at FGC, the conversation must broaden to include male circumcision, children with ambiguous genitalia due to disorders of sexual differentiation, and sexuality. Age and consent are important factors for any surgical procedure. The Dawoodi Bohras are very specific with regard to Khafd occurring around age 7 for girls as will be delineated in part 2. Issues of consent, medical effects, and psychological effects vary drastically in a neonate versus a child versus an adolescent versus an adult.

Dr. Brenda Kelly an obstetrician who runs the Oxford Rose Clinic for FGC patients in England was interviewed and explained that children less than age 2 are less likely to remember and therefore unlikely to experience post-traumatic stress disorder (PTSD) compared with children over 5 who were forcibly held down and experienced severe pain or complications after the procedure [36].

In Western countries, it is standard of care to perform routine counseling before a pediatric genital examination, with an emphasis that no force should be used to execute the exam given the risk of trauma to the patient. These practices illustrate the importance of counseling and consent. If the exam is too difficult for the child, anesthesia is recommended to avoid lasting psychological trauma.

This logic parallels the debate with regard to irreversible genital cutting of female and male infants and children with ambiguous genitalia without medical need for emergent surgical intervention. The concern with regard to psychological distress inflicted by genital surgery on infants without the ability to consent is translating into change in practice and policy. In the USA, Medicaid insurance in many states will not pay for elective nontherapeutic male circumcision in neonates, potentially reflecting a changing American social norm.

The interplay between religious mandates, such as fatwas and FGC practice patterns, is highlighted in Indonesia and Malaysia. Although the Indonesian government sanctioned the practice from 2010 to 2014, and developed medical guidelines, many traditional circumcisers were performing FGC without adhering to the protocol. The traditional circumcisers and many of the women having the procedure did not know of these medical guidelines.

The societal norms surrounding sex often preclude any open conversation. This is an obstacle to exploring the psychological and physical impact FGC may have on women's sexual experiences, sexual awareness, and sexual wellness. Most of the women in Malaysia and Indonesia affirmed that they will perpetuate the practice with their daughters. The religious mandates and the medicalization, offering FGC as a standard part of birth packages, have the power to perpetuate and motivate the practice to continue. The infant age compared with the age of 7 years old perhaps changes the risk of psychological distress, but it does not address the bioethical principle of a child's right to bodily integrity and protection from sexual harm. Medicalizing the practice of FGC can inculcate it into the culture, reinforcing or creating a social norm [37].

The well-being of all children is grounded in the health of their community, the well-being of their own parents, and their right to basic needs, which includes safety from psychological and physical distress, and an intrinsic right to bodily integrity. When discussing FGC in Asian and African countries, attention must be given to genital cutting in Western countries, and the language used should not be ethnocentric. By using language such as "mutilation," people from communities who adhere to genital cutting are not encouraged to engage [18]. Such language does not respect their heritage and motivation behind the community's practice of FGC. Western countries sanctioning nonmedical neonatal circumcision and radical gender reassignment surgeries for infants and children with ambiguous genitalia due to disorders of sexual differentiation, which can be delayed into adolescence after gender identity develops, do not respect the integrity of the child. The neonates and children do not have a voice in this debate, and the future well-being of those children demands the attention of all stakeholders.

Compliance with Ethical Standards

Conflict of Interest The author declares that she has no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:
•• Of major importance

1. American Academy of Pediatrics. Recommendations for preventative pediatric health care. Bright Futures. s.l. American Academy of Pediatrics. Accessed online October 2018 @ https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.
2. Committee on Practice and Ambulatory Medicine. Policy Statement - Use of chaperones during the physical exam of the pediatric patient, Pediatrics. Vol. 2011;127:991.
3. Hagan JF, et al. Bright futures guidelines for health supervision of infants, children, and adolescents. In: Elk Grove Village. 4th ed: American Academy of Pediatrics; 2017.
4. Cheikhelard A, Chaktoura Z, Thibaud E. Prepubertal female child gynecologic exam. Endocrinology. 2012;22:1–10.
5. World Health Organization. Care of girls and women living with female genital mutilation: a clinical handbook. Geneva; 2018. s.n.. Licence: CC BY-NC-SA 3.0 IGO
6.•• Cappa C, Van Baelen L, Leye E. The practice of female genital mutilation across the world: data availability and approaches to measurement. Glob Public Health. 2019:1–14. https://doi.org/10.1080/17441692.2019.1571091 **Most up to date description of prevalence of FGC practice worldwide.**
7.•• Isa AR, Shuib R, Othman MS. The practice of female circumcision among Muslims in Kelantan, Malaysia. Reprod Health Matters. 1999;7:137–44. https://doi.org/10.1016/S0968-8080(99)90125-8 **Provides insight into social norms and religious basis for FGC. It is also similar FGC practice to what is described in the Bohra community.**
8.•• Patel R, Roy K. Female genital cutting in Indonesia; a field study. Islamic Relief Canada. 2013. Field Study Report. Accessed online 11/9/18 @ http://islamicreliefcanada.org/wp-content/uploads/2016/04/IRC_FGC_Report.pdf. **Qualitative study examining FGC practice providing insight into social norms and religious basis for FGC. It is also similar FGC practice to what is described in the Bohra community.**
9. Wickramage K, Senanayake L, Mapitigama N, Karunasinghe J, Teagal E. The need for an evidence-informed, multi-sectoral and community participatory action framework to address the practice of female genital mutilation in Sri Lanka. Ceylon Med J. 2018;63:53–7.
10. American Academy of Pediatrics. Circumcision policy statement. Pediatrics. 2012;130:585–6. https://doi.org/10.1542/peds.2012-1989 originally published online August 27, 2012.
11. Earp BD, Frisch M. Circumcision of male infants and children as a public health measure in developed countries: a critical assessment of recent evidence. Glob Public Health. 2018;13:626–41. https://doi.org/10.1080/17441692.2016.1184292.
12. CIRP. Circumcision: medical organization official policy statements. [Online] March 21, 2016. [Cited: October 15, 2018]. http://www.cirp.org/library/statements/.
13. Barthold JS. Disorders of sex differentiation: a pediatric urologist's perspective of new terminology and recommendations. J Urol. 2011;185:393–400.
14. Earp B. In: Edmonds D, editor. Ethics and the contemporary world: the child's right to bodily integrity. Abingdon: Routledge; 2019. p. 217–35.
15. Clitoral unhooding. [Online] October 20, 2006. http://www.Clitoralunhooding.com.
16. Hussein A. Female circumcision an islamic practice brings untold benefits to women. Daily Mirror. September 18, 2018. Accessed

online October 2018 @ http://www.dailymirror.lk/article/Female-Circumcision-An-Islamic-practice-brings-untold-benefits-to-women-155646.html.
17. Behrendt A. Listening to African voices; female genital mutilation/cutting among immigrants in Hamburg: knowledge, attitudes and practice. [Online] 2011. http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.400.67&rep=rep1&type=pdf18.
18. Duivenbode R, Padela AI. Female genital cutting (FGC) and the cultural boundaries of medical practice. Am J Bioeth. 19:3–6. https://doi.org/10.1080/15265161.2018.1554412.
19. Zakir M. WHO's stance and the criminalization of female circumcision: the protection of or violation of human rights? [Article link found on websites for Female Circumcision and Dawoodi Bohra Women for Religious Freedom]. 2016. Accessed online @ https://dbwrf.org/causes/4 and https://femalecircumcision.org/wp-content/uploads/2018/02/The-protection-of-or-violation-of-human-rights-Copy.pdf. https://dbwrf.org/causes/4.
20. Abdulcadir J, et al. Seven things to know about female genital surgeries in Africa. Hastings Center. 2012;42(6).
21. WHO. Neonatal and child male circumcision: a global review. s.l. : UNAIDS, 2010. UNAIDS/10.07E – JC1672E. https://www.who.int/hiv/pub/malecircumcision/neonatal_child_MC_UNAIDS.pdf. Accessed online June 21, 2019.
22. Morris BJ, Krieger JN, Klausner JD. CDC's male circumcision recommendations represent a key public health measure. Glob Health Sci Pract. 2017;5:15–27. https://doi.org/10.9745/GHSP-D-16-00390.
23. Earp B. You Tube. You Tube - National Secular Society. [Online] [Cited: June 23, 2019]. https://www.youtube.com/watch?v=oV7oADV2kIQ&t=517s.
24. Hussein A. Female genital mutilation. Daily Mirror. October 11, 2018. Accessed online October 2018 @ https://www.pressreader.com/sri-lanka/daily-mirror-sri-lanka/20181011/281883004298213.
25. Pemberton FA. The Prepuce of the clitoris and gonorrhea: Clodi and Schopper: Wiener Klinische Wochenschrift: 1922, xxxv, 197. Am J Obstet Gynecol. 1925;10:304.
26. Pilot I, Kanteh AE. Studies of fusiform bacilli and spirochetes: III. Occurrence in normal women about the clitoris and significance in certain genital infections. J Infect Dis. 1923;32:204–7.
27. McDonald CF. Circumcision of the female. Gen Pract. 1958;XVIII:98–9 Accessed online 11/3/18 @ http://www.noharmm.org/circumfemale.htm.
28. D'Souza G, et al. Case control study of human papillomavirus and oropharyngeal cancer. N Engl J Med. 2007;356:1944–56.
29. Gillison M. Human papillomavirus and oropharyngeal cancer correspondence. N Engl J Med. 2007;357:1156–8.
30. Ainslie M. The 2009 Malaysian female circumcision fatwa: state ownership of Islam and the current impasse. Women's Stud Int Forum. 2015;52:1–9.
31. Wikipedia. Fatimid Caliphate. [Online] [Cited: November 10, 2018]. https://en.wikipedia.org/wiki/Fatimid_Caliphate.
32. Unicef Data: Monitoring the situation of children and women. [Online] December 15, 2014. https://data.unicef.org/wp-content/uploads/country_profiles/Indonesia/FGMC_IDN.pdf.
33. Debate on female circumcision in Indonesia heats up even as minor howls through pain. Hindustan Times. April 24, 2017. Accessed 11/10/18 online @ https://www.hindustantimes.com/world-news/debate-on-female-circumcision-in-indonesia-heats-up-even-as-minor-howls-through-pain/story-0MgwbeKw5Gxfp0MMZkAjtI.html.
34. Fernando V. Female genital mutilation: a lifetime of scarred agony. Sunday Observer; 2018. Accessed online 11/2/18 @ http://www.sundayobserver.lk/2018/10/21/news-features/female-genital-mutilation-lifetime-scarred-agony.
35. Behary H. Female Genital mutilation is forbidden in Islam: Dar Al-Ifta. Egypt Independent; 2018.
36. Chung S. 28 Too Many. The psychological effects of female genital mutilation. [Online] May 16, 2016. [Cited: January 9, 2019.] https://www.28toomany.org/blog/the-psychological-effects-of-female-genital-mutilation-research-blog-by-serene-chung/.
37. Newman, Anneke and 28 Too Many. FGM and social norms: a guide to designing culturally sensitive community programmes. 2019. Accessed at: https://www.28toomany.org/thematic/social-norms-and-fgm/ June 21,2019.