Policy brief

Medicalisation of female genital mutilation/cutting in South and South East Asia

October 2025

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Equality Now
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ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

ASIA NETWORK TO END FGM/C

arrow

About ARROW

The Asian-Pacific Resource and Research Centre for Women is a non-profit women's NGO with a consultative status with the Economic and Social Council of the United Nations and an observer status with the United Nations Framework Convention on Climate Change. Based in Kuala Lumpur, Malaysia, ARROW has been working since 1993 to champion women and young people's sexual and reproductive rights. ARROW occupies a strategic niche in the Asia Pacific region and is a Global South-based, feminist, and women-led organisation that focuses on the equality, gender, health, and human rights of women.

About Asia Network to End FGM/C

The Asia Network to End Female Genital Mutilation/Cutting (FGM/C) is a group of civil-society actors, led by ARROW and Orchid Project, working across Asia to end all forms of FGM/C. It does this by connecting, collaborating and supporting Asian actors and survivors to advocate for an end to this harmful practice. The Network comprises almost 100 members across 12 countries in the Asia region. Members are activists, civil society organisations, survivors, researchers, medical professionals, journalists and religious leaders, who are committed to working collaboratively together to promote the abandonment of all forms of FGM/C across the Asia region.

Equality Now
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About Equality Now

Equality Now is a worldwide human rights organisation dedicated to securing the legal and systemic change needed to end discrimination against all women and girls, everywhere in the world. Since its inception in 1992, it has played a role in reforming 120 discriminatory laws globally, positively impacting the lives of hundreds of millions of women and girls, their communities and nations, both now and for generations to come.

Working with partners at national, regional and global levels, Equality Now draws on deep legal expertise and a diverse range of social, political and cultural perspectives to continue to lead the way in steering, shaping and driving the change needed to achieve enduring gender equality, to the benefit of all.

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FEMALE GENITAL CUTTING

About Orchid Project

Orchid Project is an international NGO, with offices in Nairobi and London, working at the forefront of the global movement to create a world free from FGM/C. At the heart of our mission are grassroots organisations that are pioneering change, and by working together, one step at a time, we believe we can help to end FGM/C globally.

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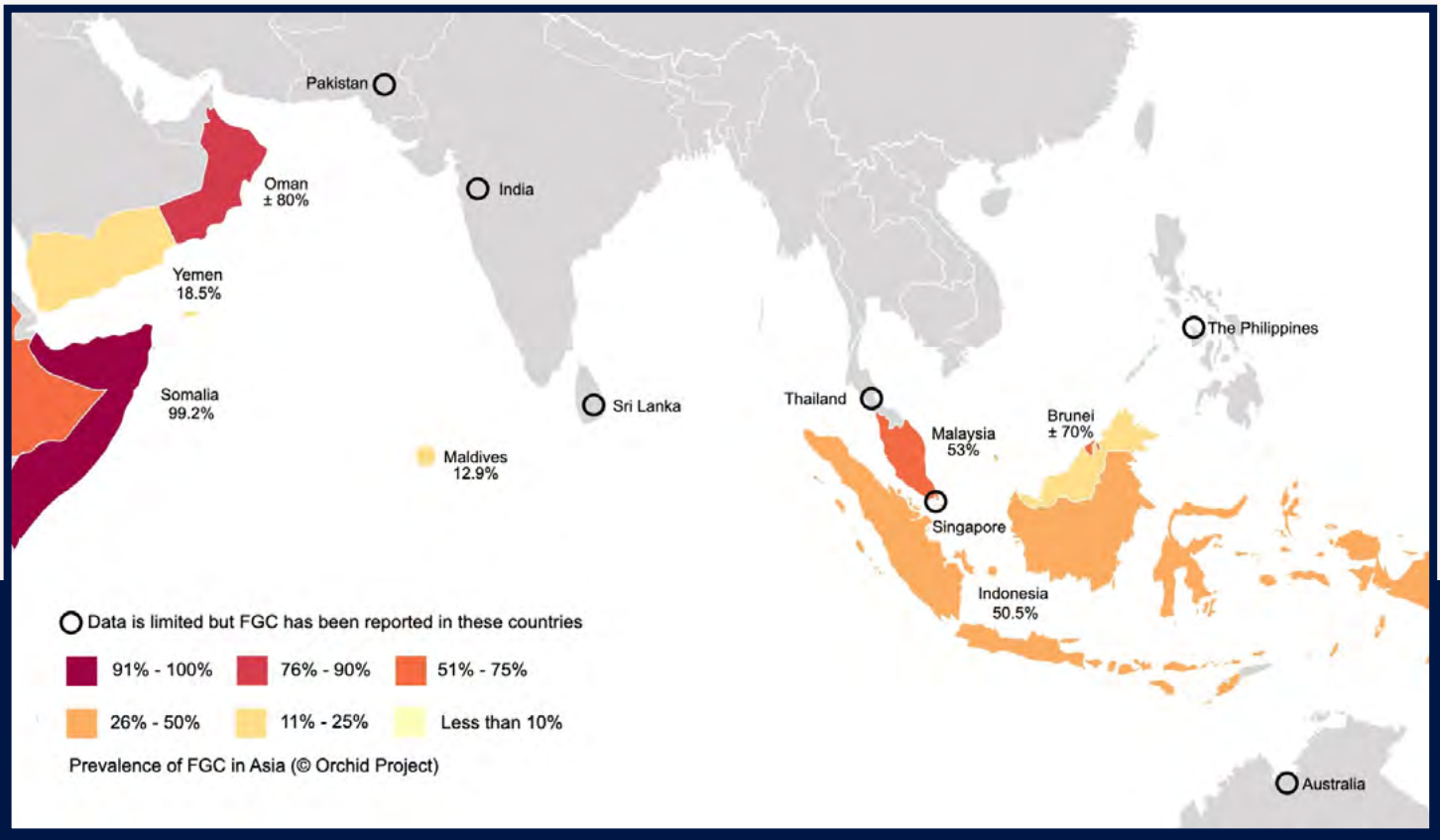
Contents

Background

Female genital mutilation/cutting (FGM/C) is internationally recognised as a gross violation of human rights, a form of violence against women and girls, and a manifestation of gender inequality. As such, its elimination is included as a specific target within Goal 5 of the Sustainable Development Goals (SDGs) dedicated to Gender Equity. Target 5.3 of the SDGs requires all 193 countries that signed onto the SDGs to take action to end FGM/C.[1]

The most recent data on FGM/C prevalence released by UNICEF in March 2024 shows that there are 230 million women and girls living with or at risk of FGM/C globally. For the first time, UNICEF data includes estimates of FGM/C prevalence in Asia (80 million), the Middle East (6 million), and countries where FGM/C is practised by sporadic communities or diaspora populations (1-2 million).[2] In Asia, there is evidence that FGM/C takes place in at least 12 countries across South and South East Asia. The types of FGM/C most commonly practised in Asia include Type 1 (particularly Type 1a - removal of the clitoral hood/prepuce) and Type 4 (pricking, scraping, etc) as well as certain symbolic forms of FGM/C.

FGM/C has no health or medical benefits and has no sound scientific basis. The short- and long-term effects of FGM/C in Asia are largely undocumented, and further research is required to unpack the harm caused, especially in the context of anecdotal information pointing to possible post-procedural complications such as infections,[3] long-term pain after child delivery,[4] negative impact on women's sex life,[5] and emotional impacts. Documented complications of Type I from other regions, also practised in Asia, include severe pain, genital swelling, haemorrhage, infection, tetanus, and risk of septicaemia.



The "medicalisation" of FGM/C refers to situations in which FGM/C is performed by any category of health care provider, whether in a public or a private clinic, at home or elsewhere.[6] Globally, there is an increased trend towards the medicalisation of FGM/C, with recent estimates indicating that around 52 million women and girls alive today were subjected to FGM/C by a health worker.[7]

Medicalisation of FGM/C is potentially driven by trends of urbanisation; the decline of traditional birth attendants within formalised health systems; and the increasing demand from parents who may have become more acquainted with the potential health complications of FGM/C customarily done by traditional healers using unsterilised equipment.

Therefore, perceived **harm reduction**, **religion**, and **financial implications** are reasons for medical practitioners to continue performing FGM/C.[8] However, it has been internationally recognised that the medicalisation of the procedure does not eliminate the harm of FGM/C and has no sound scientific basis. Healthcare professionals are not taught how to perform FGM/C in medical schools, and they mostly learn how to perform it informally from senior doctors or traditional healers.[9] There are serious risks associated with the medicalisation of FGM/C. Its performance by medical personnel may "wrongly legitimize the practice as medically sound or beneficial for girls and women's health. It can also further institutionalize the procedure as medical personnel often hold power, authority, and respect in society."[10]

Note on terminology:

This policy brief uses the broad term "female genital mutilation/cutting" to refer to all procedures involving partial or total removal of the female external genitalia or other injuries to the female genital organs for non-medical reasons. It is also intended to include "symbolic forms of female circumcision" within its scope. There are many terms used to describe this practice in different countries in South and South East Asia, including 'female circumcision,' 'female genital cutting,' 'khatna,' 'sunat,' 'sunat perempuan,' 'khitna,' and many other terms or acronyms depending on the specific local context involved. The term FGM/C, as used in this brief, is intended to be inclusive of all such terms.

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International human rights frameworks relating to the medicalisation of female genital mutilation/cutting

Female genital mutilation/cutting (FGM/C), including medicalised FGM/C, is widely recognised as a severe violation of international human rights, contravening key human rights laws, principles, norms, and standards.

Several international human rights treaties create binding legal obligations for state parties to eliminate FGM/C and protect the rights of women and girls. The Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) obliges states to eliminate harmful practices that discriminate against women, including FGM/C.[11] Similarly, the Convention on the Rights of the Child (CRC) mandates the protection of children from all forms of harmful traditional practices.[12] The UN General Assembly has also passed specific bi-annual resolutions on intensifying global efforts for the elimination of FGM/C since 2012, which include recommendations on measures to address the medicalisation of FGM/C.[13]

FGM/C also contravenes a range of well-established international human rights principles that guide state conduct. These include the principles of equality and non-discrimination, the right to life, the right to freedom from torture and ill-treatment, the right to the highest attainable standard of health, and the right of the child to physical and mental integrity.[14] Multiple UN treaty-monitoring bodies and mechanisms have characterised FGM/C as a form of violence against women and girls, and a practice that entrenches harmful gender stereotypes and social norms that are inconsistent with international human rights obligations.[15]

The medicalisation of FGM/C, where the procedure is performed by health professionals in clinical or semi-clinical settings, has also been unequivocally condemned under international human rights law.

The Joint General Recommendation No. 31 of the CEDAW Committee and General Comment No. 18 of the CRC on harmful practices recommends that where medical professionals are "involved or complicit in carrying out harmful practices, their status and responsibility, including to report, should be seen as an aggravating circumstance in the determination of criminal sanctions or administrative sanctions such as loss of a professional licence or termination of contract, which should be preceded by the issuance of warnings. Systematic training for relevant professionals is considered to be an effective preventive measure in this regard."[16] The Human Rights Council, in its biannual resolutions on FGM/C passed since 2014, has also highlighted the need to address the medicalisation of FGM/C. For instance, the HRC resolution 44/16, passed in 2020, called upon States to stop the medicalisation of FGM/C, including by "drawing up and disseminating guidance and legal provisions for medical personnel and traditional birth attendants so that they are able to respond to social pressures in their interaction with local communities to perform medicalized female genital mutilation".[17]

International law recognises that the procedure remains a violation of human rights, regardless of the setting or the provider. Medicalisation does not eliminate the physical, psychological, and emotional harm caused by FGM/C, nor does it address the underlying issue of gender-based discrimination. The World Health Organisation (WHO) and other UN agencies state:

- There is no medical justification for FGM/C under any circumstances;[18]
- Medicalisation does not make the practice safe or acceptable, as it continues to cause significant harm;[19]
- Health professionals have ethical and legal obligations to refrain from performing FGM/C, as it is incompatible with human rights standards and medical ethics.[20]

In order to comply with their obligations under international human rights law, states must adopt and enforce legislation that prohibits both traditional and medicalised forms of FGM/C, and ensure accountability for those who perform or facilitate the practice. Governments are expected to take comprehensive legal, policy, and public health measures to eliminate FGM/C, in accordance with their international human rights obligations.

Context analysis: Medicalisation of female genital mutilation/ cutting in Asia

There is evidence that medicalisation of female genital mutilation/cutting (FGM/C) is taking place in at least eight countries in South and South East Asia: Brunei, India, Indonesia, Malaysia, Pakistan, Singapore, Sri Lanka and Thailand.

In the remaining countries, there is either insufficient evidence or the available evidence demonstrates that FGM/C is largely being carried out by traditional practitioners. For instance, in the Philippines, the most recent study from 2021 found that FGM/C was carried out in most cases by traditional birth attendants, known as *pandays*.[21]

It is also important to note that in practising countries, some people who continue the practice wrongly associate the practice with medical and health benefits, including the belief that it improves overall wellbeing, enhances fertility, enables less painful childbirth, prevents gynaecological illnesses, and safeguards the health of future generations.[23]

Credit: Aakansha Saxena

For countries where there is available data on the medicalisation of FGM/C, a summary of the situation in each country is provided in the table below:

Brunei Darussalam	There is a lack of clear evidence on the medicalisation of FGM/C in Brunei. However, a survey of 20 respondents conducted by Musawah had found that all 20 had undergone FGM/C and "some noted that this was a 'default' procedure that occurs in all government hospitals".[23] Additionally, given that FGM/C in Brunei is practiced by the ethnic Malay Muslim community in a very similar manner as in Malaysia, where there is an increasing preference amongst parents for FGM/C to be performed by healthcare practitioners, it is likely that medicalisation is occurring in Brunei as well.[24]
India	Though there is a lack of evidence on the extent to which FGM/C is medicalised in India, existing studies do demonstrate that the cutting is taking place by doctors and in medical clinics. A research study by WeSpeakOut (2018) found that out of 81 respondents (most of whom were from the Bohra community), only six were subjected to FGM/C by a medical doctor (around 7%).[25] However, the qualitative interviews demonstrated a rising trend of parents wanting to move away from traditional circumcisers to medical doctors, particularly for younger generations. Sahiyo's study (2017) similarly found that 12% of Indian Bohra women studied reported being cut in a health clinic.[26] Informal investigations by Sahiyo on the practice of FGM/C within the Sunni Muslim community in Kerala also unearthed evidence of medical clinics in the state which were confirmed to carry out FGM/C.[27]
Indonesia	Over the past two decades, Indonesia has witnessed a gradual shift toward the medicalisation of FGM/C, with nearly half of all FGM/C interventions being carried out by midwives, due to perceived safety, accessibility, and inclusion of the practice as part of standard maternity packages. National prevalence data show that in urban areas, 58.2% of cases were performed by medical professionals, while in rural areas, it drops to 35.2%.[28] Asia Network's study (2025) finds that reasons cited by Indonesian healthcare workers for continuing to carry out FGM/C include parental demand and fear of social exclusion, sharing community values, as well as a belief that FGM/C can occur more safely in a hygienic medical setting.[29] Some studies indicate that healthcare practitioners may be more likely to perform more severe forms of cutting.[30] A 2017 study found that health professionals are twice as likely to perform Type 1a FGM/C (46%) as compared to traditional birth attendants (23%), who are more likely to perform Type 4 (35%) or a symbolic form of FGM/C.[31]

Malaysia	Since the 1980s, Malaysian women have gradually shifted from traditional midwives to health professionals when it comes to carrying out FGM/C. In Malaysia, a 2020 study found that 20.5% of doctors had reported practising FGM/C.[32] Medicalised FGM/C in Malaysia is performed almost entirely by medical doctors, though a small minority of cases are also performed by nurses/midwives. They mainly perform nicking of the clitoris/prepuce (Type 4), with a small number of doctors practising a more invasive form by cutting the external clitoris (Type 1).[33] 85.4% of doctors interviewed were of the opinion that FGC should continue and that medical doctors should be the ones to conduct FGC (63.9%).[34] The study shows that medicalisation and the role of the health workforce are important to consider as a challenge to progress, requiring attention in Malaysia.
Pakistan	There is no clear data to show medicalisation of FGM/C in Pakistan; if the trend follows India, there may be increasing rates of medicalisation reported in the future. Sahiyo's 2017 survey finds that out of 44 women in Pakistan who had been subjected to FGM/C, all were cut by traditional circumcisers in a private residence and not in a clinic.[35] Qualitative research by Syyed (2024), however, through second-hand accounts and anecdotes, demonstrates a shift towards medicalisation, especially in younger generations.[36]
Singapore	A 2020 Pilot Study by End FGC Singapore found that 47.3 % of respondents who had undergone FGM/C were cut by doctors.[37] However, a significant percentage of respondents (35%) indicate that they did not know who performed the cutting, indicating that medicalisation may be much higher. At present, FGM/C in Singapore has been highly medicalised.[38] End FGC Singapore has noted that most cases of FGM/C, which they are aware of, are occurring in about 5 General Practitioner (GP) clinics, performed by Muslim female doctors across the island.[39]
Sri Lanka	Though there is limited data from Sri Lanka, a study by Women's Action Network (2025), which engaged nearly 998 participants, showed that while traditional practitioners, known as *ostha maamis*, historically performed most of FGM/C in Sri Lanka, there is an increasing trend of FGM/C being performed discreetly by physicians mostly in private clinics.[40] It was noted that in metropolitan areas in particular, FGM/C is advertised to the community on social media, with listings of doctors and hospitals who provide female circumcision services. Earlier studies, including those by Ibrahim & Tegal (2019), also make reference to a few cases where FGM/C was performed by a doctor.[41]
Thailand	Orchid Project and ARROW's report (2024) has relied on media reports and states that more girls are undergoing FGM/C in health facilities – either in hospitals following the girl's birth or in clinics during the following few weeks.[42] A few doctors have been quoted in news reports as saying that they perform between ten and twenty procedures a month and that they believe the procedure, if done by a doctor, should not be considered mutilation.[43]

Analysis

The key takeaways based on an analysis of available data on the medicalisation of female genital mutilation/cutting (FGM/C), as set out in the table above, are:

The highest rates of medicalisation are seen in Singapore, Indonesia and Malaysia.

- However, the data from other countries indicates that medicalisation of FGM/C is on the rise across the region, with almost all countries reporting that younger girls were more likely to be subjected to FGM/C by healthcare practitioners as compared to the older generation. A common theme was also a higher trend towards medicalisation in urban areas as compared to rural areas in many countries.

- This rising trend in medicalisation is driven by a number of factors, including the belief that FGM/C performed by healthcare practitioners is more hygienic and less likely to lead to health complications. Another factor is a decrease in the number of traditional practitioners. For example, *bidans* who traditionally performed FGM/C in Malaysia and Southern Thailand are dying out. In Thailand, the long-term policy is to eliminate the practice of *mak bidans* in Southern Thailand, as they are no longer being granted training or licenses.[44] With no corresponding decrease in demand from FGM/C from the community, this is contributing to increasing trends of medicalisation.[45]

- Most studies on medicalisation have highlighted that often the healthcare practitioners performing FGM/C belong to the same communities in which the practice is prevalent. This is likely due to them believing in the religious and cultural justifications; being aware of social consequences towards girls and the family as a result of not being cut; and perceived minimal or reduction in harm if done in a medical setting, despite receiving no formal training on how to undertake the practice. A number of studies have noted that this information is informally passed down by older practitioners as a form of community knowledge.

- There are also increasing instances of standardisation of FGM/C as a "medical practice" in formal healthcare systems, with FGM/C being offered as part of packages with other procedures carried out on babies, such as ear piercings or other birth packages (as in Malaysia, Indonesia and Sri Lanka), as well as being openly advertised (as in Singapore and Sri Lanka). Such standardisation can provide legitimacy to the practice and even lead to further spread of the practice.

- Based on the studies conducted so far, there is no evidence to show that the medicalisation of FGM/C has led to harm reduction. In fact, studies from Indonesia[46] and Malaysia[47] indicate that healthcare professionals are more likely to undertake more severe forms of cutting (Type 1a) as compared to traditional practitioners, with the involvement of anaesthetics and anatomical knowledge possibly resulting in deeper and more extensive cuts. However, there are also reports indicating that in recent years, more midwives in Indonesia are refusing to perform FGM/C, choosing to merely clean the baby's genitals with betadine without informing parents, which gives cause for hope.[48]

National legal and policy frameworks

Indonesia's experience

National legal and policy frameworks on female genital mutilation/cutting (FGM/C) remain scarce in Asia. In 2024, Indonesia became the first Asian country to pass a specific legal provision against FGM/C through Government Regulation No.28/2024 regarding implementing the Health Law, which prohibits 'female circumcision' for infants, toddlers, and preschool children (likely only covering children under the age of 5).[49] Following this, Regulation of the Minister of Health Number 2 of 2025, which is an implementing regulation, also provides for the elimination of FGM/C.[50] Concerningly, this new regulation appears to limit the application of the legal prohibition on FGM/C to "female circumcision practices that endanger the Reproductive System", which include practices of cutting and/or injuring or other actions that cause damage to the female genital organs. There is a widespread understanding amongst key stakeholders in Indonesia that this new regulation means that "symbolic practices of FGM/C" which do not include cutting (but rather may include touching or scraping the clitoris with an instrument) are not prohibited by the new regulation. Further, the National Commission on Violence Against Women (Komnas Perempuan) has noted that the current prohibition on FGM/C only applies to infants, toddlers and preschool children, and recommended that the policy to eliminate FGM/C should be expanded to apply to women of all ages.[51]

However, despite Indonesia's recent strides towards introducing progressive legal and policy frameworks on FGM/C, the long-lasting impacts of past regressive policies, which promoted the medicalisation of FGM/C in Indonesia, still continue to be felt in the country. In 2010, after pressure from the Indonesian Ulema Council which had issued a fatwa promoting FGM/C, the Ministry of Health issued a decree, PMK No. 1636/2010, which prohibited "grave types of FGM" and stipulated that only licensed doctors, midwives and nurses (preferably female) may practice FGM/C, and that it should only be performed upon the request or approval of those undergoing the procedure or their parent/guardian, and included a detailed standard operating procedure to be followed by skilled health personnel performing FGM/C.[52] As a consequence of this circular, "every hospital, even private maternity clinics, continued to perform female circumcision on the grounds that it was considered safer and more hygienic if it was performed by trained medical personnel".[53]

Though the 2010 circular was withdrawn by the Ministry of Health in 2014 after national and international outcry, including efforts from Komnas Perempuan, there was no ban on healthcare practitioners performing FGM/C until 10 years later. This promotion of medicalisation of FGM/C by the Ministry of Health contributed to FGM/C becoming a standardised procedure, which was marketed as part of a birth package in medical facilities across the country. The widespread effects of such standardisation have been highlighted for example, in a study by Islamic Relief Canada, which found that mothers who are delivering babies are sometimes unaware of what FGM/C entails but agree to have it carried out on their daughters simply because it comes as part of a complete birth package – which includes regular vaccinations and medical check-ups - which legitimised the practice.[54]

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National circulars and policies on female genital mutilation/cutting and its medicalisation

Despite the scarcity of laws specifically relating to FGM/C in South and South East Asia, there are examples of circulars and policies being issued by governments or national medical bodies specifically prohibiting FGM/C from being performed by healthcare practitioners in South and South East Asia. For example,

- **Indonesia:** Circular Letter No. 0319/PPIBI/ II/2024 issued by the Chairperson of the Indonesian Midwives Association (Ikatan Bidan Indonesia/ IBI) in 2024 mandates the abolition of FGM/C practices and the prohibition of midwives from providing FGM/C services.[55]
- **Sri Lanka:** The Sri Lankan Ministry of Health, Nutrition and Indigenous Medicine, Circular on Medical Professionals Involvement in Female Genital Mutilation, 2018 states that: "all Medical Professionals whose primary ethical and moral obligation towards mankind is to 'do no harm' are instructed to refrain from any involvement regarding female genital mutilation. Disciplinary action shall be taken against any Medical Professional practising or promoting Female Genital Mutilation and not adhering to the stipulated instructions."[56] However, as a recent 2025 study found, many doctors have no knowledge of the existing circular, and no disciplinary actions have been taken against medical professionals practising or promoting FGM/C.[57]
- **India:** In India, though there is no official government circular regarding the practice of FGM/C, the Federation of Obstetrics and Gynaecology in India (FOGSI) has issued a circular on FGM/C in 2020, which directs its members and all other healthcare providers to desist from performing FGM/C.[58]

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Protection gaps in laws and policies on female genital mutilation/cutting

Most countries in South and South East Asia, except Indonesia, do not have any official laws and policies issued by the government explicitly prohibiting performing FGM/C by healthcare practitioners.

This is a significant protection gap which enables medicalised FGM/C to continue to take place across the region. It is important to note that FGM/C could potentially be prosecuted under general criminal laws and codes; however, longstanding sensitivities around the practice further complicate policy development and enforcement.

In other countries, policy approaches vary and may allow for medical involvement under certain circumstances. For instance, the Thai Government, in its response to the CEDAW Committee, noted that the practice of FGM/C or *khitan* in Thailand "should be subject to the consideration of a qualified medical professional and discouraged."[59] Similarly, the Brunei government has supported the practice of female circumcision (excision of the prepuce) as being *wajib* (compulsory) under Islamic law.[60] With Musawah reporting that FGM/C in Brunei is being offered in government hospitals,[61] this indicates government support for medicalised FGM/C.

Promoting accountability of healthcare practitioners

The involvement of healthcare practitioners in FGM/C poses a serious ethical concern. Healthcare providers are not merely service providers – they are custodians of medical legitimacy. Their participation in FGM/C risks legitimising FGM/C as a medical procedure, thus perpetuating social norms that are anchored in medical disinformation, gender-based discrimination, and potential harm. The WHO Guideline on the prevention of female genital mutilation and clinical management of complications (2025) includes specific recommendations on capacity-building for health workers, as well as the creation and enforcement of laws and policies against FGM/C, and professional codes of conduct for health workers, to ensure accountability.[62]

Performing FGM/C contravenes the widely accepted ethical framework developed by Beauchamp and Childress,[63] which includes four core principles: autonomy, beneficence, non-maleficence, and justice.

- **Autonomy** is fundamentally violated when female infants or young girls are subjected to procedures without their informed consent. Parents should not be permitted to consent on behalf of their children to non-essential interventions that lack medical benefit and are not lifesaving.
- **Beneficence**, the obligation to act in the patient's best interest, is rendered moot in the context of FGM/C, as the practice confers no medical benefit whatsoever.
- **Non-maleficence** is the duty to "do no harm." Central to this argument is the perception that the subtypes of Type 4 FGM/C practised in Asia do not cause harm, and thus, they are used to justify the continuation of the practice by claiming the duty of non-maleficence does not apply. While some contemporary studies[64] suggest these forms may not result in long-term physical complications, the mere absence of demonstrable harm does not justify a procedure that lacks medical necessity and carries the risk of psychological, social, and symbolic damage.
- **Justice**, particularly in the context of gender equality, is undermined by the targeting of women and girls for a practice rooted in discriminatory norms.

These principles serve not only as ethical guidelines but also as practical tools for medical decision-making. When applied rigorously, they compel healthcare professionals to reject FGM/C under any circumstance.

The WHO Global Strategy to stop healthcare providers from performing female genital mutilation requires that, to ensure accountability, professional regulatory bodies such as medical and nursing councils must establish enforceable standards that explicitly prohibit FGM/C.[65] Licensing criteria should require a demonstrated understanding of both medical ethics and human rights obligations. This will contribute to ensuring that practitioners found to engage in or enable FGM/C face meaningful sanctions, complemented by clear institutional procedures for investigation and reporting.[66] Mandatory reporting mechanisms and whistleblower protections can empower colleagues to intervene when ethical lines are crossed.

In many high-prevalence contexts, FGM/C is performed by healthcare providers with no formal training on its ethical or medical implications. Reforming medical, nursing, and other allied healthcare professional curricula to include modules on gender-based violence, harmful traditional practices, and ethical reasoning is essential. This is particularly urgent given the rise in "package-based" offers of FGM/C within formal healthcare systems in countries such as Malaysia,[67] Singapore,[68] and Indonesia.[69]

Accountability doesn't necessarily begin with punishment; it should also involve equipping health professionals to challenge harmful norms within their communities. Healthcare workers hold unique authority and are well-placed to advocate against FGM/C. Where culturally sensitive, partnerships with religious leaders and community elders can further legitimise medical opposition to FGM/C.

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Major challenges in combating medicalisation in Asia

Though efforts to address the medicalisation of FGM/C in South and South East Asia are fairly new, they have already been facing significant challenges, of which the main ones are set out below:

1. The discourse of minimal or no harm

Until recently, international anti-FGM/C advocacy has largely centred on Africa, often overlooking its prevalence and persistence in parts of Asia. In response, proponents of so-called "female circumcision" in Asian contexts have sought to distance their practices from "FGM/C in Africa" by invoking the argument of minimal or no harm. It is important to note that practising communities and medical professionals do not generally intend to cause harm or hurt, and/or strongly believe in the religious and cultural justifications to practice it, and this rationale allows the continuation of the practice under the guise of cultural or religious obligation. For example, the Malaysian Federal Mufti Office has declared "female circumcision" as *wajib* (obligatory) in Islam, while simultaneously emphasising that it should be performed in a manner that avoids what they define as mutilation, thereby distinguishing it from FGM/C, which is widely acknowledged as harmful.[70]

However, such reasoning is grounded in a limited understanding of female genital anatomy, particularly in infants. The assumption that minimal cutting equates to no harm fails to recognise the anatomical complexity and sensitivity of the clitoral structure, as well as the broader ethical, psychological, and human rights implications of the practice.

2. Resistance and social obstacles to ending female genital mutilation/cutting

Advocates working to end FGM/C in Asia often encounter significant challenges in bringing the issue to the forefront of public and stakeholder discourse. Unlike in some African contexts, where FGM/C is deeply intertwined with social constructs such as marriageability or child marriage, the practice in parts of Asia is often seen as a discrete ritual, detached from broader societal consequences. As a result, efforts to raise awareness are frequently met with indifference, dismissal or resistance. The denial that "female circumcision" constitutes FGM/C further marginalises the issue, leading many to perceive it as trivial, sensationalist or culturally insignificant.

In many cases, advocacy against the practice is viewed as part of a " Western agenda," which has strengthened the resolve of communities to cut as a cultural and traditional practice that should be allowed to continue without Western imposition. This is further exacerbated by Islamophobic narratives that further entrench FGM/C in Asia, especially in Muslim-minority countries like Singapore, Sri Lanka and India. Advocating against FGM/C is usually considered as going against religion, and minority communities are especially defensive about being called out for their practices, especially in the face of increasing curbing of their minority rights. While acknowledging and critiquing the shortcomings of a reductive framing of the issue, which views practising communities as actively wanting to harm their girls and women, advocates from the community grapple with highlighting the legitimate human rights concerns and ethical violations of legitimising and medicalising a precarious practice that has no medical or health benefit.

3. The silence of medical authorities and their reluctance to classify female genital mutilation/cutting as non-medical

"Female circumcision" is not included in the curriculum of any accredited healthcare degree program worldwide. Instead, it is often informally passed down by senior doctors or healthcare professionals (typically from within the same community) who regard it as a religious or cultural duty. Crucially, this practice has no basis in medical science, yet cultural and religious pressures have led to a troubling silence among many medical professional bodies. Rather than taking a clear stance against it, some choose to remain non-committal, hoping the issue will quietly resolve itself.

In some cases, religious authorities defer responsibility to medical experts, while medical experts, in turn, defer to religious authorities, creating a cycle of inaction.

Moreover, in some Asian countries, where FGM/C is practised primarily within a marginalised minority community, medical professionals from outside that community are reluctant to intervene. This is due to fears that speaking out or condemning the procedure may be misconstrued as measures motivated by religious intolerance targeting a minority community. This reluctance to confront the practice perpetuates harm and undermines the ethical responsibility of the medical community to protect vulnerable populations.

Recommendations

National-level recommendations for governments and national actors

Laws and policies

- **Enact comprehensive laws and policies on female genital mutilation/cutting (FGM/C)**, which also have specific provisions to prevent and prohibit the medicalisation of the practice.
- In countries where legal frameworks exist, **enforce the prohibition of FGM/C by issuing clear, binding guidelines with robust monitoring and accountable mechanisms** applicable to all healthcare settings, including private clinics, to curb the growing trend of medicalisation of FGM/C.
- **Issue national circulars from the Ministry of Health**, as well as professional doctors/midwives associations, prohibiting all healthcare practitioners from carrying out FGM/C (including practices known as 'female circumcision') and providing for clear mechanisms for enforcement. These circulars should apply to all healthcare practitioners in the country (including doctors, nurses and midwives) irrespective of whether they work in private or government hospitals and clinics.
- **Include clear, comprehensive definitions of FGM/C within all laws, policies and circulars** addressing the medicalisation of FGM/C and ensure that all forms of FGM/C or 'female circumcision', including symbolic practices, are included within its scope.
- **Implement measures to ensure and meet the government's international commitments to safeguarding the rights and well-being of women and girls**, including but not limited to CEDAW and CRC recommendations.
- **Set up a cross-sectoral working group bringing together health professionals, religious authorities, legal experts, and policymakers** to ensure coordinated efforts to end the medicalisation of FGM/C, including advising on legal and policy responses.

Awareness and capacity-building

- **Provide comprehensive training on FGM/C and its harmful impacts to healthcare practitioners**, including in pre- and in-service curricula and training, as well as refresher courses and updates for all healthcare providers, particularly those in routine maternal and child health services. Training programmes should include community engagement techniques, values clarification workshops, and peer-led interventions that empower providers to reject the practice publicly.
- **Integrate FGM/C awareness into healthcare services, including postpartum care education**, by training healthcare providers and midwives to address the issue sensitively during routine maternal and child health visits, creating opportunities for education and early intervention.
- **Implement national awareness campaigns aimed at the general public** to clarify the distinction between medicalised FGM/C and other legitimate medically required healthcare practices, highlighting that no form of FGM/C is medically necessary and all forms are harmful.
- **Reform medical, nursing, and other allied healthcare professional curricula** to include modules on gender-based violence, harmful traditional practices (including FGM/C) and ethical reasoning.
- **Ensure that licensing criteria for healthcare professionals require a demonstrated understanding of both medical ethics and human rights obligations.**
- **Develop national guidelines for various health-care providers** (including midwives) on how to deal with issues related to FGM/C, including the lack of health and medical benefits, how to care for complications and how to resist pressure to perform any form of FGM/C.

Research and evidence generation

- **Require national health institutions and hospitals to collect accurate and reliable data on the prevalence of FGM/C.** Where possible, FGM/C indicators should be integrated into upcoming national health surveys and monitoring frameworks.
- **Invest in further research on the medicalisation of FGM/C**, particularly in countries with little or no data, to ensure access to accurate, updated and publicly accessible data on the extent and impact of medicalisation. This includes support for the conduct of longitudinal research, which will help to understand the long-term physical and psychological impact of FGM/C, and provide clearer evidence on the consequences of medicalisation and further underscore its harmful nature.
- **Undertake research to assess effectiveness of programs which are aimed at addressing medicalisation** to determine best practices in the Asian context and to guide future programming.

Accountability of healthcare practitioners

- **Ensure that healthcare practitioners found to engage in or enable FGM/C face meaningful sanctions**, including fines, suspension, license revocation, and legal action, complemented by clear institutional procedures for investigation and reporting.
- **Provide for mandatory reporting mechanisms and whistleblower protection** to enable healthcare practitioners to report colleagues who are performing FGM/C.
- **Adopt and implement the 'WHO Global Strategy to stop healthcare providers from performing female genital mutilation' at the national level.**
- **Monitor effectiveness of health sector trainings on a regular basis**, and track complaints and disciplinary and legal actions taken to ensure accountability of healthcare practitioners.

Regional policy recommendations for human rights and development partners

- **Leverage Beijing+30 and ICPD commitments**, which explicitly call for the prohibition and elimination of FGM/C, to reinforce that the practice, whether performed by traditional practitioners or health professionals, remains a violation of gender equality and Sexual and Reproductive Health and Rights (SRHR).
- **Leverage International Human Rights treaties**, particularly the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Convention on the Rights of the Child (CRC), to reinforce global norms that prohibit any form of FGM/C, including when performed by healthcare providers. Advocate for health actors to align clinical ethics with human rights obligations, ensuring that medical boards, licensing bodies, and health ministries adopt and enforce zero-tolerance policies.
- **Strengthen International and Regional Partnerships with agencies such as ASEAN, WHO and UNESCO** and engage actively to ensure that FGM/C is integrated into broader gender equality and child protection agendas. This includes supporting ASEAN's renewed 10-year Gender Mainstreaming Strategic Framework and advocating for the explicit inclusion of FGM/C as a priority issue within its implementation under the Commission on the Promotion and Protection of the Rights of Women and Children Agenda (ACWC) and advocating for the explicit recognition that medicalisation is not a harm-reduction measure.
- **Support knowledge generation and evidence-based advocacy** by working with regional feminist and human rights organisations working on research, advocacy, and grassroots mobilisation, such as Asia Network to End FGM/C and Equality Now, to generate and disseminate data showing that medicalisation perpetuates the practice rather than eliminating it.
- **Support regional medical and midwifery associations**, such as The Midwives Alliance of Asia (MAA), in developing and promoting professional guidelines that explicitly oppose the medicalisation of FGM/C, prohibit members from performing FGM/C in any capacity, and promote disciplinary action against providers who perform FGM/C.

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