



TOWARDS UNDERSTANDING FEMALE GENITAL CUTTING IN SRI LANKA

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EXECUTIVE SUMMARY

The Family Planning Association of Sri Lanka (FPA) commissioned a brief study in 2018 to understand the physical and psychosocial impacts of Female Genital Cutting (FGC)¹ as reported by women in Sri Lanka. This exploratory work was done in a context where there is little formally published information on this issue in Sri Lanka in terms of what happens, what the motivations are and what women want in terms of support or services. This report aims to contribute to a deeper and more nuanced understanding of the issue, to inform ways of addressing any harmful impacts of the practice, whilst ensuring that community perceptions and views are respected in the process.

Any consideration of the practice needs to also be placed within a context of some important external factors that have a bearing on the way the issue is framed and may be addressed. These include the context of heightened religious tensions in Sri Lanka, particularly following the devastating terrorist attacks of April 21st, 2019. In the aftermath of this, there was a sharp increase of incidents reported from across Sri Lanka of harassment, discrimination, mob violence and threats to people who identify or perceived to identify as Muslim and a heightened sense of fear experienced particularly by Muslim women due to legal restrictions and extralegal actions on types of clothing that included face and head covers – common clothing among Muslim women. This context possibly shaped the conversations that this report is based on and will need to inform the ways the practice of FGC is framed and addressed and in consideration of potential points of entry and intervention. The issue of FGC is certainly one that has a bearing on the rights of children, since the procedure is performed on infants and young girls. Equally, a rights-based approach that considers women’s bodily integrity and their rights to sexual health is considered paramount in the ways impacts on girls and women are understood, explained and addressed. As this report shows, the spaces available to women to articulate and explore this issue is limited, even in the medical sphere, although that provides one trusted entry point for women. When the issue is not viewed through the framework of women’s sexual health and rights and rights to her bodily integrity, it also has a bearing on the type of support and services that are both asked for by women and recommended by other stakeholders.

This brief exploratory consultation had three main objectives:

- 1) To understand the practice of female genital cutting from the perspective of women who have experienced the practice.
- 2) To understand how women who have experienced the practice interpret the practice in relation to their health, sexual pleasure, bodily integrity and their relationship to their parents, family, community and faith.
- 3) To engage medical practitioners and community practitioners involved in sexual and reproductive health and rights to engage with the findings from (1) and (2) to recommend services and ways forward.

¹The term female genital cutting is used in this report for several reasons: the term cutting appears to reflect more accurately the procedure and practice that takes place in Sri Lanka and the ways women spoke of the practice, relative to the term mutilation. It is also seen as a possibly useful way to engage the community in dialogue on the topic whilst minimizing the risk of alienation, particularly given Sri Lanka's wider socio-political context in relation to attitudes towards the Muslim community. There is a more extensive discussion of the implications of terminology later in the report.

In order to understand what was known and observed of the practice among the medical community and to better inform any conversations with women, the process to generate this report began with a series of 10 interviews with medical professionals – obstetrician-gynecologists, reproductive health specialists, a psychologist and a medical anthropologist. These preliminary conversations presented some important reflections for the next phase of the process, which included the fact that medical professionals were not aware of the practice until recently, and in the belief that it does not take place, had not looked for signs of it and it did not form part of routine examinations that are usually centered on reproductive concerns. Further that it may be difficult to observe, most doctors had not received formal training on the practice in Sri Lanka. Given this insight, this report centres the experiences of women in terms of what they know and share of the practice, their reasons and ideas for support and services. The consultation process involved detailed conversations with 26 women between the ages of 21 and 70 years, in Colombo, Puttalam and Panadura, from multiple groupings / identities / sects within the Muslim community in Sri Lanka, carried out from March to November 2019. The findings from these consultations with women then informed a series of engagements with stakeholder groups, including medical practitioners and activists engaged in the area of and sexual and reproductive health and rights of women and girls.

This report details the practice of female genital cutting as described by these women, with the experiences broadly corresponding to Type 1 (partial or total removal of the clitoris and/or clitoral hood/prepuce (clitoridectomy) and Type 4 (all other medically unnecessary procedures like nicking, pricking, piercing and cauterisation of the female genitalia) classifications of the practice by the World Health Organisation. It provides an insight into the nature of the practice, the wide diversity of reasons given for the practice, and describes what women consider physical and psychosocial impacts and their views on support and services.

Concluding observations of this consultation note the following: a) Female genital cutting is not practiced by all Muslim communities in Sri Lanka and that there is diversity of experiences and significant variation in the narratives and justifications that accompany the practice. b) The conversation on female genital cutting is evolving and it was clear that women needed spaces, conversation starters, information and solidarity to navigate the complexities that surfaced. Some of these complexities included the notions of FGC as an identity marker and the difficulties of expressing identity related practices in a backdrop of religious intolerance; difficulties in talking about sexual pleasure, bodily integrity and autonomy; difficulties in challenging patriarchal, religious and political institutions and individuals holding power over religious knowledge and policing speech and actions; the particularities of family dynamics and difficulties in taking a position contrary to the wishes of parents and in-laws. c) There is no enabling environment for conversations of bodily integrity, sexual rights and pleasure for women, and those working in this area may have to consider what implications this has on identifying and addressing this issue. d) There is no formal medical training on the practice in Sri Lanka. e) Medical professionals, whilst being among the first to respond to this issue in Sri Lanka, have also expressed a reluctance to speak or engage publicly on the practice for the reason that such measures may be misconstrued as measures motivated by religious intolerance targeting a minority community.

The recommendations of this report include the following:

1. **Develop a non-judgmental and non-discriminatory approach** for working on FGC in Sri Lanka. This refers also to development of language capable of sensitively talking about FGC with women and also sensitively raising the issue in public when necessary.
2. **Develop material for women and relevant communities** to engage in discussions on FGC. This responds to some women expressing an interest in obtaining more information. This includes medical information, information on religious positioning, and to address myths about the practice.
3. **Address the specific concerns and needs raised by women of the Dawoodi Bohra community** with greater urgency, as they experience the practice of FGC differently and relatively more severely than other Muslim communities in Sri Lanka.
4. **Create safe spaces and avenues for women** and relevant communities to engage in discussion on FGC.
5. **Build knowledge, evidence-based guidelines and training tools for medical professionals.** Guidelines must include information on how to talk to patients about FGC sensitively, for obstetric and gynecological management, for mid-wives and public health nurses to identify and address questions women and men have about FGC.
6. **Design ways and spaces for more systematic observation** of the physical and emotional impacts of the practice to deepen learning and refine support.

ACKNOWLEDGEMENTS

This report is dedicated to the women who participated in the consultations that this report is based on. Their willingness and interest to engage in conversation, to open up their living rooms to the consultants and reflect openly about this subject was admirable and heartening.

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INTRODUCTION

The Family Planning Association of Sri Lanka (FPA) commissioned a brief study to understand the physical and psychosocial impacts of Female Genital Cutting as reported by women in Sri Lanka. Over the past four years, the practice of FGC has received some limited public attention in the country, as a few women raised in public details of their personal experiences and sought a response from the State to stop the practice.

This consultation report is a response to the testimonies of women that highlighted the physical and emotional impacts of FGC. It was felt important to better understand the lived experience to commence thinking about, framing and responding to the sexual and reproductive health and rights aspects of the practice. This report attempts to broaden the understanding of women's experiences of genital cutting in Sri Lanka and the political, community, family and individual motivations for the practice.

The main challenge was the context of heightened religious tension during the timeframe in which these consultations were taking place. The devastating terrorist attacks of 21st April 2019 were accompanied by public allegations of involvement of the international terror group, the Islamic State (IS). Subsequently, there was a sharp increase of incidents reported from across Sri Lanka of harassment, discrimination, mob violence and threats to personal security of persons who were identified as or perceived to be Muslim. The heightened sense of fear was experienced particularly by Muslim women, particularly because of temporary legal bans on face-covering and extralegal actions taken towards those who practiced the dress code of abaya (long cloak), or niqab (face cover together with headscarf) or indeed other forms of head cover. The fact that some prominent instances of victimisation were based on allegations of Muslims being engaged in 'forced sterilisation' of other ethnic groups, and allegations of growth of Muslim population were attributed to adoption of increased reproduction and family planning strategies by Muslims, meant that the entire area of reproductive health and rights became easily linked to the victimisation experienced by the community. In this context, conducting consultations with Muslim women required a special sensitiveness to the socio-political context, with implications for not only the methods for engagement with women, but also the interpretation of findings and framing of recommendations.

Compiling this report was undertaken despite the overbearing context on the principle that women's concerns particularly if they speak of violence cannot be delayed, de-prioritised or sidestepped. It is perhaps a most difficult time to raise the voice of Muslim women and yet there is no alternative but to account for the context and hear their truth. It cannot be overstated that this piece of work is about strengthening the voices of women. Any attempts to use the content of this report to belittle, disparage, victimise or attack any individual or community would constitute a gross misuse.

This report hopes to contribute to the development of a more nuanced understanding of the context and nature of female genital cutting in Sri Lanka. The recommendations seek to guide future work by professionals, researchers, practitioners and policy makers on this sensitive subject.

1. UNDERSTANDING CONTEXT: A REVIEW OF LITERATURE

1.1 Definitions and terminology – what’s in a name?

The practice of what is often called Female Genital Mutilation (FGM), is also known by a variety of other names in global, regional and local contexts. In English, some other terms include ‘female genital cutting,’ ‘female genital alteration,’ ‘female genital surgery’ and ‘female circumcision.’ The term ‘Khatna’ is also used in Sri Lanka and this study has also surfaced several other terms in Tamil that will be discussed later in this report. The World Health Organisation (WHO), provides an often cited clinical definition and classification for FGM as follows: ‘Female genital mutilation (FGM) comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for non-medical reasons’ (WHO, 2007).

The WHO Guidelines classify four types of FGM:

- 1) **Type 1** is the partial or total removal of the clitoris and/or clitoral hood/prepuce (Clitoridectomy).
- 2) **Type 2** or Excision is the partial or total removal of the clitoris and labia minora, with or without the labia majora. ,
- 3) **Type 3** or Infibulation is the removal of the labia minora, labia majora and sewing of the vaginal opening with or without removal of the clitoris.
- 4) **Type 4** includes all other medically unnecessary procedures like nicking, pricking, piercing and cauterisation of the female genitalia.

Figure 1 and 2 below provide a visual guide to Type 1 classifications of FGM as per WHO classifications.²

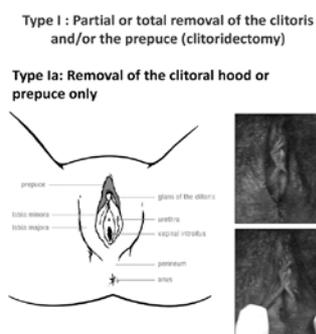


Figure 1: Type 1a

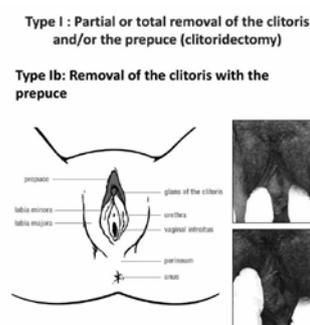


Figure 2: Type 1b

The use of the term mutilation emphasises the aspects of physical pain and ‘stress what some construe as the intentional infliction of harm’ (Lewis, 1995) and brings the attention to the physical damage and consequences of well-being to women and girls. However, there has been disagreement about the use of the term FGM with objections raised in some literature about the ‘value-laden and judgmental’ nature of the term as well as questioning its suitability in the case of relatively ‘milder’ procedures. Some African feminists have explored the tensions in feminist discourse about how best to approach this issue from a rights based as well as a cross-cultural lens,

² Visual guide on Type 1 and Type 4 based on ‘Female Genital Mutilation: A Visual Reference & Learning Tool for Healthcare Professionals,’ as cited in Anantnarayan, Diler and Menon, 2018.

given that activists in cultures where it does not traditionally take place have also raised concerns over the practice and its serious health consequences (Lewis, 1995). Lewis argues that one of the objections to the term mutilation is, 'because it implies a deliberate attempt by practitioners to hurt or disfigure members of their own families and communities,' (Lewis, 1995), which is often not the intention as parents and community often carry out the practice in the belief that it would help girls become fully accepted members of their communities. In a study in Indonesia, where Type 1 and 4 FGC of the WHO classification are among the common types practiced, experiences have shown that in some instances, girls and women who have undergone FGC can feel victimised, stigmatised and offended by the word 'mutilation' and its derogatory connotations (Patel and Roy, 2016).

The term 'female genital cutting' has been preferred by some because it is seen as more effective in engaging groups in dialogue around the practice instead of alienating and offending (Gillespie, 2013). The term FGM is also seen sometimes as conflating all procedures that alter female genitalia, while not accounting for differences in extent of risk posed by the different methods (Earp, 2015). While some arguments have been made for use of the term 'female circumcision', this has also been countered by arguments that this could be commonly perceived as articulating a religious obligation (Al-Hibri, Ghazal and Alassaf, 2018), particularly as the religious basis for this practice has been challenged. Using the term circumcision also draws immediate parallels to male circumcision, which under-plays the problematic patriarchal social norms that keep this practice in place for women, distinguishing it from the reasoning given for male circumcision.

For this report, the term female genital cutting (FGC) has been adopted (except where it has been referred to by another name either in the literature cited or by those quoted in this report), while adhering to the clinical typology as described by the WHO. While the consultants take the position that all types of female genital cutting without voluntary informed consent is a violation of a child or woman's right to her bodily integrity, this report also recognises that the forms of cutting described cannot at this point accurately be described as mutilation, with all the connotations of that word. Further, the use of the word 'cutting' places emphasis on the impact to the physical health and well-being of survivors reflects the way women also spoke of the practice, thus privileging the experiences and perspectives of women and girls.

1.2 Background and context of the practice in Sri Lanka

The practice of female genital cutting (FGC), also known by a variety of other names in local contexts such as 'Khatna' or 'Sunnat' among others, is widespread and commonplace among some sections of the Muslim community in Sri Lanka. The practice of FGC has been known among many local Muslim communities for generations. In 2008, the All Ceylon Jamiyathul Ulema (ACJU) of Sri Lanka issued a fatwa on 'female circumcision' in response to a query from a member of the public, saying it is obligatory and recommended, citing religious teachings as well as the view that circumcision is important to maintain cleanliness of the genitals and 'for enjoyment in family life' (ACJU, 2008).

There is little formally published information on the practice of FGC among Muslim groups in Sri Lanka to date and no published research studies to date. There has been reference to 'female

circumcision' in Sri Lanka in a UN Economic and Social Commission for Asia and the Pacific Study in 2012 that looked at harmful traditional practices in three countries of South Asia (Goonesekere, 2012). In this report the practice has been described as follows:

“It is apparent that a form of genital incision is practiced on infant girls four to five weeks after birth on the rationale of circumcision. The practice involves making a tiny incision on some part of the female genital area and is performed by a traditional midwife or female elder to draw blood. Though the women confirmed that their daughters were subject to this ritual, none of those interviewed had participated in the ritual itself nor witnessed the procedure... . There is also anecdotal evidence of a similar practice in a sect known as the Borah Muslim community in Sri Lanka. Female circumcision is said to be practiced in this community on teenage girls, though there was a reluctance to describe the practice. It is said that on marriage, a medical certificate from a doctor is required by in-laws to indicate that a girl has been “circumcised”. Families that can afford private medical services and do not follow the practice are said to obtain such a certificate without adhering to the practice (Goonesekere, S. 2012, p48).

The report goes on to note that there was no evidence of mutilation of the vagina and that no source could be obtained to elaborate on the ritual. Goonesekera makes the argument for viewing this practice as a form of violence against women that must be prohibited by law and be seen as criminal conduct as it is ‘a practice that has no religious or public legitimacy’ and is an infringement on the rights of women and children.

It is in the last few years – from 2016 onwards - that the practice of female genital cutting has surfaced in public dialogue in Sri Lanka, including in the media. A few women, primarily from the Dawoodi Bohra Muslim community, came forward to speak about their experiences and ask the state for a response to stop this practice, via confidential submissions made in multiple forums including the Human Rights Commission of Sri Lanka, the National Child Protection Authority of Sri Lanka, the Sectoral Oversight Committee on Women and Gender of the Sri Lanka Parliament and the Women’s Caucus. These confidential submissions were supported by testimonials from 15 women, who described their varied experiences and in the case of Bohra women – their memories of the practice as the ritual often takes place among this community when girls are around 7 years old. These testimonials provided accounts of some Bohra women saying they remember the trauma of being taken for this procedure as girls and at least two women who have been medically examined as adults said there were instances of permanent harm to their genitalia.

The efforts by these women in Sri Lanka together with supportive public health officials resulted in a circular being issued by the Ministry of Health that asked doctors in the public health system to not engage in the practice (Ministry of Health, 2018). The practice has not been formally studied or acknowledged by the medical profession in Sri Lanka until the issuing of the circular in 2018, having historically being considered as a practice that does not take place in the country at all or in any significant way that required intervention. In fact, there have been several official reports from Sri Lanka that have concluded that the practice is non-existent in the country (Wickramage, Senanayake, Mapitigama, Karunasinghe and Teagal, 2018). The WHO reported a ‘zero-score’ for female genital mutilation in Sri Lanka in a report on Gender-Based Violence (GBV) in 2008; UNICEF’s national report card on essential indicators relevant to maternal and child health in Sri Lanka since

2005 states that ‘female genital mutilation’ has remained nil. A joint Ministry of Health (MOH) and WHO report on Violence and Health in Sri Lanka in 2008 stated categorically that female genital mutilations “do not exist in Sri Lanka.” The Department of Census and Statistics (DCS) – the state organisation recording the status of Sustainable Development Goals (SDG) in Sri Lanka has not included indicator 5.3.2 on “Proportion of girls and women aged 15-49 years who have undergone female genital mutilation, by age” (Wickramage, et al, 2018).

There is some level of medicalisation from within the Bohra community as far as is known, with traditional practitioners performing the ritual among other sections of the non-Bohra Muslim community. Some Muslim groups³ have publicly called for medicalisation of the practice and the withdrawing of the Government circular prohibiting medical professionals from carrying out FGC, on the grounds that the practice is not mutilation but circumcision and the two are distinct; that female circumcision is an ‘obligatory religious duty’ and that the procedure as practiced in Sri Lanka, is beneficial to women. Addressing reports of medical complications from traditional practitioners, they argue that this would be a reason to medicalise the procedure so it can be done safely, instead of prohibiting it (Daily Mirror, 2018). An article published by a Sri Lankan woman who has undergone what she describes as female genital cutting , directly challenges calls to medicalise the practice, saying that she was cut by a qualified doctor in a sterile environment when she was 7 years old and has scarring that has resulted in pain during sexual intercourse as an adult (Anonymous, 2018).

Proponents of female genital mutilation in Sri Lanka have claimed benefits of reduction in the spread of disease, cleanliness and enhanced sexual pleasure for women in adulthood and equating the practice to a legal cosmetic procedure performed on adult women. The argument has also been made for a distinction in terminology between genital circumcision and genital mutilation, and in defense of the religious beliefs that underpin it and what is considered a cultural practice (Hussein, 2018). Claims to medical benefits and spread of disease by women who have not been ‘circumcised’ have been challenged by Sri Lankan doctors with considerable medical and surgical experience, who argue that differences in genital anatomies means that ‘what applies to one need not necessarily apply to the other, and also express caution that the female clitoris and hood is a much smaller organ relative to the male penis, and hidden in labial folds, particularly in children (Sheriffdeen and Haniffa, 2018). This challenges the notion of FGC being a simple procedure. Some Sri Lankan rights activists have also raised objections that advocating for a possibly harmful procedure on girl children for unproven potential sexual benefits as an adult is a disturbing sexualisation of the body of the girl child. They further stated that whilst adult women can make informed choices about procedures intended to enhance their sexual pleasure, such procedures must not be forced upon children as they cannot offer informed consent (Bakamoono.lk, 2018).

One of the earliest available media reports from Sri Lanka on this issue is from 1996 where a teacher says the practice was done on all her five daughters. The article also makes reference to FGC being performed on a 20 year old adult women on conversion to Islam (Senanayake, 1996). Towards the end of 2017 and into 2018, the issue was discussed widely in mainstream newspapers in addition to

³ Members of the All Ceylon Jamiyathul Ulama, All Ceylon YMMA Conference, Centre for Islamic Studies and United Religions Initiative.

social media pages.⁴ Several of the articles provided space for voices of women affected by the practice, as well as views supporting the practice, opinions of medical doctors and efforts by state and other private actors in relation to this issue.

From what is known of the practice from the submission by women survivors referenced earlier, related news and media reports, as well as this study, FGC is carried out almost entirely in the Muslim community, but not among all Muslim sects or groups. All descriptions of the practice so far have fallen within the definitions of Type 1 and Type 4 as classified by the WHO. It is performed on children at varying ages, the youngest being between 9 days and 40 days and the oldest recorded age being 7 years. There is *ad hoc* information about the practice on adult women who convert to Islam particularly for marriage. There is very little information available on what the extent of the cutting is, as the testimonies have varied, and there have been no formal clinical studies on this in Sri Lanka, to date.

1.3 Regional experiences of type 1 and type 4 FGC

Globally the WHO estimates that more than 200 million women and girls have been subject to FGM/C, with the practice most common in 30 countries in Western, Eastern and North-Eastern Africa and in some countries in the Middle East and Asia. Due to global migration, the issue of care for women and girls in host countries is also a growing consideration.

Most of the information available on Type 1 and Type 4 FGC reviewed in this report comes from East Asia and India and the review of literature attempts to understand the impacts of procedures that fall within these two types, given the similarities to the practice in Sri Lanka. A review of existing literature on female genital cutting and suggested ways forward by authors in the *Ceylon Medical Journal* (Wickramage et al, 2018) points to evidence of negative impacts of FGM on reproductivity morbidity and mental health: excisions of tissue resulting in scar tissue formation, keloid formation, *Bartholin's* cysts on vulva among other physical impacts, while mental health impacts include the trauma of the cutting itself; memory of it; pain and reduced pleasure during sexual intercourse; taking long or being unable to climax; relationship difficulties; and feelings of being violated because the act had been carried out on them as children without consent, impacts to self-esteem/notions of femininity and beauty, among others (Wickramage et al, 2018).

From a medical examination perspective, there have been reports that have considered the difficulties in clinical observations of FGC particularly of the Types 1 and 4 from genital inspections. The reasons for this could also be because the cut may heal completely, leaving a small scar that may be difficult to detect. This is particularly so if the observation is made years after, as genitalia also changes with normal growth and development, while there could also be naturally occurring congenital variations in the skin of the vulva and clitoris. Therefore, examinations may need to be done by those who have experience in identifying or understanding FGC (Creighton and Hodes, 2015). The literature does identify a gap in information on the range of how FGC presents in clinical settings, and related risks.

⁴ See References at the end of this report for a detailed list of media articles.

A detailed qualitative study in India published in January 2018 spoke to 83 women and 11 men from 13 locations across five states and some expatriates from three countries. The study documents their views on physical and sexual health impacts of FGC specifically among the Bohra community.⁵ It is one of the first studies to document the sexual impact of Type 1 and 4 FGC as experienced by Bohra women, which has been described as cutting of the clitoral hood and/or part or all of the clitoris and ‘nicking’ of the clitoral hood although there is no clear medical definition of what a ‘nick’ entails. According to this study, approximately 33% of women subjected to ‘*Khafd*’ (term used in India for FGC) in the study believe it has negatively impacted their sexual life. Some of the problems identified included a low sex drive, inability to feel sexual pleasure, difficulty trusting sexual partners, and over sensitivity in the clitoral area. Amongst the psychological consequences of FGC, many participants in the study reported feelings of fear, anxiety, shame, anger, depression, low self-esteem, and difficulty trusting people as some of the fallouts of their experience (Anantnarayan, Diler and Menon, 2018). The same study provided medical reports by doctors, which offers an interesting and useful parallel to some of the conversations with medical doctors from Sri Lanka in this study. One gynaecologist observed the FGC status in 20 of his patients from the Bohra community and made this observation,

“The clitoris is very small and there is a very small region between the skin and the clitoris. Only a specialist with a lot of experience can maybe separate the two and be able to cut only the skin/hood/ prepuce. So, in most cases the clitoris does get affected” (Dr. Sujaat Vali as cited in The Clitoral Hood, 2018, p.38).

Indonesia seems to have a range of practice of FGC described as “touching, scraping, piercing and cutting the genitals with noticeable bleeding – especially where there was piercing and cutting involved,” with Type 1 and Type 4 being the more typical practice across the country, although other types have also been recorded in some areas (Patel and Roy, 2016). There has been an attempt at medicalisation / medical regulation of the practice in Indonesia under specific guidelines following an authorisation from the Ministry of Health in 2010 and supporting legislation that said FGC must only be performed under medical supervision and in accordance with specific guidelines. This legislation was overturned in 2014. The attempt at medicalisation the study notes, has contributed to the idea of FGC as circumcision, and is included in ‘birth packages’ offered by medical clinics.

It is important to note that the effort to mobilise against this issue in Sri Lanka was also taking place in a wider regional and global context of mobilisation against the practice, and some of the first legal cases being filed to challenge the practice and introduce criminal sanction against it. Two notable cases include: The High Court of Australia in October 2019 which held that female genital mutilation in all its forms is illegal and it set aside the acquittal of three people from the Dawoodi Bohra community in Australia. The ruling also stated that cutting of the clitoral hood is included in definitions of female genital mutilation. This ruling is the conclusion of Australia’s first case on FGM which began in 2015 when charges were brought against a mother of two girls, a former nurse who performed the procedure and a leader of the Dawoodi Bohra community. They were found guilty of breaching a ban on FGM in New South Wales, but their conviction was initially set aside by the

⁵ In India, FGC is reportedly practiced among a few Muslim sects including Dawoodi, Suleimani, and Alvi Bohras and a few Sunni sub-sects in Kerala – The Clitoral Hood.

Court of Appeal on the grounds that the terms ‘mutilates’ and ‘clitoris’ was misrepresented. The acquittals were thereafter set aside by the recent High Court verdict in 2019. The judgment is valued by activists against FGM elsewhere as well, particularly because of the ruling on what can constitute mutilation (Mumbai Mirror, 2017). In the US however, one of the first cases to be brought under a federal anti-FGM law was against a doctor in 2017, alleging that she had performed FGM acts of Type 2 which involved partial removal of the clitoris. Six of the eight charges were dismissed on the grounds that the law was unconstitutional as the Congress did not have a right to criminalise the practice, and that the power to outlaw FGM was a matter for individual states (Equality Now, 2019).

The relevance of the two above mentioned court cases in Australia and the United States of America is that it was female genital mutilation / cutting as practiced by the Dawoodi Bohra community that was under scrutiny, and the practices of this community have regional relevance, and also particularly for Sri Lanka. There is an ongoing court case in the South Asian region on FGM in India. The public interest case filed in the Supreme Court of India was referred to a 5 judge bench in September 2018 to consider the constitutionality of the practice as an expression of religious freedom (The Times of India, 2018).

There have also been strong survivor-led movements in India and elsewhere, calling for an end to the practice. Executive Director of Global Muslim women’s rights network Musawah (headquartered in Malaysia) Zainah Anwar has argued that religious freedom arguments cannot be used in the defense of FGC since it is not a religious practice but a cultural one. She has been quoted as saying, “It has been proven to be harmful to women and girls”, she added, “and is therefore an un-Islamic practice” that is “deeply entrenched in the patriarchal need to control women's bodies and sexualities” (Archer and Provost, 2019).

1.4 International and local legislation, policies and positions on FGC/FGM

In terms of universally accepted human rights principles, the practice of FGM in any form violates principles of equality and non-discrimination based on the basis of sex and gender, the right to freedom from torture or cruel, inhuman or degrading treatment or punishment, and the rights of a child. Several UN Human Rights treaty bodies have called for an end to the practice including the UN Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the UN Convention on the Rights of the Child (CRC), while a UN General Assembly Resolution in 2012 describes the practice as “an irreparable, irreversible abuse that impacts negatively on the human rights of women and girls” (UN General Assembly, 2012).

Further, the right to the highest attainable standard of health also includes the right to sexual health. As per the WHO, “sexual health is widely understood as a state of physical, emotional, mental and social well-being in relation to sexuality and it encompasses not only certain aspects of reproductive health – such as being able to control one’s fertility through access to contraception and abortion, and being free from sexually transmitted infections (STIs), sexual dysfunction and sequelae related to sexual violence or FGM – but also the possibility of having pleasurable, safe sexual experiences, free of coercion, discrimination and violence” (WHO, 2016). The rights of the girl child in relation to freedom from specific forms of violence including FGM and the rights of

women to enjoy sexual health and rights are also critical areas enshrined in the Beijing Platform for Action (1995). Recognition of the sexual and reproductive rights of women as being a key element of human rights, particularly concepts of women's bodily integrity and sexual autonomy are critical considerations in the women's health movement globally (Abeysekera, 1997).

UNFPA estimates at least 59 countries have passed laws against FGM, including the United Kingdom, Canada, Denmark, Spain, Norway, Sweden and New Zealand. Of the 29 countries in Africa where female genital mutilation is traditionally practiced, 26 have laws prohibiting it (Equality Now, 2019). In Sri Lanka, there is no specific law banning or criminalising FGM/FGC. It has been opined that FGC is liable to be prosecuted under provisions of the domestic Penal Code, such as Section 308 (A)(1) which states that any persons who causes willful assault, ill-treatment, neglect or injury to the health of a person under the age of eighteen "commits the offence of cruelty to children." Further, Section 311(H) deals with 'grievous hurt' states that any injury which endangers life or (I) which requires the sufferer to be in severe bodily pain would be subject to imprisonment and a fine.

1.5 Religious positions on FGC

It was outside the scope of this consultation to delve into an exploration of the religious and belief based perspectives on this issue. However, the report takes note that religious positions have been given as a basis for FGC in contexts where it is practiced, including in Sri Lanka – both formally as the ACJU fatwa that was discussed earlier and in testimonials by women who have undergone the practice as well as in informal conversations. This basis has also been challenged by the lack of reference in religious texts such as the Quran, historical evidence that the practice predates Islam, as well as by alternative feminist interpretations of religion based arguments in defense of the practice. 'Karamah - Muslim Women Lawyers for Human Rights' in a paper on 'Debunking the Myth that Islam Requires Female Circumcision' challenge the validity and authenticity of several religious teachings / sayings used to support the practice of FGC, while also outlining Islamic traditions of support for women's sexual pleasure (Al-Hibri, Ghazal and Alassaf, 2018). There have also been varied religious positions taken by different Islamic scholars and religious bodies both speaking out for⁶ and against⁷ the practice, across the world. Certainly in Sri Lanka too, there are different opinions as to the religious basis and the 'obligatory' nature of FGC among different Muslim sects and groupings, as this report will reflect. The varied positions, at the very minimum, speaks to the widely contested nature of the practice as one that is obligated by Islam on every Muslim woman.

6 Nahdlatul Ulama (NU), one of Indonesia's largest Muslim organisations had endorsed the supposedly sunnah practice by advising their followers 'not to cut too much'. They supported the Government's legalization of FGC and regulations of the practice as reducing harm to girls (Patel and Roy, 2016).

7 Religious clerics from the Bohra community have spoken out against the practice (Bhat, 2016); A statement by the Organisation of Islamic Cooperation (having a membership of 53 Muslim Majority Countries) at the World Interfaith Harmony Week in 2013 denounced FGM; In Indonesia, Muslim group Muhammadiyah – stated that there were conflicting internal arguments on whether FGC should be allowed and, as a result, no fixed ruling has been issued by the group" (Patel and Roy, 2016).

1.6 Services and Support for people who have experienced FGC

In many contexts, a health services approach has been taken to address the risks and impacts of FGC, and has involved medical personnel addressing the issue from a fact-based perspective of impacts and response. In 2016, some of the first evidence-based guidelines on management of health complications of FGM were developed by the World Health Organization (WHO) in collaboration with the ‘UNFPA-UNICEF joint program on FGM’. These guidelines were based on the best available evidence on health interventions for women living with different forms of FGC. The guidelines are not tailored necessarily to some of the relatively less severe types of FGC as is prevalent in some countries of Asia, including Sri Lanka (WHO, 2016).⁸ Some of the overarching best practice guidelines that could apply include information, education and communication on FGM and women’s health to be provided to girls and women living with any type of FGC; responsibility of healthcare workers to convey accurate and clear information on the issue in ways that can be easily understood, and this information on types of FGM and any immediate and long-term health risks to be available to them in turn. The information needs to be evidence-informed and scientifically accurate, non-prejudicial, non-judgmental, sensitive and respectful. Studies in India on FGC among Bohra women identified a lack of information and education needed on sexuality and sexual health amongst both young and older women (Anantnarayan, Diler and Menon, 2018). The same study also suggested a targeted, grassroots level outreach program to reach younger women between 19-30 years in small towns and medium cities.

While the public health response is an important entry point on the issue, there are also limitations of this approach that must be considered in any holistic consideration of how to tackle FGC. A ‘health-risk approach’ – where respected healthcare professionals provide factual messaging on the practice and its risks – has in some countries led to calls for and medicalisation of the practice, where healthcare providers perform the FGC procedure(s). There is the view that medicalisation could prevent any harm/injury or be safer because it would be under clinical conditions and by a trained medical professional. The WHO however has warned against medicalisation of all forms of FGM on the basis that it is a harmful practice, it perpetuates the practice further and risks of the procedure outweigh any potential benefit. Where prevalence of other forms of FGC is also high, a ‘health-risk approach’ has led to increased support from governments and organisations for less severe forms of cutting such as pricking the clitoris, under hygienic conditions. Therefore, there was a shift in the practice but not necessarily abandonment of the practice (WHO, 2016). In India activists against the practice have called for a ‘zero-tolerance’ policy on FGM/C from the Indian Medical Association on the basis that it violates medical ethics of ‘Do-No-Harm’ if doctors were to engage in the practice (Anantnarayan, Diler and Menon, 2018). This is a sentiment echoed by some doctors in Sri Lanka as well, adding that as medical professionals there is an imperative to report and take action to inhibit the practice (Wickramage et al, 2018).

The discussion above underscores the fact that, if eradication is the goal, while providing information about the associated health risks of the practice is essential, it needs to be supported by community-based approaches that address the strong cultural beliefs around it that keep the

⁸ These guidelines have the stated aim of also providing standards that may serve as the basis for developing local and national guidelines and health-care provider training programmes.

practice in place. Several women who were interviewed in the Indian study cited above who shared that there were challenges in their sexual lives because of '*Khafd*' (FGC) 'expressed an urgent need for a closed safe group for survivors to share experiences and build a support network' (Anantnarayan, Diler and Menon, 2018). There have been calls for an 'evidence-informed, multi-sectoral and community participatory action framework' in culturally sensitive ways to address the issue in Sri Lanka (Wickramage et al, 2018). The call for collective action and approaches was seen as important in creating an inhibiting environment for the practice.

2. METHODOLOGY

2.1 Objectives

The purpose for which this report was commissioned was to inform and guide on approaches and possible services required by women who have experienced any form of female genital cutting in Sri Lanka.

The specific objectives for this exploratory consultation process were as follows:

- 1) To understand the practice of female genital cutting from the perspective of women who have experienced the practice.
- 2) To understand how women who have experienced the practice interpret the practice in relation to their health, sexual pleasure, bodily integrity and their relationship to their parents, family, community and faith.
- 3) To engage medical practitioners and community practitioners involved in sexual and reproductive health to engage with the findings from (1) and (2) to recommend services and ways forward.

Given the lack of information available on FGC in Sri Lanka, this exploratory study began with an initial scoping exercise that consisted of a series of preliminary interviews with medical doctors, to understand what was known of the practice in the healthcare sector, what doctors had witnessed of the practice and the possible areas of intervention from a healthcare perspective. These interviews were extremely helpful in helping the consultants to better appreciate the context and frame the scope and expectations and of the consultations that would follow. These interviews influenced the methodology adopted, which centered on conversations with women who had undergone the practice of FGC. The following sections discuss some of these early findings and the subsequent approach adopted.

2.2 Preliminary interviews

The preliminary interviews enabled the consultants to understand the landscape of medical and other services in relation to women's sexual and reproductive health and rights concerns. Ten interviews were conducted with gynecologists, reproductive health specialists and a psychologist between June and December 2018.

Those interviewed in the preliminary interviews included Dr. Nethanjali Mapitigama, Consultant Community Physician, National Programme Manager Gender & Women's Health of the Family Health Bureau; Dr. Janaki Vidhanapathirana, President of the Council of the College of Community Physicians of Sri Lanka (December 2018); Dr. Himani Molligoda, Senior Lecturer in Clinical Sciences, Postgraduate Institute of Medicine, University of Colombo; Ms. Roshan Dhammapala, Psychologist; Dr. Zaneefa Careem Drahaman, General Practitioner; Dr. Sumithra Tissera, Reproductive Health and Family Planning, Vindana Reproductive Health Centre; Dr. Nusrath Nasoordeen, Deputy Medical Director of the FPA, and three other medical professionals.

The main findings and insights from the scoping were:

- a. Almost all medical professionals interviewed said they had not been aware of the practice in Sri Lanka until recently, with only one saying she had been aware of the practice. There was consensus on the fact no training was provided to medical practitioners in the course of their professional education in Sri Lanka on identifying or addressing female genital cutting.

- b. As a consequence of the lack of training on the practice of female genital cutting, the interviewed medical professionals also said they had not looked for signs of the practice in the course of their work. It did not form part of their routine examinations to look for any physical signs of female genital cutting. Apart from one of the medical professionals, the others had never been approached by or had engaged with women in Sri Lanka regarding this practice.
- c. There was broad opinion amongst the medical professionals that given the available anecdotal descriptions of what takes place, it might be difficult to observe any physical signs unless there was a significant cut or removal of any part of the genitalia. It was suggested that the natural variation in the shape female genitalia and the fact that the practice most likely is of the Type 1 or Type 4 WHO classification of FGM may mean that identification of whether the practice has taken place or not could be very difficult.
- d. The medical professionals interviewed indicated that in their experience of providing services in Sri Lanka (most had over 20 years of experience) that women primarily approach them about reproductive concerns. It was very rarely that women's sexual pleasure or sexual health and rights was part of the conversation. Therefore, it was said to be unlikely that the impact on women's sexual pleasure resulting from any damage to the clitoris from female genital cutting would be understood, spoken of or framed in that way by women engaging with medical services, or indeed this consultation process.
- e. The psychologist interviewed highlighted the need for adequate time being allocated for women to speak about an issue of this nature. Given the difficulties expected, it was suggested that it might be useful to consider having an introductory conversation allowing women to think about and decide on how to respond to the subject. It was also suggested that time might be necessary for women to reflect on what the experience may mean to them. It was said that due consideration may have to be given to the fact that the subject may for reasons of faith, religion, culture, politics, patriarchy be difficult for women to discuss and have an opinion on. It was also suggested that in the event women experience some distress as a result of talking about this, it would be a good practice to ensure that access to appropriate support for the participating women be built into the process in case it was required.
- f. While Sri Lanka's medical community has addressed harmful traditional practices before, one medical professional with considerable experience and influence in the public health arena said that female genital cutting could not be addressed in the same way as other traditional practices because it affected only one specific community and direct or overt intervention may inadvertently cause or be used to fuel ethnic or religious disharmony.

2.3 Change in expectations and methodology

The preliminary interviews challenged a key assumption made at the time the consultations were proposed, making it necessary to shift both the expectations of the study and the methodology adopted. This was the assumption that doctors would have observed physical signs of FGC in the course of their work or routine examinations, and these could contribute to an understanding of the range of physical impact. However, as most doctors explained, routine examinations of women were primarily in relation to reproduction and the nature of examination did not involve close examination of the clitoris, which is the main site affected by FGC. Neither did they have reason to look for physical signs, nor was it immediately clear what to look for in an examination of FGC. Therefore, the consultants ruled out provision for medical observations of physical impact. Instead, they focused only on women's experiences and their descriptions of any physical and psychosocial impacts if at all, as well as their expectations of support, to guide a further conversation with medical doctors and other stakeholders in the process.

2.4 Final methodology adopted

A decision was taken to focus the consultations on women who had undergone FGC or believed they had been subjected to it. The approaches outlined below were selected for this study because it allowed the consultants to obtain an in-depth understanding of the practice and its impacts from the women, particularly given that the topic is sensitive and potentially difficult to talk about.

Theoretical framework: The approach taken to analyse the findings was based on the Interpretative Phenomenological Analysis (IPA) methodology. The methodology of IPA involves a detailed analysis of personal accounts and narratives – in this case, exploring how people perceive and talk about the practice of FGC and their understanding, attitudes, experiences and expectations. This is followed by presenting and discussing the themes that emerge, paired with the researchers' own interpretation of the narratives. This methodological approach draws on disciplines of phenomenology, hermeneutics, and idiography.⁹

- The phenomenological component of this report is on how women perceive and talk about the practice of FGC. The focus is on the way things appear to individuals in experience.
- The hermeneutical component of the study is to comprehend the mind-set of a person and language which mediates one's experiences of the world, in order to translate his or her message (Freeman, 2008). In this report, this component is the process of analysis undertaken by the consultants. There is an active role for the researcher (consultant) and the resultant analysis is an interpretation of the subject's personal world.
- The third component that IPA relies on is idiography, meaning that the consultants focus on the particular (i.e. these set of accounts) rather than the universal (Smith, Harre, & VanLangenhove, 1995).

Selection of women for consultations: The women were approached purposively through the Family Planning Association's contacts in areas they work in, and the Consultants' own networks. The identification and recruitment of participants for consultation around this highly sensitive and personal topic was heavily dependent on access to communities based on existing relationships with women's organisations and networks that worked closely with Muslim women. A snowball sampling method was used by which some women would also suggest others to speak to and sometimes bring other women into the discussion. As far as possible the consultation sought to include women from diverse age groups and representing different sects and religious groupings from among Sri Lanka's Muslim communities. Another consideration was to include women from towns or areas with well-established and distinct Muslim communities, although selection of geographic areas was also limited by where it was possible gain access to women willing to speak on this issue. Except for three women, the consultants had no prior interaction with any of the women interviewed for the study. A total of 26 women over 18 years of age who had experienced female genital cutting were interviewed between March 2019 and October 2019. The inclusion criteria were the participant (i) is briefed on area of study and is willing and able to give informed consent for participation, (ii) is a female aged 18 and above, and (iii) has experienced or believes that she has experienced 'circumcision', 'Khatna', 'Sunnat' or any form of female genital cutting or has permitted to be done for her child.

⁹ This methodology in terms of theoretical underpinnings and process is detailed in the article "A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology" by Pietkiewicz, I. & Smith, J.A. (2012).

The method of consultations with women: Conversations with women were in a place and at a time of their choosing, which was often in their homes in the morning when the rest of their family was at work or school, and often over the course of an hour or at times longer. As far as possible the consultants spoke to women individually, except in some locations where women preferred to meet in groups. The discussions were in either Tamil or Sinhala depending on the language of comfort of the woman or women being interviewed. Sometimes the assistance of an interpreter was engaged. The two interpreters engaged were Muslim women with a strong track record and exceptional capacity to engage women on sensitive topics.

Initial conversations were held with women to explain what the consultation was about, what the scope of the conversations were, and provide an option to not participate in the conversations or to speak to the consultants at a later date. Although provision was available for women to access either a doctor for an examination or a counsellor should this emerge as a need in any of the conversations, this was not requested nor identified as a need during the course of the consultations. It was decided not to audio record any of the interviews as a confidence building measure. Women were informed and their consent obtained for notetaking. At least one of the consultants engaged in detailed notetaking at each consultation. Women were also informed that their details would be anonymised in the final report. Women participating were not provided any financial remuneration for participating in the interview.

The conversations were based on a semi-structured interview guide, although time was also built in at the end portion of the consultation for women to ask their own questions in turn. The questions focused on: demographic information: age; number of siblings; number and sex of children parents occupation; their own and spouse's occupation; location of birth/hometown; the sect or religious grouping they identify with; their knowledge of the practice in their family and community; terms used to describe the practice; personal experiences of FGC; description of any impacts – physical or emotional/ psychosocial; perceptions of prevalence and continuation of the practice; and their ideas on the need for any support or services in relation to this practice.

Stakeholder consultations: The knowledge and experiences shared by women fed into a series of consultations held in November 2019 to collectively reflect on what has been said, what women have suggested in terms of next steps for support. The approach to consulting with stakeholders allowed the researchers to centre women's experiences and their stated needs, and attempt to reach a consensus on recommendations for the same. The two stakeholder groups included a) medical doctors and healthcare personnel; b) SRHR and women's rights activists, NGOs and state institutions with a human rights and social justice mandate. While two other stakeholder consultations were planned – one with traditional practitioners and another with midwives and others involved in community level healthcare, these could not be conducted due to limitations of access.

Key Informant Interviews: In the course of these consultation it became necessary to speak to specific people to fill in gaps that were emerging in the method, or to better understand emerging themes. The Consultants obtained input from the following:

- 1) A psychologist and a medical anthropologist to review the tools and/or methodology of the study.
- 2) A lecturer and researcher at Colombo University who could provide insight on the different group and sects within the Muslim community.
- 3) A medical doctor who is conducting research on Gender-Based Violence in the Muslim community including the practice of FGC, in specific locations in the North-Western Province.

2.5 Limitations

In speaking to women about female genital cutting, there were concerns of about access, trust, and difficulties around talking about emotions, which could have methodological consequences in the form of concealment or omission. The Easter Sunday attacks in April 2019 and the subsequent backlash against the Muslim community, required added caution and sensitivity in speaking to women on this issue. It could have also resulted in a fear to speak out on an issue that could be used to victimise the community.

Difficulties in expressing complex sentiments or personal interests related to self, family, community and faith could also affect how much women are able to communicate. The fact that the practice is conducted in secrecy and is considered a taboo subject means that there was very limited language, terms and phrases that were used in describing both the conduct and sentiments relating to it. The lack of an open discourse about the practice means that there is often very limited individual internal appraisal of the consequences of the practices. It was expected that the sentiments relating to the practice to be underdeveloped meaning that interviewees may not have given much thought to how they feel about the practice or whether they thought the practice could be challenged.

As a result of the difficulty in speaking about such a sensitive and controversial issue, accessing large or representative samples of the relevant populations would have been extremely challenging, and was seen to be beyond the scope of the consultations. The strategy adopted nevertheless sought to ensure diversity as far as possible, based on religious sect, age and location.

2.6 Declaration of any conflict of interests of the consultant team

Declaration of interests: the consultants state that they have no personal, religious or political convictions that represent a conflict of interest in undertaking this consultation in a fair and open manner. They disclose past work, since 2016, of engagement with women who have raised concerns about the practice of female genital cutting in Sri Lanka. The consultants assisted these women to document and represent their personal experiences in the consultants' professional capacities as a researcher and a lawyer. The consultants also co-authored an article published by Al Jazeera highlighting the perspectives of the women they had spoken with (Ibrahim and Tegal, 2017). It was ensured that the majority of women included in this consultation process were those whom the consultants had not spoken with previously.

2.7 The consultant team

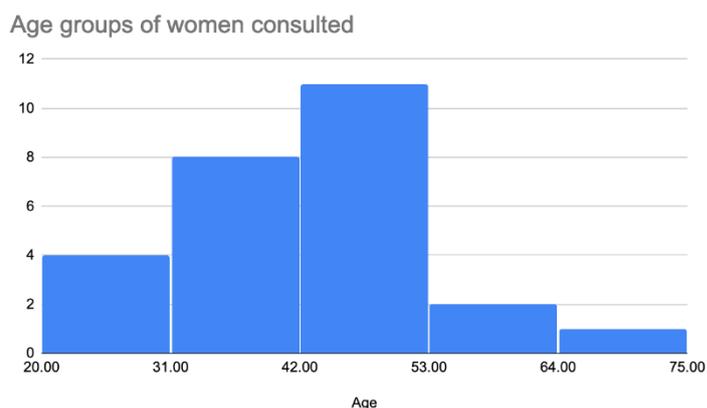
The team consisted of Zainab Ibrahim, a researcher and Ermiza Tegal, a lawyer. Both had experience of engagement with Muslim women advocating for institutional responses to concerns on practice of female genital cutting in Sri Lanka. Zainab Ibrahim had also documented testimonials of women who have experienced the practice. As such, they were familiar with the context, landscape and stakeholders on the issue of FGC in Sri Lanka. In terms of their educational and professional backgrounds, Zainab Ibrahim has a Master's Degree in Development Studies from the Tata Institute of Social Sciences, Mumbai and has over ten years of experience primarily addressing issues of women's rights including prevention of gender-based violence and has documented inter religious violence and related conflict in Sri Lanka. Ermiza Tegal has a Masters in Law, Governance and Development from the School of Oriental and African Studies, University of London, has been practicing law for over 12 years in the areas of fundamental rights, family law and domestic violence and has 19 years of experience in human rights advocacy work.

3. DESCRIPTION OF PARTICIPANTS

Description of the women consulted

The consultation process interviewed 26 women between the period March and October 2019.

Age: The women were aged between 21 and 70 years. The majority were aged between 31 and 53 years.



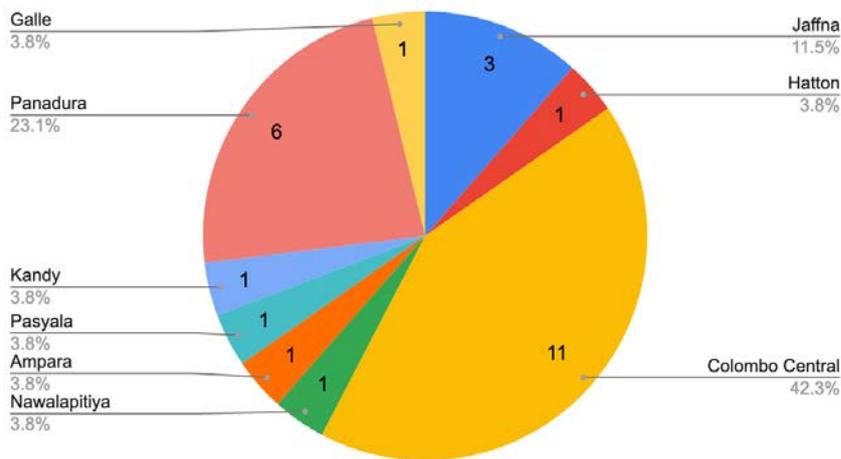
Geographic locations: The interviews of women took place in three main geographic locations: Colombo, Puttalam and Panadura.



However, the women also described their identities in terms of links to communities in other geographic locations, and when these were mapped it appeared that the social, cultural and religious identities of the women interviewed were associated with the areas of Ampara, Colombo, Galle, Hatton, Jaffna, Kandy, Nawalapitiya, Panadura and Pasyala.

Religious and ethnic identity:

Geographic community of women (as self identified)



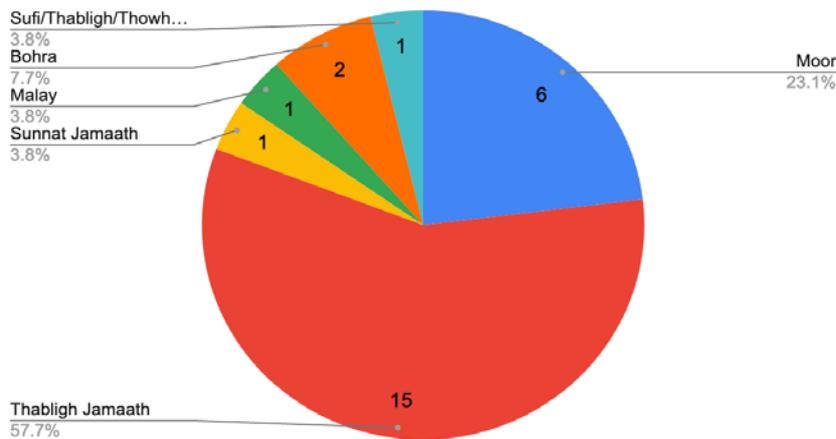
All women interviewed identified as Muslim. However, the women also linked their identities to specific religious groupings within the broader Muslim community. These groupings are known to have theological and political characteristics. Some identified as belonging to particular schools of jurisprudence (*Madhabs* or Sects) such as Sufi, Hanafi, followers of Imam Shafi'i. Some identified as Thabligh and Thowheed which are groupings that have identities linked to particular political histories. Some women identified as belonging to particular ethnic communities such as being Malay or Bohra, whilst the majority were Moors (although this was usually unstated).

Some Muslim women who were approached for this consultation said that (in their understanding) the practice of FGC was not seen as required by their culture or religion and as such could not speak to the impacts of the practice. These women identified with two specific groupings, the Memons and the Thowheed group. In contrast, one interviewee referred to the Jamaath-e Islam group as promoting the practice. Engaging the views of women from communities that are said to not practice female genital cutting were beyond the scope of this consultation, and as such are not represented in this report.

Therefore, for the purposes of understanding the practice of female genital cutting, it is important to acknowledge that the 'Muslim community' in Sri Lanka is not a homogenous identity group. Aside from ethnic differences, there are other important identities asserted based on theological and political ideology.¹⁰ Understanding the reasons underpinning the differences of opinion and practice of the different Muslim identity groups was outside the scope of these consultations. However, this report takes note that this indicates a variety and divergence of opinions within Muslim communities and would be necessary understanding in future work.

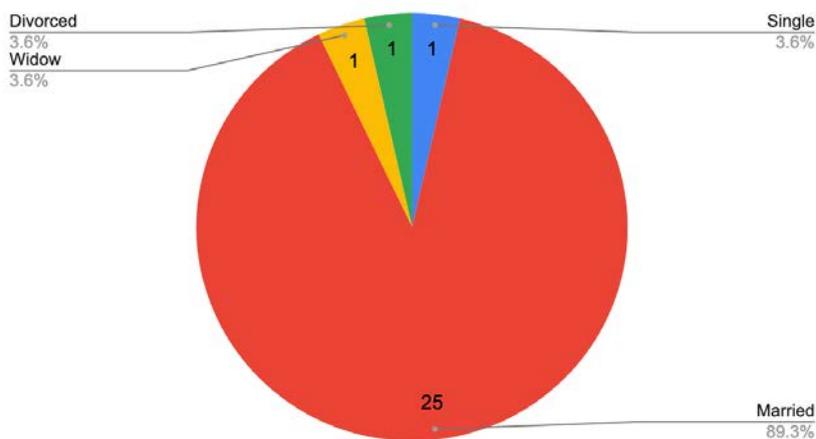
¹⁰ See as an example of the discussion of the different identity groupings of Muslims in Sri Lanka - "Fracturing Community: Intra Group Relations amongst Muslims of Sri Lanka" by Mohammed Faslan and Nadine Vanniasinkam, International Center of Ethnic Studies, November 2015.

Women's ethno-religious identity



Of the women consulted, 25 of the 26 women were married or had been married. However, this was not a criteria for selection and the consultations were not limited to participants who identified as married / once married.

Marital status of women consulted



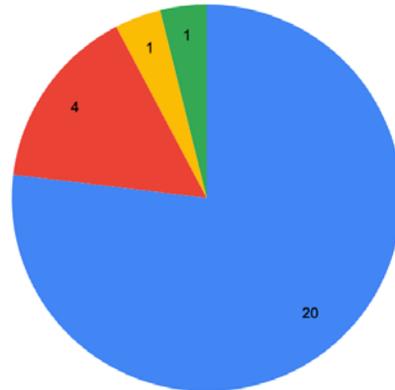
Of the 26 women, 23 were mothers and one was pregnant with her first child. The 23 mothers had amongst them 33 daughters and 30 sons.

Of the women interviewed, 23 women had a range of educational backgrounds ranging from completing 5th Grade, 7th Grade, and 9th Grade to Advanced levels. Of these 23 women, one said she had completed a Madrasa (Islamic school) education. One said she was a teacher and all the others identified as being homemakers. Two of the homemakers also identified as being engaged in home-based catering services and one earned an income from tailoring. Three women had completed higher education and professional training and were employed in a professional capacity.

Self-Identification as 'circumcised': Of the women interviewed, 20 women self-identified as having undergone the practice. Four women said that they believed that they had been 'circumcised' because everyone in their family had undergone it, while 1 said she herself had not undergone it but that her daughter had.

Women who self identified as 'circumcised'

● Circumcised ● Assumed to be circumcised ● Does not know whether circumcised (Also does not want to know) ● Not circumcised



4. FINDINGS AND ANALYSIS

This section contains the findings of the consultation process, followed by additional observations and impressions as noted by the interviewers, in keeping with methodology of this study. This is followed by an interpretation of the findings.¹¹ Please note that names of women interviewed have been changed to ensure anonymity.

The findings and analysis are clustered under the following themes:

- 1) Knowledge and attitudes towards the practice
 - a. Terminology in local languages
 - b. The secretive nature of female genital cutting
 - c. People who influence and reproduce the practice of FGC
 - d. Personal meaning and significance of FGC
- 2) Perceptions of prevalence and sustained nature of the practice
- 3) Description of the process of female genital cutting
- 4) Description of physical and psychosocial impacts
- 5) Reasons for performing female genital cutting
- 6) Services and support for women living with female genital cutting

4.1 Knowledge and attitudes towards the practice

4.1.1 Terminology in local languages

While women identified the practice of female genital cutting when referred to as ‘Sunnat’ and ‘Khatna’, and some did use these terms to refer to the practice, it was also found that there was often localised terminology for this in the Tamil language. The localised terms for the practice identified during the consultations were ‘Imaan Kollurathu’, ‘Iman Vaikkirathu’ (both loosely refer to ‘completing a part of the religion’), ‘Thuppuravu Seiyarathu’ (loosely means to ‘make clean’ but with a religious connotation), ‘Islam-la Edukkarathu’ / ‘Islaathukku Edithira’ (both of these terms loosely refers to ‘bringing a child into Islam; also ‘Islaathukku’ is a local way of referring to Islam) and ‘Sadangu Sayrathu’ (refers to the ceremony of performing this ritual).

Similarly the traditional practitioner who carried out the practice was referred to by varying terminology. Osthī Maami was the most popular and easily recognised of the terms in use. Other terms were ‘Ambattam Pombula’ (refers to the ‘woman who shaves’, in reference to shaving of the baby’s head), ‘Imaan Kollevakkara Pombala’ (refers to a ‘woman who brings a child into Islam’, ‘Ambaddachi’ (‘barber woman – also a reference to shaving of the baby’s head), ‘Hajumma Aunty’ (meaning not known), and Naasuva Pombula (refers to the ‘woman who shaves’, in reference to shaving of the baby’s head).

All of the terms appear to reflect meaning of the ritual to the women, and does not refer to the process or procedure of cutting as the terminology in English often does.

¹¹ As in the rest of the report the term FGC – Female Genital Cutting – is used, except where women refer to the practice by another name, in which case this is indicated in quotation marks.

4.1.2 The secretive nature of female genital cutting

All women conveyed a strong sense that the subject of ‘circumcision’ was not something to be openly discussed in their respective contexts. Many of the women said that they first heard of it from their mothers, after they had married and usually when it needed to be done to their daughters. The fact that this is not talked about or that the women were not part of a conversation /had not heard of a conversation about it until after reaching adulthood, speaks to the restricted nature of the subject. Women described the general secrecy around this practice in a number of different ways and all the women spoke to this.

- (i) Little to no conversation in close social relationships
 - Several women said directly that they themselves do not talk about it with other women, even with women in their own families.
 - One woman said she had only spoken about the issue for the first time with another woman immediately prior to participating in this consultation.
 - One woman stated *“I have not even spoken about it with my sister”*
 - One woman was shocked when her mother told her it had been done to her but that the reason she was not told is because *“there was nothing to feel”* and *“it was a secret”*.
- (ii) Taboos around talking of ‘women’s issues’
 - A few women said that when they came to know that the interview would be about the practice of ‘circumcision’ they were unsure and curious as to why it was a topic of conversation.
 - Some explained the reason for the secrecy as being related to a social norm of generally not discussing issues pertaining to girl children.
 - One of the older women expressed relief that the interview was conducted individually as the subject was not one she felt she could speak about with others present.
 - One woman said her parents disapproved of her talking about her experience.
 - One woman said it is ‘modest’ and a ‘good thing’ not to discuss female issues.
- (iii) No knowledge of what actually takes place
 - A few women said *“We don’t know if it has happened for sure, no one talks about it. But they must have done it for us since we were asked to do it for our daughters.”* - *Women from Panadura.*
- (iv) Fears of social sanction
 - One woman said it was a taboo subject with a lot of pressure to conform by the community.
 - A young woman expressed a fear that she would be rejected by her community for speaking openly about the practice.

One of the locations in Colombo for conversations with women was a block of apartments arranged close to each other and housed a community of people closely interacting with each other. Despite the familiarity of the women with each other and their clear knowledge of the circumstances of each other’s lives, it was observed that the range of reasons provided for the practice of FGC varied very widely, and it was clear that this was not a subject that they had spoken about with each other prior to the consultations.

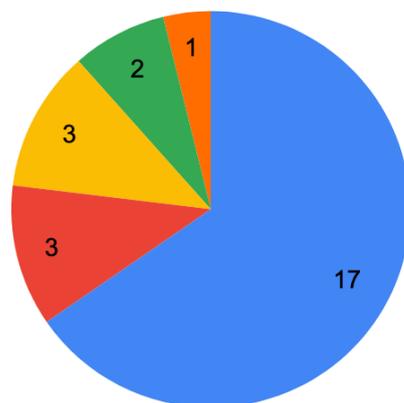
In all of the conversations, there seemed to be limited language or vocabulary available to women to express ideas and opinions on the subject. The general and vague language of ‘feelings’ (which could not be described), ‘must be done’ and ‘no problem’ were recurrent in the conversation about female genital cutting. Self-censorship around the topic was strong, and this finding is an important context to the consultations that were had and the conversations it was possible to have.

4.1.3 People who influence and reproduce the practice of FGC

Of the women interviewed, at least 23 out of 26 (88%) of women identified a female person as being the key influencer and reproducer of the practice in their experience. Most - 17 women - identified their mothers as being the person from whom they first learnt about FGC, while 3 women said they were informed about it by other women in their family, 3 said they were told to perform this ritual by their mother in law, 1 by her husband and 2 women did not provide information about who their influencer was.

Influencers and Reproducers of FGC

● Mother ● Other females in her family ● Mother in law ● No info
 ● Husband (as informed by a moulavi or religious teacher)



It is important to make a general note here that women are often seen as being responsible for upholding traditions and custom in the family, particularly as they relate to women. While there may be strong personal belief in the traditions as well, there is also the possibility of social sanction for failing to do so. The practice of FGC is perhaps no different.

4.1.4 Personal meaning and significance of FGC

In the narratives of women talking about their experiences of FGC, just 3 women appeared to have already reflected on the meaning and significance of the practice. These included the two women from the Dawoodi-Bohra community in Sri Lanka who reflected on why it was done, on their parents’ participation in the procedure, and how they felt about this being done to them.¹² Both women also appeared to have taken a personal position against the practice and critiqued it as a violation. The third woman, who identified as being of mixed Islamic identity (non-Bohra) had undertaken some study of the practice, reflected on whether the cutting had impacted her sex

¹² In Sri Lanka’s Dawoodi-Bohra community, the ritual of female genital cutting takes place when the girl child is 7 years old – rather than when she is an infant (which is the common practice in the other sects and groups) - and unlike the others identified during the consultations. So she is more aware of the procedure and may continue to have memories of this into adulthood.

drive, engaged in conversation with her partner about it and had reflected on the justification for the practice. She too had taken a position against the continuation of the practice. She did not articulate her rejection of the practice in terms of her needs or her bodily integrity instead she demonstrated that her learnings led her to believe that FGC was not Islamic.

The other 23 women did not convey the impression that they had spent much time reflecting on the practice or felt the need to. In a few of these conversations women chose to highlight other pressing concerns they faced instead, such as economic precariousness, difficulty in securing a living wage, difficulty in collecting maintenance ordered by the Quazi court for the sustenance of their children, the burden of bearing the responsibilities of head of the family, concerns about contraception and one mentioned domestic violence.

It is difficult to identify what factors may have contributed to creating greater opportunity to reflect and form a considered opinion or take a position on the practice. Some of the main differences however, between the women who appeared to have reflected on the meaning and significance of the practice and those who appeared to be speaking at some length about the practice for the first time, were as follows:

- The two women who were most reflective had experienced the more severe form of cutting of anyone in these consultations, and had permanent physical damage or alteration of their body;
- All three women who demonstrated reflection on the practice were well educated, professionally engaged and economically independent.
- Those who appeared to have reflected less on the practice also spoke of other pressing concerns they faced.

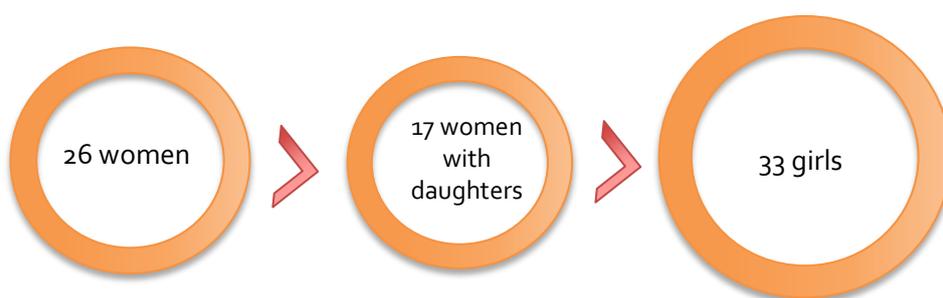
4.2 Perceptions of prevalence and sustaining the practice

This consultation process did not set out to map prevalence, but in order to get a sense of how widespread the practice is, it asked women about prevalence in two ways: how common do you think the practice is in your family and community; have you had this procedure done to your daughters? Women consulted knew or believed the practice was routine in their families and community. Some of what they said to this effect is as follows:

- *Circumcision was practiced more in the area I had moved to after marriage (She had moved from Hatton to Puttalam)*
- *20 to 25 girls have had it done in last 10 years.*
- *I know over 20 women who have been circumcised.*
- *My sisters have also had it done to them.*
- *All my brothers have daughters and they have all had it done*
- *We have to do it for all.*
- *Everyone in my family has done it.*
- *My mother's side of the family continue to do it.*
- *We have done it for generations, it is my responsibility to ensure these practices continue. .*
- *In my family almost every woman or girl, whether in Sri Lanka or in India has been subjected to FGM or FGC for the last 4 generations.*

It is important to note that perceptions of high prevalence were from women who belong to groups that believed it to be a requirement of Islam. In groups that believe that Islam does not promote the practice, it follows that perceptions of prevalence in their community would be low or non-existent. Therefore, although being Muslim may be a shared identity, perceptions of prevalence may vary based on specific sect/group that they identify as belonging to.

Of the 26 women who were consulted, 17 had daughters – a total of 33 girls between them – and all of them had undergone FGC. One woman said that she herself had not undergone this because her mother had objected at the time, but she had allowed it to be performed on her daughter as it had been required by her husband's family. A statement by a woman in Puttalam also speaks to sustaining the practice *"I have told my sons 'if you have daughters you should do this'"*.



4.3 Descriptions of the practice of female genital cutting

The descriptions given by women of the practice of female genital cutting fall into two broad categories of experiences. Some of these descriptions correspond to the nature of the cutting as described by the World Health Organisation as 'Type 1 and Type 4 FGM', but also goes beyond this classification to encompass other experiences related to the practice. These will be discussed below as:

- i. Category A: The 'nick' or 'cut' that corresponds to WHO FGM classification Type 4.
- ii. Category B: Removal of parts of external genitalia that corresponds to WHO FGM classification Type 1.

Category A – the 'nick or cut'

The cutting referred to in this category falls within the definition of Type 4¹³ of the WHO classification and was described by 24 women.

This takes place when the girl child is an infant, at 7 days or 9 days or 15 days or 40 days after birth. One response stated that the cutting was done at 60 days after birth as the baby was born prematurely and was considered too small to undergo it. The cutting is done by an Osthī Maami (traditional female practitioner) who is procured for the purpose of conducting a number of rituals on the infant including the first occasion of cutting of her hair, clipping her nails, on some occasions piercing of her ears for earrings, and bathing the infant.

¹³ **Type 4** includes all other medically unnecessary procedures like nicking, pricking, piercing and cauterisation of the female genitalia.

Physical nature of the cutting: Of the 26 women who spoke of this practice, just 4 women had witnessed it for themselves. Between them they had seen it done for 6 girls. They described it as “a new blade or small knife was used to ‘draw a line’, ‘scrape’, or ‘take off a piece’ in the child’s genital area.” They were not able to indicate where exactly the cut or scrape was done. It was described as done quickly and cotton or white cloth was used to dab the cut area and a small drop of blood would be seen on the cotton/cloth. Some described use of eau-de-cologne or turmeric on the cut. Most of the women said nothing could be seen a few days after the cutting, a few said they were said that they were scared and they did not look at the cut area. Two responses stated that the cut dried up in one or two days.

“I saw it done for my daughter - there was a small cut that was put - a line. It is not supposed to be a deep cut and there shouldn’t be any piece taken out.” (Mariam, Colombo 05)

All the women whether they were present or not, described the baby crying when the cut was made and one woman said the baby cried when urinating for the first day after the procedure was done.

Immediate emotional response of mothers: In terms of the mother’s emotional response in relation to the cutting, the women said they experienced fear and concern about causing hurt to the child.

Responses included *“She was crying, I was too scared to look. She was too small. It was difficult for me.”*- Nuzrath, Colombo 10, *“I did not want to be there. I did not want her ears pierced because then she would have hurt twice.”*- Shanaz, Colombo 10, *“I think it hurts. I would advise another not to do it. - Ayesha, Colombo 10, “Mothers get scared so they don’t allow the mother to be present.”(Group discussion with women, Colombo 5).*

A few said they questioned whether it was necessary. One response stated *“I asked the woman who did it, why it should be done. She said it was good. Friends also didn’t know. We need more information”* - Nuzrath, Colombo 10, *“I was scared...I want to discuss this my husband. He is a Moulavi”* - Nur, Colombo 10.

There were also concerns about whether the procedure was done ‘correctly’. Responses included *“I have a doubt whether it was done properly”* – Nuzrath, Colombo 05 and *“my husband did not want it done by an old woman whose hand may shake.”* Mariam, Colombo 05.

One woman had asked that it not be done. *“I told the woman not to do it. She said had to do. I think it hurts.”* - Ayesha, Colombo 10. In this case she came from family which did not practice it and the practice was imposed by her mother-in-law.

It was observed that mothers spoke about their emotional relationship to the practice differently at different times in the conversation. When narrating details of the cutting, they expressed some emotional disturbance. However, when reflecting on the practice in general or the impact of the practice on their lives or the lives of their daughters, they expressed less concern. A few responses compared their experiences in relation to their sons’ ‘circumcision’ and stated that they felt more disturbed by male ‘circumcision’ because they felt the male child experienced more hurt and were engaged longer in caring for them after their circumcision compared to their daughters. Therefore, in comparison, they felt ‘it was not so bad’ for the girl child. In speaking of the perceived impact of the practice many felt that it had no impact.

Category B – the ‘removal of parts of external genitalia’

The cutting referred to in this category falls within the definition of Type 1¹⁴ of the WHO classification and was described by 2 women, both from the Dawoodi Bohra community.

These women described their experiences from their recollection as it took place when they were around 7 years old. The cutting was done by a medical doctor and the women remembered being taken to a doctor’s clinic. One woman does not remember her experience at the clinic, while the other recalls being stripped down, the doctor examining her vagina, and her mother being close to her and holding her gaze. Both women stated that they could not recall details of what transpired. One said she was unsure what happened during the rest of that day.

Physical nature of the cutting: The two women had no information about the physical nature of the cutting or the conversations around it at the time the cutting took place. However, both had been examined by gynecologists as adults and shared the observations of the changes that was visible on their bodies as a result of the cutting. One was informed that ‘a bit of the clitoris and part of the labia had been taken off’ and the other was informed that ‘part of her genitalia had been extracted and exposed nerves had become extremely sensitive, causing pain on touch.’

One woman also shared a memory of physical impact that she had associated with the practice. There was no medical opinion sought as to whether there was a correlation. She said “... I went to the bathroom and I couldn’t pee. My bladder was full and it was hurting me and it was burning down there. I remember crying. But I don’t know how soon after the visit to the doctor that this happened.”- Sarah, Dawoodi Bohra, Colombo.

One of the doctors interviewed in the initial stages of this consultation process said that 6 women had come to her to be examined and except for two of them where she did not see any evidence of FGC, she observed some signs in the others. She said,

“What I observed in one of the women who came in was that the clitoral hood was flat and the area was scarred. The labia was fine. After that I was more observant – sometimes the upper third of the labia majora and minora was gone. Some shriveling and scars but old scars of varying degree. The worst I have seen is that there is nothing in the clitoral hood area, just scar tissue. So the labia majora just pops out like a butterfly and it’s not fused with the clitoral hood like it should be.”

“Of those I examined, I didn’t see this (female genital cutting) in everyone. For a few, the top of the clitoris was gone. I have seen some damage when women have come in at the neo-natal stage. Of the 6 women I examined, maybe two didn’t have.”

Emotional experience immediately related to the cutting: Both women were not able to recall the experience of physically undergoing the cutting. Both said that they can only remember visiting the medical professional. One recalled being ‘stripped down’ as she remembered feeling as a child that she had not previously exposed herself in this way except in front of her mother or caretaker. One woman spoke about her attempt to remember what happened “I have tried to remember more, but I can’t. I remember quite fondly a lot of childhood memories, so my explanation for not remembering this incident leads me to believe that the experience must have been traumatic or painful and thus my brain has suppressed it.”- Sarah, Dawoodi Bohra, Colombo.

¹⁴Type 1 is the partial or total removal of the clitoris and/or clitoral hood/prepuce (Clitoridectomy).

The doctor referred to above described the experience of a woman who came to her to be examined and said, 'I think something has happened to me. I think I remember it being done when I was 7 years old, so please examine me.' "So, I did and it had happened and she cried. She said it hurts her to know that it was done to her. It had hurt her and she bled at the time. She remembers pain and being in the room and the process."

FGC on adult women: As part of these consultations there were two unverified anecdotal accounts relayed of adult women being required to undergo FGC prior to marriage to a Muslim man. The consultants are also aware of a testimonial by a Dawoodi Bohra woman who spoke of having undergone the practice at the age of 20 which formed part of submissions made in 2017 to various Sri Lankan state agencies. It would be necessary to consult women with this experience to verify and understand the impact of the practice. Due to limitations of access, this could not be verified during the course of these consultations. It is flagged here to draw attention to the possibility of such experiences and to ensure sensitivity is extended or considered to this experience in any future work.

4.4 Description of longer-term physical and psychosocial impacts

Category A – the 'nick or cut'

Women whose experiences corresponded to Type 4 FGM, claimed to not have any lasting or permanent impact. They said they could not identify any changes to their body from having undergone the practice. Only two responses differed in view regarding physical impact. One, said that 'the part' (meaning the genitalia) was differently shaped as a result of the practice. She said it becomes clearer as you become older and that she had seen the 'shape' which she attributed to the practice on herself and her daughters. She described the shape in a rough drawing as a small visible cleft in the girl's genitalia.

Of the 24 women who described this type of experience, 22 of them said they felt 'normal'. They said it had no impact nor had they experienced any consequential medical issues. Many said they did not attribute the practice to any impact on their 'relations' between their husbands and themselves. The women did not appear to have the interest or willingness or need to explore this question on any sustained impact, further. Of the other 2 women, one said she felt that she was not interested in sexual relations and wondered whether it was a result of having undergone the cutting. The other said she did not know whether she had undergone the practice and did not want to know.

The specific question of sexual pleasure was a very limited conversation. It was a difficult conversation to have because the women sometimes expressed embarrassment and felt that the topic was too personal or not appropriate. On the two limited occasions in which women engaged on the subject of pleasure, they expressed their understanding of pleasure in terms of the man's / their husband's satisfaction. The language used was also very limited and mainly consisted of 'feelings', 'happy' and 'good relations between husband and wife.'

In the initial interviews with medical practitioners, they described very limited engagement with women on the question of sexual pleasure. It was observed that in general and not limited to the Muslim community alone, the instances when advice on sexual pleasure was given was usually in the context of difficulties around reproduction. Practitioners also said that the language available as well as the training on engaging in conversations around sexual pleasure particularly for women, was limited. Therefore, even in a professional setting, it is possible to assume that there would be limited capacity to advise women and men on sexual pleasure.

Category B – the ‘removal of parts of external genitalia’

The two Dawoodi-Bohra women reflected on their emotional response to the cutting as adults. Extracts from their interview demonstrate their feelings:

“I got scared and wondered what had happened, to what extent. I felt lost because I didn’t know what had happened to me. This practice is an invasion of my body and something I didn’t consent to. Now that I know, I can never go back to a normal state. It is not possible to be unaffected by it, it does shape you a bit.”- Sarah, Dawoodi Bohra, Colombo.

“I’m a victim of Female Genital Mutilation, I refuse to call it circumcision since what was done to me was no mere ‘prick’, ‘nick’ or ‘cut.’ - Jamila, Dawoodi Bohra, Colombo.

“It should not be up to the elders to stamp the body of a girl child at the age of seven, (a process that is irreversible irrespective of the extent of damage), and decide what her religious convictions should be” - Jamila, Dawoodi Bohra, Colombo.

One of the two women said that she did not realise the extent of the damage till she was married and experienced extreme pain on her wedding night. The other said she was unmarried and that she is unable to say whether the practice has impacted her ability to experience sexual pleasure. She also felt that the practice was about controlling women and people.

“I don’t know if I can feel that kind of pleasure, I don’t know. How do I even know what that is – if something has been taken off, then this is something I won’t know about and cannot have prior experience of.”- Sarah, Dawoodi Bohra, Colombo

4.5 Celebrations acknowledging the practice

Many of the women described the practice as being done without public ceremony. One said that sometimes even the father of the child does not know that the girl child is ‘circumcised’. A few women spoke of making and distributing kiribath and bananas to a few people who knew that the child was being ‘circumcised’ to mark the occasion of the practice. A few said that the practice used to be celebrated, one even mentioned a feast, but that now people did not have these celebrations. The move away from celebrations was attributed to being considered a waste of money or the need to do these things quietly. Some drew a comparison between the bigger celebrations organised for ‘circumcision’ of boys as opposed to for girls. Two responses given as to the reason for this difference was that girls’ issues “must be kept quiet” and “must not be spoken of publicly”.

The Bohra community was said to celebrate the occasion by inviting families with other young children to a small celebration. The public celebration was considered a means by which the community would become aware that the practice had taken place.

4.6 Reasons for performing female genital cutting

Women spoke of a wide range of reasons as to why they believed they engaged in female genital cutting. The 26 women spoken to in these consultations gave more than 50 statements as justifications and reasons for the practice. Among all the women who were consulted, all those whose experiences fell within Category A (corresponding to Type 4), provided their own justifications for the practice. For the two women whose experiences fell within Category B (Type

1), they said they did not personally justify the practice, but explained the reasons given by family and community as being a religious requirement.

By popularity, the justifications for the cutting were as follows:

1. It was perceived as a religious requirement.
2. It was perceived as a means of establishing a ‘Muslim identity’
3. It was believed necessary to control women’s sexual feelings
4. It was believed to be medically beneficial
5. It was believed to be a tradition or customary ritual
6. It was perceived as improving the appearance of female genitalia
7. It was perceived as improving sexual partners interest
8. It was perceived as improving sexual experience of the woman

The chart below reflects the number of statements received by the respondents as justifications for the practice of female genital cutting. Four women explicitly spoke about not personally approving of the practice but spoke to the justification given by their family or community.

Reasons given for justification of the FGC (by number of responses)



The following table provides a fuller range of reasons provided for Female Genital Cutting.

Table 1: Reasons/Justifications for FGC

Thematic Category	Range of responses (repeated responses have been removed)
Religious requirement	<ol style="list-style-type: none"> 1. I don't know if this is in the Quran. I have not read that much. We follow the Sunnah of the prophet and it must be said in that. 2. If religion says it, if elders say must do it (FGC), I don't need any further information. I read a book on Islam that said to do it, so I believe it is good. 3. It is said in Islam that we need to do it. 4. A Moulavi advised my husband to do it for my daughter saying it is a must. 5. <i>Khatna</i> is <i>sunnah</i> and so it should be done. This has been said by a Tabligh Moulavi in Sri Lanka. I saw this in a video on my phone. 6. It is not said in the Quran, it's said in the Hadeeth to do it. As Tawheed Jamaath people only look at the Quran and not at the Hadeeth, they are saying not to do it.

	<ol style="list-style-type: none"> 7. It is in the <i>Kitaab</i> (the Quran) but we haven't been told much about it. It's a law in Islam. 8. Imam Shafi'i has said to do it. Even if we don't know why, it is a <i>sunnah</i> and we have to take it forward and do it. 9. In Madarasas they say the reason this is done is because it is <i>Sunnat</i> for boys and girls) and we haven't asked about girls' <i>Sunnat</i> at these classes. 10. Islam has not forced anyone. It is a rule (in Islam). People can decide what they want to do or not based on their level of faith and how much they want to do it or not do it. 11. I went for these (Madrassa) classes for two years before I got married, I did not hear them talk of female <i>Sunnat</i>. It must be in the religion.
Control of sexuality	<ol style="list-style-type: none"> 1. Husbands are away from home on Jamaath for 40 days. This is needed to control women's feelings. 2. To control women's (sexual) excitement because they generally have more. 3. Girls have a lot of 'emotions' and that this had to be reduced/controlled. 4. If the right amount is cut, it controls sexual feelings. If you cut too much, then the sexual feeling will be stronger and the girl will lose shame. I don't know what it would be by not cutting. 5. They will be in a better frame of mind and won't talk about sex so openly compared to those who have not had it done. 6. Feelings will reduce. <i>Sunnat</i> (recommended) for men also to control their feelings.
Medical	<ol style="list-style-type: none"> 1. Will prevent infection. It prevents infection and disease in girls, just like for boys. To remove the part where urine collects and causes infection. 2. Will help in an easy delivery when the girl has a baby when older. 3. When women urinate, the cut helps to keep that area clean because it will be open. Cleanliness is very important. 4. Without circumcision when women urinate, they urinate little by little, not a stream. After circumcision they pass urine like passing water through a pipe. We have seen that difference.
Custom or Tradition	<ol style="list-style-type: none"> 1. I have not heard that it is in the Quran but it is a ritual practice that is done for years; girls are now being taught how to do it, because we need girls to do it for girls. 2. It is a 100 year old practice, not a new practice that that has suddenly started. 3. I don't know the reason. Now they are questioning whether it should be done. It is done as a ritual. 4. I think it is an old custom. We didn't ask. 5. All my family members have done it. 6. It is a traditional cultural practice so it needs to be done. 7. Has been done for generations from my mother's time.
Appearance	<ol style="list-style-type: none"> 1. Makes that part more beautiful. When the baby is born it is ugly, after <i>Khatna</i> it becomes beautiful. The shape is much nicer after <i>Khatna</i>. Without <i>Khatna</i> that area is closed up and I feel that is ugly. When opened up it is more beautiful. 2. Women become beautiful if it is done. 3. When that part is cut, it will be shapely, beautiful and neat. If not it will be ugly and men will not want to see it.

Improves sex for partner	<ol style="list-style-type: none"> 1. When having sexual relations, men will know whether it has been cut or not and won't be interested in them if it has not been done. 2. When that part is cut, it will be shapely and beautiful and neat. Otherwise it will be ugly and men won't want to see it. 3. Husband will have more desire for the wife during sex.
Improves sex for women	<ol style="list-style-type: none"> 1. Women will have more feeling if this is done. Muslim women feel more pleasure with Muslim men, maybe because they both have had <i>Khatna</i> done. 2. After marriage, sex life will be good if this is done.

Some overall impressions of the reasons and justifications provided for the practice are:

1. **Shifting explanations for the practice:** For women whose experiences were in Category A (corresponding to Type 4), in the course of a single interview, each woman often gave multiple reasons for the practice. The reasoning also appeared to evolve through the course of a conversation. The question as to why the practice was done was sometimes initially responded to with "I don't know." This gave the impression that the question was not a familiar one or had not been reflected on. Further into conversations the same individual would move from the position of not knowing to drawing on religion or custom as a justification. This left the interviewer with the impression that a justification was being built up over the course of a conversation, or perhaps that this might have been one of the first times there was a reflection on why this was being done. The phenomena of talking about taboo subjects was a consideration in the methodology and the method of consultation was to hold the space for participants to express themselves in any way they wanted to – which meant also possibly accommodating evolving responses, accepting that responses may not be forthcoming and perhaps even contradictory responses.
2. **Contradictory reasons for the same practice:** There was a wide, sometimes contradictory range of reasons given for the practice of female genital cutting, which ranged from religion to cleanliness to appearance. Some contradictions were that some stated that the practice was in the Quran, whilst some said it was not. Some viewed it as mandatory, while few articulated having a choice. One interview contained the internal contradiction that there was no physical change or impact of FGC, but also that the practice was the way a body of a person could be identified as Muslim.
3. **The reasons were not always strongly held:** Custom and tradition across generations was among the reasoning that was most clearly and strongly articulated. For some women, the reasons did not appear to be strongly held, with some responses including, *"I do not know. Perhaps to be recognised as Muslim"*, *"They say that the feelings will reduce"*, *"I don't know the reason. ... It is done as a ritual"*, *I think it is an old custom. We hadn't asked."*, *"I must ask my husband about it."*
4. **Relevance of theological positions in the practice of FGC:** The relevance of different theological positions in justifying the practice was apparent in the response of one woman who said that it was in the Hadeeth (referring to the traditions or sayings of the Prophet

Muhammed) and that the reason people belonging to the group known as Thawheed did not practice it is that they only follow the Quran and not the Hadeeth.

4.7 Resistance to the practice of FGC

There were 6 responses from 6 women that could be interpreted as statements denoting forms of resistance of the practice.

- I thought it would be good not to do it (for my daughter).
- If I am told not to do it, I can stop.
- I did not want it to be done for my daughter. I would advise another not to do it. Children should not be hurt.
- I will not do it for my child.
- Even if it was just a nick, this still shouldn't have even happened.
- It should not be up to the elders to stamp the body of a girl child

For these 6 women out of the 26 consulted there was a sense of discomfort with or a need to reject the practice. Articulating these feelings in terms of lack of consent and the fact that hurt is caused to a child reflect some of the main arguments made against the practice.

4.8 Women's views on services and support for women living with FGC

i) No support is needed

To the question posed as to whether women felt they needed any support services – medical or other, as a consequence of having undergone the practice, almost all of the Category A experience (corresponding to Type 4) women said that they did not think any support was necessary.

This response was interpreted in the context of the popular perception that no harm was felt and that there was 'no problem' and the secretive nature of the conversation. There were also notably two views expressed about difficulties of talking about such things with non-Muslim medical personnel, mainly in reference to mid-wives.

ii) More awareness is needed

There were 5 clear responses from 5 women about wanting more information.

- "I want to know what the religion says (about the practice)."
- "The younger generation is asking questions about sexual health."
- "I was feeling odd (when it was done to my daughter). I asked her why they do it for girls and she said it was good to do. Friends also didn't know. I would like to have more information."
- "It is only now that the younger generation has started asking the questions."
- "Can you give me more information?"

While there were other responses that were not as clear in the request for information, the above responses indicate that approximately 20% of the respondents were interested in understanding the practice. They also expressed an interest to understand what doctors

thought, what the interviewers thought and what the practice was in other Muslim countries.

iii) Expressed preference for Muslim female medical professionals performing the cutting

Women who expressed this preference also stated that they had confidence in medical professionals. A few responses appeared to base their recommendation on the fact that they had opted to have their sons' 'circumcised' by a medical practitioner at a medical clinic.

iv) Expressed an interest having training within the community for traditional practitioners

Women whose experiences fall under Category A (corresponding to Type 4) commented on the fact that there was a shortage of traditional practitioners available for the practice. One mentioned that there was an initiative to train practitioners. Those who expressed this interest in having trained practitioners also saw the practice as an important cultural or religious practice that needed to be continued.

5. CONCLUDING OBSERVATIONS

This section summaries the key observations of these consultations.

Female genital cutting is not practiced by all Muslim communities in Sri Lanka. The practice is perceived as mandated by religion or custom by specific, not all, Muslim communities. As described, it falls into either the Type 1 or Type 4 classification by WHO. The practice by the Bohra community takes the more severe form with possibly permanent consequences. The experience of women within the Bohra community is different from the experiences of other Muslim women who undergo the practice.

Inconsistency and diversity of experiences, narratives and justifications accompany the practice. It was observed that women's personal attachment to the practice was very weak particularly for the women who underwent the Category A experience. These women had a myriad of reasons either expressed with notes of uncertainty, in contradictory opinions and sometimes without scientific basis or accuracy. The relationship between women who identified with the Category B experience and the practice, was clear and strong. It was mandated by their religious leadership and open resistance was believed to have negative consequences.

Evolving conversations. The fact that almost all of the women had little space to reflect and develop relationship and meaning with the practice means that the conversation on FGC in Sri Lanka is still nascent. The consultants were left with the impression that a few of the women consulted were interested in following up on the issue. It was clear that women needed spaces, conversation starters, information and solidarity to navigate the complexities that surfaced. The conversation on the issue is dependent on the space created for discussing other related complexities. The complexities revealed in talking about FGC were many: notions of FGC as an identity-marker in the context of difficulties of expressing identity related practice in the backdrop of religious intolerance, difficulties of speaking about sexual pleasure, bodily integrity and autonomy, difficulties of challenging patriarchal religious and political institutions and individuals holding power over religious knowledge and policing speech, actions or adoption of alternate practices. The particularities of family dynamics and difficulties of challenging parents and in laws also may need to be evaluated for the role it has in conversations on FGC in Sri Lanka.

The other aspect of the evolving nature of the conversation deals with perceived impact and rejection of services. It is difficult to assume that women articulated their response on impact and services well and with sufficient self-reflection given the many factors which limited women's narrative. It is necessary that the responses to impact and services be evaluated again after sufficient space for conversation is created.

It is possible that even amongst the women consulted that the issue may have been raised in their consciousness. Similarly, there was an impression that the medical professionals engaged in consultation for this report, being aware of the practice would enable them to consider it as a possible reason for medical issues presented, such as difficulties when fitting a catheter.¹⁵

For women who have undergone the practice, for new mothers, for medical professionals and community practitioners of sexual and reproductive health and rights work, responding to this learning will form part of an evolving conversation.

¹⁵ This view was shared by at least two doctors who attended a consultation in November 2019 as part of this consultation process, to listen to initial findings and collectively reflect on possible ways forward.

No enabling environment for conversations on bodily integrity and sexual rights and pleasure.

It was observed that talking about sexual intercourse and sexual pleasure were difficult for most of the women consulted. Any limited conversation was framed in terms of the man's satisfaction or, "having to go when the man called," (denoting obedience in relation to sexual intercourse). The reference to women having 'more feelings' was also spoken about in terms of the need to control or restrict such feelings. Language used did not center women's needs, rights and pleasure. The concept of bodily integrity was only articulated in some form by the Dawoodi Bohra women consulted. While it is difficult to attribute what factors facilitated such articulation, it was noted that a majority of those consulted did not speak in terms of bodily integrity or rights.

Medical professionals in the preliminary interviews raised this as something they were familiar with. They had noted that men and women most often sought medical advice on sexual health with regard to reproduction. Amongst those consulted no one shared any instance of medical and health advice sought on sexual pleasure. It was also shared by a few medical practitioners that there was no training to engage in these subjects.

The concluding observation is that this is an under-developed discourse and those working on these issues may also have to consider what implications this has on identifying and addressing violence, including sexual violence.

No formal medical training on the practice in Sri Lanka. It was learnt that currently, to the best of the knowledge of all medical professionals consulted, female genital cutting was not part of the medical training received in Sri Lanka. One medical professional with over 20 years of experience observed that if a disease or concern is not believed to be found in Sri Lanka no prominence would be attached to it in curricular or other forms of training and health education for medical professionals. All medical professionals engaged by the consultations stated that they had not received training on the issue in Sri Lanka. A few mentioned that they had been exposed to the concern when training or working in countries such as the United Kingdom.

Another aspect was the difficulty women articulated in accessing mid-wives and medical professionals on topics such as FGC. The burden must be borne by health workers and medical professionals, and by the health sector in general to create non-judgmental and trusted spaces for these types of conversations.

Medical professionals express a reluctance to engage. Medical professionals expressed a reluctance to speak or engage publicly on the practice for the reason that such measures may be misconstrued as measures motivated by religious intolerance targeting a minority community. It spoke to the sense that the political context was not favourable to the Muslim community and there were strong possibilities that disruptive elements would create opportunity for mischief causing victimisation of Muslims and drawing medical professionals and institutions into political conflicts. It was a reluctance that also spoke to the value the medical professionals placed on maintaining impartiality, non-discrimination and safe access to medical services for all.

6. RECOMMENDATIONS

6.1 Develop a non-judgmental and non-discriminatory approach for working on FGC in Sri Lanka.

This refers also to development of language capable of sensitively talking about FGC with women and also sensitively raising the issue in public when necessary. The following are contributions towards the development of the approach.

- Be sensitive to the local context of intolerance and possible victimisation that public discussion of the issue may lead to.
- Refrain from making generalisations regarding the practice to all persons belonging to the Islamic faith.
- Do not belittle belief, myths about the practice and scientific misconceptions. Engage in conversation to understand, engage in clarification and express opinion as personal opinion.
- Understand the terminology used and select use of appropriate terminology.
- Develop distinct approaches when addressing different experiences of FGC. For example, engagement with the Dawoodi Bohra community will necessarily be different from engagement with other Muslim communities over the issue.
- Engage in positive messaging of creating space for questions, information and services if required.
- When engaging with religious justifications – understand that there is debate within religious communities about the obligatory or necessary nature of practice, clarify your positions on the practice and if there is disagreement – agree to disagree. Demonstrate respect and tolerance for differences of views and opinions.

6.2 Develop material for women and relevant communities to engage in discussion on FGC.

This recommendation responds to women expressing an interest in obtaining more information. It also responds to secure as far as possible informed consent of adults who may consider the practice for themselves.

In developing information for women and communities, the following types of information were suggested:

- Medical information of what the practice is believed to entail. This must be based on clinical studies and conversations with traditional practitioners.
- Information on different religious positioning. This will place the debate on FGC with the adult woman or man seeking this information.
- Considering the myths that appear to be associated with the practice, it is important to develop information that address these myths. This may require a multi stakeholder effort – medical, reproductive health and rights, and public communications expertise.
- Share information about practice, women's experience and responses in other countries, especially from the South Asia and South East Asia region.

6.3 Improve understanding and address concerns raised by women of the Dawoodi Bohra community.

As the experiences of Dawoodi Bohra women of FGC in this consultation appears to be of a more severe form than that practiced by others in Sri Lanka. It is necessary to treat their concerns with greater urgency. Consider ways to engage community leaders and develop appropriate institutional policy and legal measures that could address the specific concerns and provide support services if required.

6.4 Create safe spaces and avenues for women and relevant communities to engage in discussion on FGC.

The following actions are suggested to enable safe and open conversations on FGC:

- Identify safe spaces for women to engage in conversations on the issues raised.
- Develop a child rights framework within which these conversations may take place.
- Design and conduct inquiries into men's perceptions on FGC within communities that promote the practice. Engage with men.
- Develop and engage in community conversations on informed consent relating to agender based violence.

6.5 Build knowledge, guidelines and training tools for medical professionals.

Develop relevant, evidence-based clinical guidelines for health workers such as mid-wives, public health nurses, visiting obstetricians and gynecologists (VOG) and pediatricians. Guidelines must include information on how to talk to patients about FGC sensitively, safeguarding and obstetric and gynecological management. Guidelines serve as an important basis for both pre- and in-service medical training programmes. Where appropriate, explore possibilities of learning from regional counterparts on identification, impact and development of services.

Conduct training in practical steps and measures for health and medical professionals, including for midwives, public health nurses etc., to identify and address any questions women and men may have about FGC and provide appropriate support.

Design ways and spaces for systematic observation for study of the physical and emotional impacts of the practice, to deepen learning and refine support services.

Sri Lanka Medical Association and relevant professional associations to raise awareness on the issue with their membership framed expressly as a child and women's health concern requiring sensitive, non-discriminatory and non-judgmental approaches.

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