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ASIA NETWORK TO END FGM/C

A COMPREHENSIVE ADVOCACY TOOLKIT ON TYPE 4 FGC IN MALAYSIA

A comprehensive, Malaysia-focused toolkit integrating workshop strategy, legal analysis, medical guidance, and cross-sectoral best practices to support evidence-based action on ending Type 4 FGC

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A COMPREHENSIVE ADVOCACY TOOLKIT ON TYPE 4 FGC IN MALAYSIA

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Photo Credits
Cover: aiman zafri/Shutterstock
Page 6: Kdonmuang/Shutterstock
Page 18: Creativa Images/Shutterstock
Page 40: Oqbas/Shutterstock

PUBLISHED BY

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The **Asia Network to End FGM/C** is a regional coalition of researchers, medical professionals, civil-society groups, and community leaders working to end FGC across Asia. It strengthens evidence generation, supports national advocacy, and promotes culturally sensitive, rights-based approaches. This network is hosted by the Asian-Pacific Research & Resource Centre for Women (ARROW) and Orchid Project.

The **Malaysian Chapter** localises this work by coordinating research, education, advocacy, and legal strategies to address Type 4 and medicalised FGC within Malaysia's social and legal context.

Website: https://endfgmcasia.org/

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ACKNOWLEDGEMENT

CFLI/FCIL
Canada Fund for Local Initiatives
Fonds canadien d'initiatives locales

Sincere thanks to the **Canada Fund for Local Initiatives (CFLI)** for providing the financial support that made the development of this Toolkit possible

We are grateful to the **Faculty of Languages and Linguistics of the Universiti Malaya** and **Dr Nik Soffiya Nik Mat** for co-hosting the FGC Strategic Workshop held on 30th–31st October 2025.

AIM OF TOOLKIT

This toolkit is designed to serve as the most accessible starting point for understanding FGC in Malaysia. It brings together current national and international evidence and provides clear pathways to more detailed source materials for users who wish to explore specific sub-topics further. It synthesises:

- Strategic facilitation and network-building methods from the FGC Strategic Workshop.
- Integration of recent academic studies, country reports, and policy briefs on FGC in Malaysia.
- Medical, ethical, and clinical guidance.
- The Malaysian Government's 2021 position on the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (including religious and constitutional framing).
- International human rights obligations from CEDAW/Convention on the Rights of the Child (CRC) Joint General Recommendation No. 31/18 on Harmful Practices.
- Malaysia's full legal analysis, including Penal Code, Child Act, Sharia structures, and federal–state dynamics.

Together, these documents offer a complete picture of the medical, legal, social, religious, and human rights dimensions of FGC in Malaysia. This chapter provides the core messages and strategic conclusions that will anchor all advocacy work.

CHAPTER 1
EXECUTIVE SUMMARY AND KEY MESSAGES

Female genital cutting (FGC), often referred to globally as female genital mutilation/cutting (FGM/C), remains a highly prevalent practice in Malaysia, particularly among Malay Muslim communities, where academic studies over the past 25 years consistently estimate prevalence at 93–99%. Although widely viewed as a harmless cultural or religious tradition, evidence shows that FGC has no medical benefit, violates medical ethics, and carries risks of immediate and long-term harm. Medicalisation has further entrenched the practice, with some healthcare providers performing more invasive Type 1 procedures involving the removal of clitoral tissue.

This toolkit brings together the most comprehensive Malaysian evidence base currently available, integrating academic research, clinical findings, NGO reports, legal analysis, and community perspectives. It addresses key misconceptions around religion, hygiene, and cultural identity, and highlights how gaps in national research and fragmented institutional responses have allowed the practice to continue largely unchallenged.

A central finding of this toolkit is that Malaysia's existing systems, child protection, medical regulation, and legal frameworks, contain mechanisms that could address FGC, but these mechanisms remain underutilised due to weak coordination, ambiguous responsibilities, and limited engagement between government agencies, civil society organisations, and technical experts. The influence of the 2009 national fatwa, combined with deeply embedded social norms, further reinforces the perception that FGC is obligatory or beneficial, despite the absence of scriptural requirement or clinical indication.

Ending FGC in Malaysia requires a coordinated strategy built on four mutually reinforcing pillars, following the Asia Network to End FGM/C's Theory of Change (TOC):

1. **Strengthening the Evidence Base**
   Malaysia needs robust research to capture clinical outcomes, lived experiences, health-system behaviour, and the impact of medicalisation. This toolkit outlines key research gaps and proposes practical mechanisms to build national research capacity.

2. **Expanding Education and Public Awareness**
   Accurate, context-sensitive education is essential for shifting beliefs. Priority avenues include integrating FGC into medical and religious curricula, conducting community workshops for parents, developing youth-friendly digital content, and providing refresher training for healthcare providers.

3. **Supporting Advocacy and Social Norm Change**
   Effective advocacy relies on respectful, evidence-based messaging delivered through trusted channels. The toolkit provides strategic communication guidance, media sensitisation recommendations, and community-mobilisation approaches.

4. **Strengthening Legal and Protective Mechanisms**
   The toolkit offers the most detailed legal analysis currently available in the Malaysian context, clarifying the interaction among statutory law, child protection frameworks, medical governance, and the fatwa system. A Legal Matrix summarises possible pathways for policy and legislative reform.

To operationalise these pillars, the toolkit proposes a coordinated structure of Research and Education and Advocacy Working Groups. These groups are designed to align research agendas with advocacy needs, strengthen community engagement, and build institutional capacity.

Malaysia has the opportunity to lead regionally by adopting an evidence-informed, rights-based approach to FGC. Achieving this will require sustained collaboration across government ministries, civil society organisations (CSOs), healthcare providers, researchers, youth networks, and religious leaders. With coordinated action and strengthened evidence, Malaysia can ensure that every girl (assigned female at birth) grows up free from medically unnecessary, non-consensual practices that compromise her rights, health, and bodily autonomy.

CHAPTER 2
UNDERSTANDING FGC IN MALAYSIA

OVERVIEW:
This chapter establishes the empirical and contextual foundation necessary for interpreting Malaysia's ongoing practice of female genital cutting (FGC). It synthesises 25 years of Malaysian research, emerging clinical evidence, and sociocultural dynamics to clarify how and why the practice remains near universal among Malay Muslims, how harm is understood in the Malaysian setting, and why simple awareness campaigns are insufficient for change.

ON TERMINOLOGY: FEMALE GENITAL MUTILATION (FGM)" VERSUS FEMALE GENITAL CUTTING (FGM)"

"Female Genital Mutilation (FGM)" is widely used in global advocacy to emphasise that the practice causes harm and violates girls' and women's rights. However, the term "mutilation" can be viewed as a value judgement and may not accurately describe "milder" practices.

"Female Genital Cutting (FGC)" is a more neutral, descriptive term that refers to any form of cutting of female genital tissue. In Malaysia, where the common practice involves nicking or pricking the clitoral prepuce with no visible anatomical change, the FGC is a more accurate term than FGM or "circumcision." Still, the choice of terminology affects how seriously the practice is perceived, and using softer terms can risk downplaying its potential harm.

For this document, we will use **"FGC."**

More on terminology here: *Empowering Healthcare Professionals* leaflet.

2.1 PREVALENCE OF FGC

Across Malaysia, all available academic research consistently demonstrates that female genital cutting (FGC) (also known as female circumcision, or *sunat perempuan*) is near universal among Malay Muslim women and girls, with prevalence estimated at approximately 93%, based on multiple peer-reviewed studies conducted over the last 25 years. These include early foundational work by Ab Ghani (1995), which documented widespread cutting among Malay communities and the Kelantan-based prevalence study by Isa, Shuib & Othman (1999), which found extremely high, near universal cutting among Malay Muslim women.

The strongest clinical data comes from Rashid, Iguchi & Afiqah (2020), a mixed-methods study published in PLOS Medicine, which found that 99.3% of Malay Muslim infants, some as young as one to two months old, had undergone Type 4 FGC, with a median age of six years among older participants, and documented that medicalisation has led some practitioners to perform more invasive Type 1 cutting of the clitoral prepuce or clitoral tissue itself. Additional early indications of clinical involvement were noted in a conference abstract by Dahlui, Wong, and Choo (2012), presented at the International Congress of Behavioral Medicine, which reported increasing involvement of healthcare providers in performing FGC. However, because only an abstract was published (***International Journal of Behavioral Medicine*** 2012, 19 [suppl. 1]: S7), this source lacks methodological detail and should not be interpreted as a full empirical study.

"Ending FGC in Malaysia requires more than presenting medical evidence. The practice is deeply connected to religious belief, cultural continuity, and family expectations, and is often perceived as a harmless or even protective tradition."

While academic studies provide the primary evidence base, NGO syntheses such as the ***Orchid Project Country Profile: Malaysia*** (2024) estimate that at least 93% of Malay Muslim women and girls—over 7.5 million individuals—have undergone FGC, based on census extrapolation, and the *FGM/C Report Malaysia* (2025) estimates national prevalence at 53–60% when adjusting for Malaysia's multi-ethnic demographic composition. Both reports confirm entrenched social norms, strong religious reinforcement, and increasing medicalisation as key sustaining factors.

Regarding non-Malay communities, the *FGM/C Report Malaysia* (2025) provides the only available insight, drawn from qualitative fieldwork. Among Orang Asli communities, participants reported that female circumcision is generally not practiced, with most having never encountered the practice; however, the report documents that some Muslim-convert Orang Asli women do undergo FGC, adopting it as part of Islamic identity following conversion. The report emphasises that no formal research exists on the prevalence or nature of FGC among Orang Asli or other Indigenous groups in Peninsular Malaysia, Sabah, or Sarawak, and that all available information is anecdotal rather than prevalence-based.

A significant data gap persists regarding this practice among Malaysia's migrant communities, largely originating from Indonesia, Bangladesh, Myanmar, Nepal, and smaller Asian countries such as India, Cambodia, and Lao PDR. As of July 2023, these groups made up about 8.9% of Malaysia's 33.4 million population. By November 2023, UNHCR had registered approximately 182,820 refugees and asylum seekers in Malaysia, 88% of whom were from Myanmar. The Rohingya alone accounted for 58% (about 107,520 people), with others coming from countries including Pakistan, Yemen, Syria, Somalia, Afghanistan, Iraq, and Sri Lanka. However, data on FGM/C within these populations remain unavailable.

Taken together, the academic and NGO evidence consistently shows that FGC in Malaysia is predominantly concentrated among Malay Muslims, overwhelmingly performed in infancy, increasingly medicalised, and socially reinforced across generations, while Indigenous involvement is minimal, conversion-linked, and insufficiently studied to establish prevalence. No data is available for migrant communities.

2.2 CHALLENGES OF ENDING FGC IN MALAYSIA

Ending FGC in Malaysia requires more than presenting medical evidence. The practice is deeply connected to religious belief, cultural continuity, and family expectations, and is often perceived as a harmless or even protective tradition. Efforts to question or discourage the practice are sometimes interpreted as foreign interference, particularly when global data or advocacy messages are used without any Malaysian context. These sensitivities mean that change depends on careful, respectful communication that acknowledges community beliefs while presenting accurate evidence about the risks of cutting. Strong, locally grounded information is essential to building trust and supporting meaningful dialogue.

2.3 HARMS ASSOCIATED WITH FGC IN MALAYSIA

FGC has no health or medical benefits, and all clinical, anatomical, and human rights evidence confirms that it can cause immediate and long-term harm even in its least invasive forms. In Malaysia, the practice is primarily classified as Type 4 (pricking, scraping, piercing), but medicalisation has introduced Type 1 cutting of the clitoral prepuce and, in some cases, visible clitoral tissue (Rashid et al., 2020). Harms must therefore be understood across three evidence categories: (1) documented clinical and practitioner-reported harms, (2) biological plausibility of harm, and (3) limitations of existing research, particularly Malaysia's lack of outcome studies.

Documented Evidence of Harm and Clinical Risk in Malaysia. Malaysian practitioner data demonstrate that Type 4 is far from benign. The *Empowering Healthcare Professionals* leaflet reports that 86.7% of doctors do not use anaesthetics, 62.7% do not screen for bleeding or infectious disorders, and 69.3% observe bleeding after the procedure—showing that even so-called "symbolic" cutting routinely injures tissue. Alarmingly, 36% of the 20.5% of doctors who perform FGC use surgical scissors to cut visible clitoral tissue, constituting Type 1 FGC, which global research has shown can lead to neuroma formation, scar tissue, altered sensation, and long-term sexual dysfunction. A 2018 audit by the Ministry of Health (MOH) concluded that FGC offers no medical benefit and may result in significant harm, citing a case where a baby's clitoris was lost during the procedure. These data confirm that the Malaysian practice includes forms with established harm pathways, and not mere superficial pricking.

Biological Plausibility of Harm. Anatomical evidence further explains why even apparently minor lacerations may result in enduring harm. In infants, the clitoral prepuce lies only a few millimetres from dense neurovascular bundles. Retraction of the clitoral hood is especially challenging at this age because the tissue is highly adherent, which substantially increases the risk of excessive cutting or inadvertent removal of developing tissue. Given this anatomical configuration, even a superficial incision or abrasion can reasonably be expected to damage neurovascular structures, lead to scarring, interfere with sensory development, or affect sexual function later in life. These mechanisms are well recognised in medical literature and offer a strong biological basis for anticipating harm, even in the absence of longitudinal studies specific to Malaysia.

Interpreting the Isa, Shuib & Othman (1999) Findings. Malaysia's only published study that attempted to assess long-term obstetric outcomes, Isa, Shuib & Othman (1999), conducted among Malay women in Kelantan, reported no obstetric complications attributable to FGC in their sample. While this is the only available long-term Malaysian study and is frequently cited, its findings must be interpreted with considerable caution.

- **First,** the study examined women who had undergone traditional Kelantanese Type 4 cutting, not the medicalised Type 1 procedures now increasingly documented in clinical settings. The study, therefore, does not capture harms associated with more invasive clinical techniques documented in recent research.
- **Second, t**he study relied entirely on self-reported interviews, not clinical gynaecological assessment, pelvic examination, or medical record verification.

This means it could not detect subtle anatomical changes, scar tissue, neuroma formation, sensory loss, or psychosexual dysfunction.

- **Third,** most Malaysian girls today undergo FGC in infancy, and women cut at that age cannot compare their sexual sensation, physiological responses, or comfort levels to an uncut baseline. Lifelong reduced sensation or sexual difficulty may therefore go unrecognised and unreported. However, personal communication with the author of this toolkit (Dr Hannah Nazri) indicates that Malaysian women who were cut at ages 5 to 9, especially those cut 30–40 years ago, clearly remember the procedure as extremely painful and traumatising. This reinforces that when the procedure is performed at an age where memory is intact, the experience is neither mild nor inconsequential—and that earlier infant cutting merely removes the child's ability to remember or describe the pain.
- **Fourth,** strong cultural stigma surrounding discussion of vulvas, sexual health, pain during intercourse, and women's pleasure further suppresses disclosure. Many women may lack the language, cultural permission, or clinical opportunity to report sexual or psychological consequences, even when present.

For these reasons, the "no complications" findings from Isa, Shuib & Othman (1999) should be understood as reflecting the limitations of its methodology and cultural context, rather than as evidence that Malaysian FGC, whether Type 4 or increasingly medicalised Type 1, is harmless. Instead of demonstrating safety, the study highlights a longstanding evidentiary gap: the lack of robust clinical outcome research in Malaysia examining the physical, sexual, and psychological effects of FGC across the lifespan.

Global Evidence and Interpretation in the Malaysian Context. The *FGM/C Report Malaysia* (2025) recognises FGC as an irreversible, medically unnecessary violation of SRHR and notes that the short- and long-term consequences of Malaysian Type 4 practices remain unreported. However, its Executive Summary stated that FGC causes more deaths than HIV/AIDS, measles, and meningitis without explaining that these figures come exclusively from 15 African countries where Types 2–3 (including excision and infibulation) predominate. Without this clarification, readers may inadvertently assume that such mortality patterns apply to Malaysia, where Type 4 is overwhelmingly practised. Providing clearer type- and context-specific distinctions would enhance analytical accuracy and support evidence-based discourse.

CONCLUSION

Across Malaysian practitioner surveys, anatomical evidence, and global research, it is clear that FGC, whether symbolic Type 4 or increasingly medicalised Type 1, poses real and avoidable risks. Immediate harms include pain, bleeding, and infection; while biological mechanisms and emerging clinical evidence suggest plausible long-term impacts on sexual function, sensory development, and psychological well-being. Malaysia's absence of longitudinal outcome studies signals a **research gap**, not a demonstration of safety. Applying the precautionary principle, it is evident that FGC is medically unjustified and incompatible with the rights and well-being of children.

Ensuring accuracy when communicating health harms is essential for effective advocacy. Overstating or misrepresenting evidence, particularly by applying severe global data from African Type 2–3 contexts to Malaysia's

predominantly Type 4 setting, can undermine trust among communities, healthcare providers, and religious stakeholders. In the Malaysian context, where FGC is closely tied to religious identity and cultural continuity, incorrect or exaggerated claims risk reinforcing perceptions that anti-FGC efforts are driven by Western agendas that aim to curb or erase local practices. Presenting harms based on credible Malaysian data, anatomical evidence, and well-established biological mechanisms, therefore, strengthens the case for ending FGC and ensures that advocacy remains grounded, respectful, and not easily dismissed.

"The minimal-harm narrative rests on a limited understanding of infant female genital anatomy and overlooks the ethical and human-rights implications of cutting a non-consenting child. By defining Malaysian FGC as harmless or "not African," communities unintentionally perpetuate a practice whose risks are understated and culturally obscured."

2.4 DRIVERS OF FGC IN MALAYSIA

FGC in Malaysia persists through a cohesive system of cultural continuity, religious perception, family expectation, medicalisation, limited sexual-health literacy, and regulatory ambiguity. When academic research from 2009, 2019, 2020, and 2024 is considered alongside NGO and policy reports, a consistent picture emerges: FGC continues not because of medical need or explicit religious doctrine, but because it is deeply embedded in social, cultural, and institutional structures.

Across Malay-Muslim communities, FGC is widely perceived as a **customary and expected practice**. The *FGM/C Report Malaysia* (2025) notes that participants described FGC as something "we all go through" and "part of our culture," reflecting strong social normalisation. Academic studies consistently show this: Rashid et al. (2009) found that women viewed FGC as a routine tradition; Suhaimi et al. (2024) reported that parents saw it as a "custom" tied to identity; and Nik Mat et al. (2024) showed that women associated FGC with proper upbringing and femininity. This cultural legitimacy is reinforced by the argument—common across Asia—that Malaysian FGC is merely "symbolic" or "minimal" and fundamentally different from "FGM in Africa." For years, global advocacy focused mostly on Africa, which allowed Asian communities to distance their practices from the more severe Types 2–3 and to frame Malaysian FGC as harmless. Yet the minimal-harm narrative rests on a limited understanding of infant female genital anatomy and overlooks the ethical and human-rights implications of cutting a non-consenting child. By defining Malaysian FGC as harmless or "not African," communities unintentionally perpetuate a practice whose risks are understated and culturally obscured.

Religious perception forms one of the strongest motivations. The 2009 National Fatwa, though not legislatively binding, has significantly shaped public belief by stating that FGC is obligatory unless harmful. This belief is empirically documented in the BMJ Open mixed-methods study where 87.6% of women believed FGC to be compulsory in Islam and 99.3% wanted it to continue. Suhaimi et al. (2024) found similar perceptions among parents in East Coast Malaysia, who frequently cited Islam as the main reason for cutting their daughters, even when unable to articulate the religious

source. Nik Mat et al. (2024) likewise identified religious identity and moral womanhood as core justifications. Across all studies, religious belief operates as a socially inherited expectation rather than a doctrinally grounded requirement.

Misconceptions about **hygiene and bodily cleanliness** strengthen these religious and cultural motivations. Many parents believe that removing a small piece of tissue promotes cleanliness or protects against infection. Academic studies consistently record this belief: Rashid et al. (2009) reported hygiene as a common justification; Rashid et al. (2019) found similar beliefs across two northern states, and Suhaimi et al. (2024) documented that parents thought FGC "cleans" the child or "completes" her development. These findings are mirrored in NGO reports and reflect enduring anatomical misunderstandings.

Family expectation and intergenerational pressure further sustain the practice. Rashid et al. (2009) showed that elder female relatives, especially grandmothers, function as gatekeepers of FGC tradition, determining whether daughters are cut. Suhaimi et al. (2024) found nearly identical patterns: many parents reported undergoing FGC "because our mothers asked us to" or to maintain family harmony. Nik Mat et al. (2024) similarly noted that social expectations around modesty, decency, and moral upbringing place strong pressure on parents to continue FGC. Across academic and NGO sources, refusing FGC risks social judgement or accusations of deviating from community norms.

Medicalisation now plays a central role in modern life. Families increasingly prefer clinic-based cutting, viewing it as cleaner, safer, and more "modern." Suhaimi et al. (2024) found that many parents deliberately sought out clinics for FGC, believing that healthcare workers would perform it "properly." The BMJ Open study showed that younger mothers overwhelmingly preferred medical practitioners, a trend confirmed by clinical research. Yet medicalisation does not ensure safety; the PLOS Medicine study documented that some Malaysian doctors perform Type 1 cutting, including removal of clitoral prepuce or visible clitoral tissue—contradicting the common belief that medicalised FGC is only symbolic. Medicalisation, thus, reinforces legitimacy while simultaneously increasing the potential for harm.

Limited sexual-health literacy and stigma further fuels continuation. Many parents do not know what anatomical structures are cut, and discussions about vulvas, sexual function, and long-term outcomes remain culturally taboo. Suhaimi et al. (2024) found that parents often could not describe the procedure or identify the tissue involved. Nik Mat et al. (2024) similarly noted low awareness of anatomy and sexual-health consequences among Malay-Muslim women. Unfortunately, many doctors who admitted to performing FGC were also not familiar with vulval anatomy. These gaps allow FGC to be perceived as harmless and unproblematic, reducing the likelihood that communities recognise or report complications.

Finally, the **absence of a clear national policy or legislative position** creates an enabling environment in which cultural and religious norms can operate unchecked. FGC is neither prohibited nor monitored, and it is not consistently guided by the health system. This ambiguity, documented in the ***Law and FGC Malaysia*** (2024) and current policy briefs, indirectly sustains the practice by preserving the status quo.

CHAPTER 3

LEGAL, POLICY, AND INSTITUTIONAL FRAMEWORKS ON FGC IN MALAYSIA

OVERVIEW:

This chapter maps the fragmented and often misunderstood legal landscape surrounding FGC in Malaysia. Although the practice is widely viewed as culturally sanctioned and religiously supported, Malaysian law neither authorises nor explicitly regulates it. Instead, perceptions of legality arise from statutory silence, longstanding tradition, and the non-binding nature of fatwas. The chapter clarifies how constitutional protections, criminal law, child-protection statutes, medical ethics, and Sharia governance intersect—and sometimes conflict—to shape the current policy environment. It draws in part on Orchid Project's *The Law and FGC: Malaysia* (2024), extending and contextualising that foundation within Malaysia's broader constitutional, statutory, and regulatory framework.

3.1 THE FEDERAL CONSTITUTIONAL FRAMEWORK

The Constitution of Malaysia establishes the foundational rights that should, in principle, protect children from non-consensual bodily injury.

- **Article 5** guarantees the right to life and personal liberty, which Malaysian jurisprudence interprets broadly to include dignity, bodily integrity, and security against harm. When a child is subjected to genital cutting, a non-therapeutic procedure that causes pain and carries risk, this right is implicated because the child cannot provide consent and the act does not enhance health or quality of life.
- **Article 8** reinforces this protection by establishing equality before the law and prohibiting discrimination. Because FGC is performed exclusively on girls, it raises concerns of gender-based discrimination and unequal protection, particularly when the act has no medical justification.
- **Article 10,** which protects freedom of expression, is relevant to the advocacy environment; it ensures that civil society, medical professionals, and community groups cannot be legally silenced for speaking about FGC, its harms, or the need for reform. Similarly, Article 11 protects freedom of religion, but within limits: while families may practice their faith, they cannot invoke religion to justify practices that violate federal law or endanger a child's physical well-being. Importantly, FGC is not mandated by any scriptural source and is performed largely out of tradition, perception, and communal expectation rather than religious obligation.

The constitutional provision with the greatest practical significance is **Article 75, which establishes federal supremacy.** Under this provision, any conflict between state-level religious regulations—including fatwas—and federal law must be resolved in favour of federal law. This means that no fatwa, even if gazetted, can supersede the Penal Code, the Child Act, or constitutional rights. As a result, the religious permissibility commonly associated with FGC does not translate into legal permissibility, and federal child-protection and criminal laws retain primacy.

3.2 THE PENAL CODE (ACT 574)

Although the Penal Code does not explicitly mention FGC, several provisions clearly encompass the act within the broader category of bodily harm.

- **Sections 319 to 322 define "hurt" as any act that causes bodily pain, injury, or bleeding, whereas "grievous hurt" refers to more serious injuries. Even procedures described as "just a prick" fall within the definition of hurt because they involve penetrating or injuring tissue.**
- When instruments such as scissors, blades, or needles are used, **sections 326 and 326A**—which address the use of dangerous weapons—may also be relevant.
- Liability is not limited to the practitioner alone. **Sections 109 to 116**, which govern abetment and instigation, apply to parents, guardians, and others who procure or assist in the act. Theoretically, these provisions collectively create a prosecutorial path for FGC, particularly when the procedure results in bleeding, requires instruments, or is performed by a medical professional acting outside the scope of ethical practice.

Despite clear legal routes, several barriers reduce the likelihood of successful prosecution. One challenge is the requirement to demonstrate intent or knowledge of causing harm, although such intent may be inferred when an adult authorises or performs an invasive procedure on a child.

Another challenge is **Section 95**, which provides a defence for "acts causing slight harm." In cultural contexts where FGC is considered minor, this defence may be invoked even though medical evidence shows that even superficial cutting can cause significant physical and psychological injury.

The most significant barriers arise from social silence, the absence of reporting, and the lack of medical documentation. Despite these barriers, the Penal Code remains an underutilised but potentially powerful legal tool.

3.3 THE CHILD ACT 2001 (ACT 611)

The Child Act is the strongest statutory protection available to Malaysian children.

- **Section 17** classifies a child as being in need of protection if they are at risk of physical or emotional injury. FGC, by its nature, exposes a child to both forms of harm.
- **Section 18** allows the court to issue protection orders to prevent ongoing or future acts that endanger a child, providing a direct mechanism to prevent FGC in households or communities.
- **Section 31** is particularly relevant, as it criminalises ill-treatment, neglect, exposure, or abandonment of a child. Causing non-therapeutic injury to a child—including genital injury—constitutes a violation of this provision.
- **Sections 116 and 118–119** establish duties for professionals to report suspected harm and maintain records. While these sections do not explicitly name FGC, they provide the structural basis for documenting and referring cases.

The main weakness in the Child Act is that FGC is not explicitly identified as a harmful traditional practice, resulting in limited awareness among enforcement agencies and frontline professionals. Yet from a legal standpoint, the Act clearly offers a basis for intervention and criminal liability.

3.4 MEDICAL REGULATION: THE MEDICAL ACT AND THE MALAYSIAN MEDICAL COUNCIL CODE OF CONDUCT

The Medical Act 1971 empowers the Malaysian Medical Council (MMC) to regulate medical practitioners and enforce ethical standards. The MMC Code of Professional Conduct outlines duties incompatible with performing FGC. These include the obligation to avoid unnecessary procedures, to act in patients' best interests, to prevent harm, and to obtain valid informed consent.

Because FGC has no medical benefit and exposes a child to injury, any doctor who performs it acts outside the boundaries of accepted medical practice. This constitutes professional misconduct and may lead to disciplinary action ranging from censure to suspension or removal from the medical register. The fact that some clinicians perform more invasive procedures—sometimes classified as Type 1 FGC—without anaesthesia or adequate screening further strengthens the argument that FGC violates ethical and professional standards.

However, regulatory gaps persist. No explicit MMC directive currently prohibits the procedure, and the MOH has not issued binding regulations applicable throughout the private healthcare sector. This absence of a clear policy allows some practitioners to continue performing FGC, often under the guise of cultural accommodation or parental request.

3.5 SHARIA LAW, RELIGIOUS AUTHORITIES, AND THE FATWA SYSTEM

Malaysia's dual legal system often causes public confusion about the authority of Sharia rulings in matters affecting children's health and bodily integrity. Fatwas issued by the National Fatwa Council or state muftis are not automatically binding law. They acquire legal force only when gazetted at the state level, and even then, they cannot supersede federal criminal or constitutional law under Article 75 of the Federal Constitution.

The **2009 National Fatwa** declaring female circumcision "*wajib* (obligatory) unless harmful" has strongly shaped community perception(s), even though it is not a statute and carries no criminal authority. Importantly, this fatwa is not the only Islamic position in Malaysia. The Perlis Mufti Department has clarified that female circumcision should be considered only when there is a genuine medical need and after consultation with qualified experts. It also emphasises that there is no evidence that uncircumcised women face any religious disadvantage. These differing views illustrate that Islamic interpretations on this issue are not uniform.

Regardless of these religious perspectives, fatwas do not override federal law. Sharia courts, which handle matters of family law and Islamic conduct, do not have criminal jurisdiction over acts involving physical injury unless explicitly provided for in state enactments. No state Sharia code in Malaysia legislates FGC as a punishable or permitted procedure, and no fatwa grants legal immunity to practitioners or parents. Federal child-protection and criminal laws, therefore, remain fully applicable.

RELIGIOUS PERSPECTIVE OF FGC

Maqasid al-Sharia

The primary objective of Sharia (maqasid al-sharia) is to safeguard human welfare and uphold the rights and dignity of all individuals. These higher objectives, considered essential to Islamic jurisprudence, are described as protecting:

- Religion *(din)*
- Life *(nafs)*
- Intellect *(aql)*
- Progeny *(nasl)*
- Wealth *(mal)*

Therefore, Islamic rulings must align with these foundational aims, and any action considered "religious" must be rooted in the Qur'an, authentic Sunnah, or established scholarly principles *(ijma' and qiyas)*.

In the context of FGC:

- The Qur'an does not mention female circumcision, instead explicitly warns against causing harm or altering the natural body without justification.
- *Hadith* evidence is weak, especially the commonly cited narration of *Umm Atiyyah*, which scholars have deemed unreliable.
- Because the practice can cause pain or harm and lacks clear scriptural support, FGC does not fulfil the *maqasid*, particularly the objectives of protecting life, intellect, and progeny.

The broader message is that Islamic principles prioritise the prevention of harm (darar) and the preservation of bodily integrity and thus do not provide a theological basis for FGC.

More on religious perspectives here: *Empowering Healthcare Professionals* leaflet.

3.6 LEGAL GAPS, CONTRADICTIONS, AND OPPORTUNITIES FOR REFORM

Although Malaysia's legal framework already protects children from non-therapeutic injury, FGC remains largely unaddressed in practice because these protections are rarely applied to the procedure. The main issue is not the absence of law, but the lack of explicit guidance, coordinated enforcement, and institutional clarity.

The most significant gap is the silence of federal statutes on FGC. This allows the practice to be perceived as acceptable, especially when communities rely on cultural tradition or treat fatwas as equivalent to law. As a result, legal protections that should apply—including those in the **Penal Code**, **Child Act**, and **medical regulations**—are often overlooked.

Operational inconsistencies further weaken protection. Child-protection teams do not routinely assess FGC as a form of harm, enforcement agencies lack protocols for applying criminal law to the practice, and some private clinicians continue performing it despite clear ethical duties. Without a reporting mechanism or data collection, the practice remains effectively invisible within health and welfare systems.

These gaps present straightforward opportunities for reform. Federal agencies can clarify how existing laws apply to FGC, issue binding professional standards, and introduce

targeted amendments if necessary. Because Article 75 establishes federal supremacy, such reforms can proceed without challenging religious authorities or engaging in theological disputes.

Prosecutability and Practical Enforcement. FGC is already prosecutable under current law, but enforcement is hindered by cultural normalisation, limited reporting, and the practical difficulty of documenting injuries inflicted in infancy. The lack of institutional guidance leads to inconsistent interpretation and a cycle in which silence is mistaken for legality. Addressing these procedural barriers—rather than rewriting statutes—is key to enabling enforcement.

Legal Advocacy Messaging. Advocacy should emphasise legal clarity and child protection, not cultural criticism. Key messages include FGC is not mandated by law; non-therapeutic injury to children is prohibited; medical professionals must not perform unnecessary procedures; and federal law prevails over conflicting religious opinion. This framing supports policymakers and practitioners by reinforcing existing legal obligations.

Federal Supremacy and Implications for Policy
A critical feature of Malaysia's legal architecture is Article 75, which gives federal law precedence over state-level religious enactments. This principle has direct and immediate implications for FGC policy. It means that federal child-protection statutes, medical regulations, and public-health directives automatically override contradictory fatwas or state Islamic rulings.

This constitutional structure allows the MOH, the MMC, and Parliament to act decisively and consistently. Federal leadership can standardise guidance for clinicians, ensure coherence across state jurisdictions, and align domestic law with Malaysia's international obligations under the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) and the Convention on the Rights of the Child (CRC).

3.7 STRUCTURAL BARRIERS TO LEGAL REFORM: LIMITED ENGAGEMENT BETWEEN GOVERNMENT BODIES AND CIVIL SOCIETY

A major impediment to legal progress on FGC in Malaysia is the persistent lack of meaningful engagement between government institutions, CSOs, frontline practitioners, and independent experts. Key agencies with mandates relevant to FGC—including the Legal Affairs Division (BHEUU), Attorney General's Chambers (AGC), Ministry of Women, Family and Community Development (KPWKM), Department of Social Welfare (JKM), and the Department of Islamic Development Malaysia (JAKIM)—tend to operate within highly centralised and insular policymaking processes. As a result, opportunities for transparent, substantive consultation remain limited.

Although numerous CSOs, medical professionals, and academic researchers possess significant expertise on the medical, ethical, and rights-related dimensions of FGC, their involvement in legal and policy discussions is often constrained to tokenistic or perfunctory engagements. In many instances, dialogues take the form of briefings rather than genuine consultations, with channels of input tightly controlled or selectively directed toward groups that reinforce existing positions. This dynamic creates an echo chamber in government deliberations, in which inaccurate assumptions—such as the belief that Malaysian FGC is harmless, uniformly symbolic, or culturally mandated—circulate unchallenged.

The absence of structured, institutionalised mechanisms for evidence-based consultation weakens the policymaking process. Without the perspectives of clinicians, legal scholars, anthropologists, ethicists, child-protection specialists, and survivor advocates, legal reforms risk being shaped by incomplete or outdated understandings of FGC. This has implications not only for the adequacy of any eventual legal provisions but also for Malaysia's broader obligations under international human rights standards, which emphasise participatory, rights-based approaches to lawmaking affecting women and children.

The structural disconnect between government agencies and civil society ultimately hampers the development of coherent, rights-aligned legal approaches to FGC. Addressing this gap requires more than ad hoc engagement; it necessitates formalised consultation pathways, transparent decision-making processes, and a recognition that effective legal reform must be grounded in multidisciplinary evidence and community realities. Without such measures, the prospects for meaningful legislative progress remain limited.

To ground the subsequent legal analysis in a systematic and evidence-based framework, this report employs a **Legal Options Matrix** that maps the relevant statutory, regulatory, and institutional touchpoints associated with FGC in Malaysia. The matrix, presented in **Section 7.4**, consolidates provisions from criminal law, child-protection legislation, medical and professional regulatory frameworks, and religious governance structures. By aligning these sources in a single analytical tool, the matrix clarifies gaps, overlaps, and areas of ambiguity within Malaysia's current legal landscape.

*Without the **perspectives of clinicians, legal scholars, anthropologists, ethicists, child-protection specialists, and survivor advocates**, legal reforms risk being shaped by incomplete or outdated understandings of FGC.*

CHAPTER 4

INTERNATIONAL HUMAN RIGHTS FRAMEWORK

OVERVIEW:

This chapter situates Malaysia's ongoing practice of FGC within its international human rights obligations and the global medical-ethics standards that guide state responsibility. While FGC is often framed domestically as a cultural or religious practice, Malaysia's treaty commitments require the government to prevent harmful practices, protect children from unnecessary medical procedures, and regulate healthcare providers who perform non-therapeutic interventions on minors.

4.1 MALAYSIA'S INTERNATIONAL TREATY OBLIGATIONS: CEDAW AND CRC

Malaysia is a State Party to both the **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)** and the **Convention on the Rights of the Child (CRC)**. These treaties impose clear duties to protect women and girls from harmful practices, including those justified by culture, tradition, or religion, and to regulate the role of medical professionals in perpetuating such practices.

Together, these treaties create a clear obligation: Malaysia must ensure that FGC is prevented, regulated, and ultimately eliminated, including within medical settings.

CEDAW obligates Malaysia to eliminate discrimination against women, including gender-based violence and harmful traditional practices. FGC, which targets girls exclusively, directly engages Articles 2 (elimination of discrimination), 5 (modifying cultural and social patterns), and 12 (healthcare). The CEDAW Committee has repeatedly affirmed that FGC violates women's and girls' rights to health, bodily integrity, equality, and freedom from violence.

The **CRC** requires states to protect children from all forms of physical or mental violence, injury, or harmful traditional practices (Articles 19 and 24). The Committee on the Rights of the Child has consistently held that all forms of FGC—including minimal cutting—violate the state's duty to safeguard children's health, dignity, and bodily integrity.

4.2 JOINT GENERAL RECOMMENDATION NO. 31 / GENERAL COMMENT NO. 18: OPERATIONAL CRITERIA FOR HARMFUL PRACTICES

The CEDAW and CRC Committees' joint guidance establishes four criteria to identify a harmful practice:

1. **It is traditional, customary, or culturally embedded.** FGC is widely practised among Malay Muslim communities, often justified through tradition, modesty, and perceived religious obligation.
2. **It is socially prescribed or expected.** Many families believe FGC is necessary for social acceptance or for a girl's identity.

3. **It has no medical benefit and causes harm.** Even minimal cutting entails pain, bleeding, risk of infection, and long-term sexual and psychological consequences.
4. **The victim is unable to give full, free, informed consent.** FGC in Malaysia is almost exclusively performed on infants and young children.

Under these criteria, Malaysia has a treaty-based obligation to treat FGC—regardless of type—as a harmful practice requiring legal, medical, and social intervention.

4.3 SDG 5.3: GLOBAL DEVELOPMENT COMMITMENTS

Sustainable Development Goal 5.3 commits states to eliminate all harmful practices, including FGC, by 2030. Malaysia regularly reports progress toward the SDGs but has not yet explicitly addressed FGC in its national indicators. Clarifying the state's position, reporting on prevalence, and integrating FGC into gender-equality and child-protection strategies would strengthen Malaysia's alignment with the SDGs and its international standing.

4.4 MALAYSIA'S RECENT ENGAGEMENT WITH UN BODIES

2021 Government Response to CEDAW. Malaysia's formal reply emphasised that FGC in Malaysia is "minor," "harmless," and "culturally specific." This assertion conflicts with WHO evidence, international medical consensus, and the harmful-practices criteria under Joint GR31/18.

2024 CEDAW Concluding Observations. The Committee:

- reiterated concerns about high prevalence and widespread medicalisation,
- rejected the "harmless" framing,
- urged Malaysia to prohibit all forms of FGC,
- called for national guidelines for healthcare workers,
- demanded the withdrawal of religious or cultural justifications, and
- recommended data collection, public education, and professional training.

These observations provide clear direction for policy reform.

Opportunities for Engagement. Malaysia can strengthen compliance and demonstrate leadership by:

- submitting strong shadow reports through civil society;
- using Universal Periodic Review (UPR) processes to highlight reforms;
- collaborating with UNFPA, UNICEF, and WHO on national guidance;
- engaging with Special Rapporteurs on Health, Violence Against Women, and Cultural Rights.

These mechanisms provide avenues for technical support, international legitimacy, and increased policy coherence.

CHAPTER 5
MEDICALISATION AND CLINICAL ETHICS

OVERVIEW:
This chapter examines the growing trend of medicalisation of FGC in Malaysia and its implications for ethics, child protection, and health-system governance. Although some families perceive clinical settings as safer, the involvement of healthcare professionals does not reduce the harm of FGC; instead, it introduces new ethical, regulatory, and professional challenges.

5.1 MEDICALISATION FGC IN MALAYSIA

The World Health Organization defines medicalisation of female genital mutilation as:

"…situations in which FGM is practised by any category of health-care provider, whether in a public or a private clinic, at home or elsewhere. It also includes the procedure of reinfibulation at any point in a woman's life."

In Malaysia, this shift into clinical environments has become increasingly visible. Yet the involvement of healthcare professionals does not neutralise the concerns associated with the practice; instead it raises distinct ethical and governance issues that the health system must address.

5.2 MEDICAL ETHICS AND INFORMED CONSENT

Foremost, medicalisation brings FGC into direct conflict with core principles of medical ethics. The **principle of autonomy** cannot be upheld when the procedure is carried out on infants and young children who are incapable of consent, and parental authorisation is ethically insufficient in the absence of medical benefit. **Beneficence is unmet** because FGC offers no therapeutic value, while **non-maleficence is compromised** by performing a non-indicated genital procedure on a child. The **principle of justice** is similarly challenged, as FGC is applied exclusively to girls and thereby reinforces gender-based inequity within a healthcare system committed to non-discrimination.

These ethical tensions are deepened by the lack of clear professional guidance. FGC is not explicitly addressed through binding national standards or clinical protocols, leaving practitioners to rely on personal beliefs, informal training, or community expectations rather than uniform professional norms. The absence of structured training means that the practice may be carried out without adequate grounding in anatomy, ethics, or rights-based approaches to paediatric care. This regulatory ambiguity creates inconsistent practice patterns and exposes both patients and providers to ethical and professional vulnerabilities.

Medicalisation also shapes parental perceptions in ways that complicate informed decision-making. When a procedure is offered or even quietly tolerated in a clinical setting, families may assume it is medically permissible or safe. This can obscure the reality that FGC has no clinical indication and contributes to the erosion of trust in the health system's ability to offer evidence-based, unbiased guidance. At the same time,

healthcare providers may face pressure from their own communities or patients to perform the procedure, creating a tension between professional obligations and social expectations.

Finally, framing FGC as acceptable when performed "symbolically" or in a sterile environment does not resolve its ethical implications. Medicalisation alters the presentation of the practice but not its underlying nature: it remains a non-therapeutic genital intervention on a child who cannot consent. As such, it cannot be ethically justified within contemporary standards of clinical care, paediatric rights, and professional governance.

These ethical and governance concerns place medicalised FGC at the intersection of health policy and legal accountability. A clear legal framework is therefore essential to provide national direction, protect children's rights, and ensure consistent professional standards.

5.3 INTERNATIONAL MEDICAL POSITION ON FGC

Global medical authorities are unanimous in their assessment of FGC: all forms of the practice, including pricking or nicking (Type 4), constitute a violation of medical ethics, a breach of patient rights, and an unacceptable harm to children and women. These bodies also condemn the medicalisation of FGC.

THE OBSTETRICAL & GYNAECOLOGICAL SOCIETY OF MALAYSIA WEBINAR ON FGM/C

22 May 2025

The Obstetrical and Gynaecological Society of Malaysia (OGSM), founded in the 1960s, is the country's leading professional body for specialists and trainees in women's health. The Society advances excellence in obstetrics and gynaecology through education, training, research, and scientific meetings, while also contributing to national policy development and promoting the well-being of women, girls, and newborns. Through strong regional and international partnerships, OGSM ensures that Malaysian practitioners remain aligned with global best practices in women's healthcare.

During this landmark webinar, OGSM formally clarified its position on FGC and its medicalisation, stating unequivocally that it does not support FGC or its medicalisation in any form. The session also created a platform for members to learn directly from leading FGC experts, including the author (Dr Hannah Nazri). With more than 100 obstetricians and gynaecologists in attendance, this event marks the **first time a Malaysian medical professional body has taken an open, public stance against FGC.**

This represents a significant institutional shift, closing an important gap identified in previous research regarding the absence of clear, unified professional guidance on FGC.

WORLD HEALTH ORGANIZATION (WHO)

WHO is the leading global health authority on FGC and takes an unequivocal position:

- FGC has no health benefits and causes immediate and long-term harm.
- Medicalisation is never acceptable, even when intended to reduce risk.
- Healthcare providers must refuse to perform FGC in all circumstances.
- WHO emphasises that even "minor" procedures such as pricking are still forms of FGC and constitute injury.
- WHO warns that medicalisation legitimises the practice, entrenches social norms, and undermines elimination efforts.

WHO's guidance forms the global standard for health systems, ministries, clinicians, and educators.

TABLE 1: INTERNATIONAL MEDICAL BODIES' POSITIONS OF FGC

FIGO (International Federation of Gynecology and Obstetrics)

FIGO represents national obstetrics and gynaecology societies from more than 130 countries and provides the strongest professional prohibition:

- Absolutely condemns all forms of FGC, including symbolic or "mild" forms.
- States that no obstetrician or gynaecologist should ever perform FGC, regardless of parental request or cultural justification.
- Declares that medicalisation is unethical, harmful, and incompatible with modern gynaecology.
- Requires clinicians to counsel families against the practice.
- Encourages national societies to adopt strict disciplinary positions.

FIGO's position places a professional duty on clinicians to actively prevent, not merely refuse, FGC.

RCOG (Royal College of Obstetricians and Gynaecologists – United Kingdom)

The RCOG provides detailed clinical guidance that is widely used internationally, including in Southeast Asia:

- Zero-tolerance for all forms of FGC.
- Strong condemnation of medicalisation; clinicians must not participate under any circumstances.
- Requires healthcare providers to:
  - > refuse to perform FGC,
  - > document and report cases (in jurisdictions where mandatory),
  - > provide safeguarding interventions for at-risk girls.
- Stresses that Type IV procedures still pose harm and violate children's rights.
- Emphasises training, screening, and intersectoral collaboration.

RCOG's guidance is considered a gold standard for high-quality obstetric and gynaecological practice.

CHAPTER 6

ADVOCACY STRATEGIES AND PATHWAYS FOR ENDING TYPE 4 FGC IN MALAYSIA

OVERVIEW:

This chapter outlines the Malaysian Chapter of the Asia Network to End FGM/C's national advocacy strategy for ending Type 4 FGC, grounded in evidence, community realities, and the Asia Network to End FGM/C's Theory of Change (TOC). Effective advocacy in Malaysia must go beyond information dissemination and engage with the cultural, emotional, and institutional dynamics that shape decision-making. Because silence, uncertainty, and discomfort frequently surround discussions on FGC, national strategies must prioritise trust-building, capacity-strengthening, and coherent pathways for dialogue and reform. This chapter, therefore, presents an integrated approach informed by the TOC and strengthened by the outcomes of the Strategic Workshop.

FGC STRATEGIC WORKSHOP

Held on 30th–31st October 2025, the Strategic Workshop convened clinicians, researchers, grassroots organisations, and policy advocates of the Malaysian Chapter of the Asia Network to End FGM/C for collaborative dialogue and design-thinking. Through a hybrid format, participants engaged in myth-busting exercises, institutional and community presentations, reflective practices, and structured planning sessions. The workshop clarified shared priorities, deepened emotional and epistemic literacy, and produced context-sensitive intervention concepts that informed the establishment and early direction of the Education & Advocacy and Research Working Groups (Section 6.2). Grounded in a tailored Monitoring, Evaluation, and Learning (MEL) framework, the workshop culminated in peer-reviewed intervention proposals, a collective funding vote, and a commitment to ongoing coordination, providing the foundation for Malaysia's evolving multi-sector strategy to end Type 4 FGC.

This workshop was attended by the following organisational and individual members (in alphabetical order):

ORGANISATIONAL MEMBERS

DOCTORS ON GROUND
BUILDING RESILIENT COMMUNITIES

Doctors on Ground (DnG) is a Malaysian non-profit organisation that provides community-based healthcare and support to underserved populations, including urban B40 families, refugees, and stateless communities. Established to bridge gaps in access and continuity of care, DnG operates through mobile clinics, neighbourhood health networks, and trained community health navigators. Its programmes emphasise trust-building, decentralised care, and practical health education delivered directly within communities. DnG is a new member of the Malaysian Chapter, having recently officially joined the network in May 2025.

FRHAM is a leading Malaysian non-profit federation of 13 State Member Associations, founded in 1958, focusing on sexual and reproductive health and rights (SRHR) for women, men, and young people. It is an accredited member of the International Planned Parenthood Federation (IPPF). Through its nationwide network, FRHAM provides SRHR services via health centres, capacity-building programmes, and community outreach.

The **Galen Centre for Health & Social Policy** is an independent Malaysian think tank that provides evidence-based analysis on health and social policy issues. Through research, public commentary, and policy engagement, the Centre promotes transparent, people-centred health systems and contributes to national discussions on public health, healthcare financing, and social welfare reform.

Monsters Among Us (MAU) Malaysia is a youth-led Malaysian organisation that creates accessible, culturally sensitive sexual health and gender-based violence education materials. MAU works with medical and advocacy partners to produce clear, family-friendly resources on FGC, consent, and bodily autonomy.

SIS Forum is a Malaysian non-governmental organisation that advocates for women's rights within an Islamic framework, promoting interpretations of Islam that uphold equality, justice, and dignity. Through legal literacy, public education, policy engagement, and research on Islamic family law and gender issues, SIS works to strengthen women's rights and expand access to justice. It is recognised nationally and regionally for its contributions to rights-based discourse and its efforts to support informed, community-centred reform.

INDIVIDUAL MEMBERS

Dina Abdullah
Gender, Diversity and Inclusion Specialist
International Planned Parenthood Federation
East and South East Asia and Oceania Region

Melissa Akhir
Commissioner–SUHAKAM
National Human Rights' Commission, Malaysia
and Co-Founder of Kemban Kolektif

Dr Hannah Nazri
Author and Workshop Lead
Malaysian Doctors for Women & Children

Dr Nik Ainin Soffiya Nik Mat
Researcher, Universiti Malaya

Siti Nur Afiqah Zahari
Researcher
RCSI-UCD Malaysia Campus

6.1 - FIGURE 1: THE ASIA NETWORK TO END FGM/C'S THEORY OF CHANGE (TOC)

This illustration presents a holistic vision for ending all forms of FGC by showing how four interconnected pillars, Data & Research, Education, Advocacy, and Legal & Protective Mechanisms, work together to protect the rights and well-being of girls and women.

- **Data & Research** provide the evidence needed to challenge misinformation, understand motivations, and inform effective programmes and policies.
- **Education** ensures accurate, culturally sensitive information reaches communities, health providers, educators, and children through CSE, enabling informed decisions and reducing taboos.
- **Advocacy** uses clear messaging, media engagement, community mobilisation, and survivor stories to shift social norms and strengthen public understanding.
- **Legal Structures & Protective Mechanisms** establish the policy and legislative framework needed to safeguard children, uphold rights, and link survivors to services.

Malaysia's high prevalence of Type 4 FGC is sustained by a convergence of cultural norms, religious perception, medicalisation, and regulatory ambiguity. Multiple studies over the past 25 years consistently show that FGC is near-universal among Malay Muslims,

with prevalence estimates ranging from 93% to 99%. This pattern reflects not only community expectations but also structural gaps in regulation, clinical guidance, and public information. The Asia Network to End FGM/C's Theory of Change (TOC) outlines a clear, evidence-based pathway to address these systemic issues, aligned with Malaysia's commitments under national law and international human rights frameworks.

The TOC, therefore, focuses on four interlinked policy levers:

1. **Strengthening the evidence base,** by improving the quality, accuracy, and circulation of Malaysian-specific evidence, is essential for informed policymaking. Reliance on international data from African Type 2–3 contexts has hindered productive engagement; by contrast, Malaysian clinical and anthropological findings offer a credible basis for national action.
2. **Expanding education and public awareness,** by enhancing public and professional understanding of the medical, ethical, and rights-based implications of FGC, creates the social mandate necessary for policy reform. Harm is currently underestimated, not because it is absent, but because it is poorly documented, poorly understood, or culturally difficult to articulate.
3. **Supporting advocacy and social norm change,** by amplifying accurate information about FGC using clear messaging, media engagement, and community mobilisation, and by also focussing on survivor-led narratives can shift cultural perceptions about FGC.
4. **Strengthening legal and protective mechanisms,** by clarifying the relationship between religious guidance, medical ethics, and federal law, can reduce public confusion about the status of FGC. Fostering environments where frontline professionals and community members can voice concerns without fear of backlash supports more accurate reporting, better institutional responsiveness, and stronger policy design. Policymakers are uniquely positioned to provide guidance that reflects the legal hierarchy of Malaysia's dual system and the principle that harm negates religious permissibility.

As these levers operate over time, several intermediate outcomes are expected. Increased understanding of harm and risk reduces public reliance on medicalisation as a proxy for safety. Greater clarity about the legal and religious status of FGC weakens the belief that it is compulsory. Improved visibility of health-system gaps strengthens institutional appetite for regulation. Greater public dialogue also reduces social pressure on families to continue the practice. These shifts create the enabling conditions for regulatory action, whether through clinical guidance, professional disciplinary standards, or legislative review.

In the long term, this pathway enables Malaysia to gradually abandon Type 4 FGC. The approach does not rely on punitive enforcement but on strengthening governance coherence, improving evidence quality, aligning national practice with international obligations, and supporting communities in making informed, voluntary transitions away from harmful procedures. This model respects cultural context while prioritising the health, dignity, and rights of Malaysian children—consistent with the objectives of the Child Act, the Penal Code's protections from injury, and Malaysia's commitments under CEDAW and the CRC.

6.2 INTRODUCTION OF WORKING GROUPS WITHIN THE MALAYSIAN CHAPTER OF THE ASIA NETWORK TO END FGM/C

The Malaysian Chapter faces several structural challenges, including fragmented initiatives, inconsistent engagement, limited peer-reviewed research, and the absence of a shared monitoring framework. To address these gaps and operationalise the TOC's pathways, the Chapter established two Working Groups, each facilitated by a Deputy National Coordinator: the Research Working Group and the Education & Advocacy Working Group. These groups provide the organisational structure necessary to translate strategic priorities into coordinated, long-term action. Organisational and individual members participate by joining one of the two Working Groups.

FIGURE 2: GOVERNANCE STRUCTURE

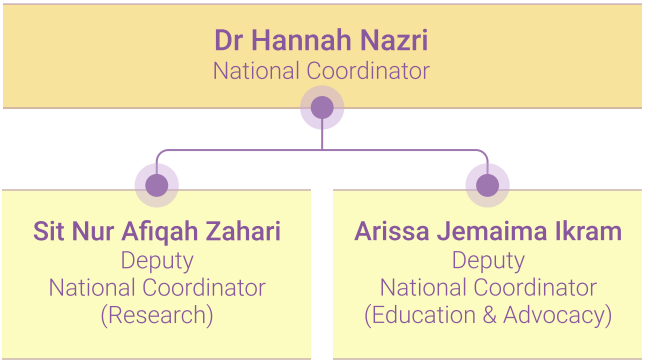

Figure 2: Illustrates the governance structure of the Asia Network to End FGM/C Malaysian Chapter 2025–Present, showing the leadership roles overseeing the Research and Education & Advocacy Working Groups. The National Coordinator provides overall strategic direction, supported by Deputy National Coordinators who lead the Research Working Group and the Education & Advocacy Working Group, respectively.

The **Research Working Group**, led by the **Deputy National Coordinator for Research, Siti Nur Afiqah Zahari (RCSI & UCD Malaysia Campus)**, focuses on strengthening the Malaysian evidence base by identifying data gaps, consolidating clinical and sociocultural findings, and guiding ethical research. This supports the TOC's emphasis on grounding national action in accurate, context-specific knowledge to correct misconceptions, inform regulatory discussions, and enable evidence-led engagement with religious and policy institutions.

The **Education & Advocacy Working Group**, facilitated by the **Deputy National Coordinator for Education & Advocacy, Arissa Jemaima Ikram (Doctors on the Ground)**, advances the TOC's pathways related to public understanding and norm change. It translates evidence into clear, culturally resonant messaging, fosters emotionally safe community dialogue, and clarifies legal, ethical, and religious misconceptions in ways that respect community sensitivities.

Together, these Working Groups provide the organisational structure to move the TOC from vision to coordinated implementation. By aligning evidence generation with effective public engagement, they help ensure that progress toward ending Type 4 FGC is consistent, coherent, and sustainable.

Table 2: The Working Groups were conceived through a rigorous review of the TOC, ensuring each stream reflects strategic priorities, emotional resonance, and pathways for sustained impact. The orange-highlighted text identifies a critical national priority—effective engagement with religious leaders—which remains one of the most challenging yet essential components of efforts to end FGC in Malaysia.

TABLE 2: THE WORKING GROUPS GOALS AND FUNCTIONS

RESEARCH WORKING GROUP
• To build a body of research through university collaboration and research institutions. • To build a network of FGM/C researchers across the region. • To encourage collaboration with CSOs to ensure evidence-based intervention at grassroots level.
EDUCATION & ADVOCACY WORKING GROUP
• To integrate FGM/C into medical and healthcare curricula to equip professionals as advocates against gender-based violence. • To incorporate FGM/C into CSE in schools (there is no national currriculum). • To prioritise public engagement to raise awareness and challenge harmful norms. • To engage medical and healthcare professional bodies in developing policy briefs, position statements, and postgraduate medical education. • To engage religious leaders in shaping position statements grounded in shared values and evidence. • To collaborate with government agencies to strengthen policy and advocacy efforts.

6.3 MALAYSIAN CHAPTER: NETWORK MEMBERSHIP, MAPPING OF ONGOING WORK AND PROPOSED PROJECTS

The activities of Federation of Reproductive Health Associations Malaysia (FRHAM), Malaysian Doctors for Women & Children (MDWC), SIS Forum, and colleagues from the RCSI & UCD Malaysia Campus collectively strengthen the pathways identified in the Malaysian Chapter's TOC. Although each actor approaches FGC from a different sector—healthcare, community SRHR, and Islamic advocacy—their work directly advances the strategic levers required for long-term abandonment.

The Strategic Workshop created a dedicated space for active members to present their initiatives, exchange insights, and identify opportunities for alignment across sectors.

Although each actor approaches FGC from a different sector—healthcare, community SRHR, and Islamic advocacy—their work directly advances the strategic levers required for long-term abandonment.

REPORTED MEMBER ACTIVITIES FROM 2024 TO OCTOBER 2025

Table 3: The summaries below reflect activities reported by organisational and individual members to the Malaysian Chapter of the Asia Network to End FGM/C for the period 2024–2025.

TABLE 3_1: MEMBER ACTIVITIES (2024-2025)

Federation of Reproductive Health Associations Malaysia (FRHAM)

- The Selangor and Kuala Lumpur member associations (FREHA) have collaborated with UNFPA, CEDAW, and the Women's Aid Organization (WAO) on a range of SRHR-related programmes. Their initiatives include a Train-the-Trainers programme led by a medical doctor to equip executive committee members, nurses, and midwives with accurate knowledge on FGM, and community health talks in low-cost flats across the Klang Valley covering topics such as FGM, breast examinations, and pap smears. These sessions involved local community leaders and incorporated survivor testimony to address misconceptions about clinical practices.
- In Kelantan, the Reproductive Health Association of Kelantan (REHAK) member association conducted a Conversation Workshop on FGM/C in 2024, in collaboration with CLFI and ARROW, to explore community perspectives and deepen understanding of the issue.

Galen Centre for Health & Social Policy

- The Galen Centre for Health & Social Policy has contributed to public understanding of FGC primarily through media reporting and policy commentary on its platforms Code Blue and Ova Health. Their coverage highlights findings, statements, and initiatives by NGOs, UN agencies, medical associations, and researchers, helping to increase public visibility of the issue. While the Galen Centre does not run dedicated FGC programmes, its reporting provides an accessible channel for disseminating evidence, documenting national and regional developments, and amplifying discussions relevant to FGC in Malaysia.

Kemban Kolektif

- Kemban Kolektif, a feminist, intergenerational, and collaborative consultancy particularly in the intersections of gender within larger human rights, provides consulting services linked to the entire project life cycle using a feminist and intersectional lens, particularly in the areas of gender, human rights, and its intersections—sexual and reproductive health rights; LGBTIQ+ rights; child rights; and disability rights.
- **Melissa Akhir** is a founder and partner at Kemban Kolektif. She has multisectoral experience in access to justice, gender equality, and children's human rights in Malaysia and Southeast Asia. She was a human rights advocate at WCC Penang and WAO for almost 10 years. Prior to NGO work, she was a Deputy Public Prosecutor and Senior Federal Counsel at the Attorney-General's Chambers for almost 10 years. Presently, she serves as the Commissioner at the National Human Rights Commission of Malaysia. In 2024, Kemban Kolektif supported the Asia Network in developing a regional MEL framework to End FGM/C.

Kemban Kolektif is not an organisational member; however, Co-founder Melissa Akhir, also presently the Commissioner at the National Human Rights Commission Malaysia, is an active member.

TABLE 3_2: MEMBER ACTIVITIES (2024-2025)

Monsters Among Us (MAU)

- MAU had collaborated with the Malaysian Doctors for Women & Children to produce a patient information leaflet on FGC (Section 7.2). This involved a series of Focus Group Discussions with the general public in 2024. This activity was funded by the Canada Fund for Local Initiatives, through ARROW.

SIS Forum

- SIS Forum plays a key role in advancing national and regional advocacy on FGC by engaging directly with international human-rights mechanisms and leading efforts to shift religious and normative narratives in Malaysia.
- In 2024, Executive Director Rozana Isa highlighted FGC at the 68th Commission on the Status of Women (CSW) in March and participated in the 88th CEDAW Committee session in May, while Senior Programme Officer Syarifatul Adibah represented SIS at the Regional Partners Roundtable on FGM in Bangkok in October.
- Beyond these engagements, SIS operationalises one of the TOC's most challenging pathways: reframing religious and cultural understandings of FGC through credible, community-led approaches. Its work–spanning CEDAW shadow reporting, media engagement, educational publications, and fatwa analyses–clarifies that FGC is not mandated in Islam and that harm contradicts Islamic principles. By documenting stalled government–JAKIM discussions and addressing normative ambiguity, SIS underscores the need for evidence-driven, culturally grounded religious engagement, a priority central to Malaysia's long-term strategy to end FGC.

Malaysian Doctors for Women & Children (MDWC)

- Malaysian Doctors for Women & Children (MDWC) is a clinician-led initiative that provides Malaysia-specific medical and anatomical evidence on the harms of FGC, helping dismantle misconceptions about "symbolic cutting." Its members actively engage the medical community through presentations, professional platforms, and national SRHR spaces, contributing to shifts in clinical norms.
- From 2024–2025, MDWC contributed to the national conversation on FGM/C primarily through its members' participation in network meetings and collaborative health-literacy efforts, producing leaflets and toolkits for medical professionals and the public.

• Dr Hannah Nazri (Director)
• Dr Nadirah Babji
• Dr Ashvinderjit Kaur
• Dr Diyanah Rafiq.

MDWC is not a member of the Asia Network to End FGM/C, however; three individuals from MDWC are members.

Notable individual member activities:

- **Dr Hannah Nazri** – Between 2024 and 2025, Dr Nazri contributed to clinical, academic, and policy engagement on FGC across national, regional, and international platforms. Her activities included participating in the Obstetrical & Gynaecological Society of Malaysia's webinar on FGC, speaking at the RCOG World Congress 2025 and the FIGO (International Federation of Gynecology and Obstetrics) World Congress 2025, contributing to the development of the RCOG FGM/C training module, co-authoring an international policy brief on medicalisation, and presenting at the International Conference on Family Planning 2025. She also collaborated with International Planned Parenthood Association (IPPA) Indonesia on healthcare guidance for FGC and delivered lectures on the topic to various universities and organisations, including

TABLE 3_3: MEMBER ACTIVITIES (2024-2025)

through the Médecins Sans Frontières Global Health and Humanitarian Course. She is a member of the RCOG Global Health Trainees' Committee and the IPPF Arab World Region Centre of Excellence for the Elimination of FGM/C Experts Committee.

- **Dr Ashvinderjit Kaur** – From April 2024 to February 2025, Dr Kaur served as the Deputy National Coordinator of the Malaysian Chapter of the Asia Network to End FGM/C. On 10th October 2024, Dr Kaur and Dr Nazri participated in the UNFPA–UNICEF Regional Partners Roundtable to End FGM/C in Southeast Asia, held in Bangkok, Thailand.
- **Dr Diyanah Rafiq** – On 10th April 2024, Dr Diyanah Rafiq spoke alongside Sean Callaghan (Orchid Project) and Dr Victoria Kinkaid (FGM Education) at a frontline-worker training session organised by Orchid Project and Practice Index. Later in the year, on 19th December 2024, Dr Diyanah Rafiq and Dr Nazri spoke at the panel discussion "FGM/C in India," organised by the Society of Indian Medical Students of Obstetrics & Gynaecology in collaboration with Equality Now.

RCSI & UCD MALAYSIA CAMPUS RUMC

• Prof Rashid Khan
• Siti Nur Afiqah Zahari

RUMC is not an organisational member, however, Prof Abdul Rashid Khan and Siti Nur Afiqah Zahari are members.

RCSI & UCD Campus Malaysia

- **Prof Rashid Khan** is a Malaysian public-health researcher and clinician known for leading the most comprehensive clinical studies on FGC in Malaysia. His work has been instrumental in documenting the prevalence, medicalisation, and shifts toward Type 1 and Type 4 cutting in clinical settings. Beyond Malaysia, Prof Rashid also conducts FGC research across Southeast Asia, contributing to regional understanding of medicalisation trends, sociocultural drivers, and health-system responses. Prof Rashid is also an Advisor of MDWC.
- **Siti Nur Afiqah Zahari** is a Malaysian medical researcher and public-health scholar focusing on FGC, sexual and reproductive health, and community-centred health systems. She is the Deputy National Coordinator for the Research Working Group of the Malaysian Chapter of the Asia Network to End FGC, where she leads national efforts to strengthen evidence generation, identify research gaps, and improve methodological standards on FGC in Malaysia.

Taken together, these efforts reflect an ecosystem working across multiple TOC pathways:

- evidence generation and myth-busting (clinical evidence, anatomy, harm),
- public education and culturally sensitive communication,
- normative and religious clarification,
- and strengthening institutional readiness for change.

The presence of diverse organisational and individual members at the Strategic Workshop underscores the potential for expanded collaboration and strengthened engagement in advancing the TOC.

6.4 OPPORTUNITIES FOR ENGAGEMENT

The TOC and earlier chapters point to clear opportunities that align with the proposed interventions. Strengthened engagement with healthcare providers can support efforts to reduce medicalisation by grounding clinical practice in accurate evidence and ethical guidance. Constructive, well-supported dialogue with religious leaders remains a critical opportunity for addressing misconceptions about religious obligations and enabling community-led reinterpretations. Community-based SRHR education offers a pathway to shift public understanding using culturally sensitive messaging delivered through trusted networks. Finally, coordinated national research focused on prevalence, clinical practices, and lived experiences can fill key data gaps and provide the evidence base needed to inform policy, advocacy, and long-term abandonment strategies. Together, these opportunities map directly onto the interventions designed to activate the TOC's pathways for sustainable change.

The Strategic Workshop brought together members of the Malaysian Chapter to refine shared priorities and translate them into concrete proposals. Participants worked to align on the thematic focus areas for the Education & Advocacy and Research Working Groups, clarify the MEL framework with agreed indicators and feedback mechanisms, and identify cross-cutting themes such as medicalisation, complicity, and cultural framing that will shape future programming and advocacy efforts. Four proposals were put forward, two from of Deputy Directors of each working group, and two from discussions with members of each working group.

PROPOSED PROJECTS

Table 4: Proposed projects by the Education & Advocacy and Research Working Groups. Projects are stratified into low, medium, and high risk according to their complexity, resource requirements, and organisational capacity needed for implementation.

TABLE 4_1: PROPOSED PROJECTS
EDUCATION & ADVOCACY WORKING GROUP
LOW RISK **Project 1: Deputy Coordinator's Special – Women First KL (Lead: Doctors On Ground–DNG)**
• *Low Risk Rationale:* Operates through small, community-based groups, requires minimal financial resources, and leverages existing networks and trusted facilitators. The activities carry low political and reputational exposure, as they focus on health literacy and community support rather than public advocacy. Its localised, women-only format further reduces sensitivity and ensures a manageable operational scope.
• *Purpose:* Community health initiative addressing Type IV FGC among urban B40 women; creates safe, trusted micro-spaces for dialogue and resistance to medicalisation.
• *Target Participants/Beneficiaries:* 100–150 women from B40 households across 10–12 PPR/PA (council homes) locations in KL and Selangor.

TABLE 4_2: **PROPOSED PROJECTS**_PROJECT 1

- *Key Challenges/Rationale:*
  - Normalisation and medicalisation of FGC.
  - Limited SRHR information and caregiving burdens.
  - Lack of safe, private spaces for honest discussion.

- *Project Overview:*
  - Duration: 12 months (Jan–Dec 2026).
  - Format: Small groups (10–15 women), community-led.

- *Objectives:*
  - Raise awareness using evidence-based discussion.
  - Provide safe spaces for dialogue.
  - Generate baseline and endline evidence.

- *Activities/Programme Components:*
  - Outreach and group facilitation.
  - Peer dialogues, shared meals, take-home materials.
  - Integrated surveys via DnG and Network MEL systems.

- *Expected Outputs:*
  - 80% improved understanding of FGC harms.
  - Greater community capacity for sensitive dialogues.
  - 100 stories of attitude change.
  - Strong baseline dataset for future advocacy.
  - Opportunities to expand the model to other Malaysian states.

- *Governance / Roles and Responsibilities:*
  - Led by Education & Advocacy Working Group with DnG and community leaders.

- *MEL Framework:*
  - Track knowledge improvement.
  - Collect qualitative stories.
  - Feed into network indicators.

- *Strategic Linkages / What's Needed:*
  - MEL integration and shared indicators.
  - Medical, legal, and faith expert support.
  - Visibility events with ARROW and Spotlight.

- *Call to Action:* Co-organise community events and use findings for 2027 policy briefs.

TABLE 4_3: **PROPOSED PROJECTS**_PROJECT 2

LOW RISK
Project 2: Group Proposal – National FGC Awareness and Advocacy Programme

- *Low Risk Rationale:* Relies on coordinated messaging rather than direct service delivery, involves minimal financial outlay, and builds on existing networks and communication channels. The main risks relate to public sensitivity and potential backlash, but these are mitigated through careful framing, cross-sector alignment, and culturally grounded messaging.

- *Purpose:* Shift public attitudes on FGC through coordinated advocacy, accurate information dissemination, and culturally grounded engagement.

- *Target Participants/Beneficiaries:* General public, families, community leaders, governmental and non-governmental institutions, CSOs.

- *Key Challenges/Rationale:*
  - Sensitivity and potential backlash.
  - Risk of misinterpretation.
  - Need for culturally grounded messaging.

- *Project Overview:*
  - A coordinated national advocacy effort across multiple organisations.

- *Objectives:*
  - Develop clear, evidence-informed messages.
  - Strengthen public understanding of FGC as harmful.
  - Build cross-sector partnerships.

- *Activities/Programme Components:*
  - Advocacy and messaging
  - Public education and awareness:
    > Four awareness workshops in 2026 (Dates to be confirmed)
  - Multi-stakeholder engagement:
    > Pre-CRC Consultation Meeting co-hosted by the Malaysian Chapter of the Asia Network to End FGM/C and SUHAKAM (24th November 2025)
    > Southeast Asia FGM/C Stakeholder Meeting, Jakarta, Indonesia (8th-9th December 2025)
    > IPPF Regional Religious Dialogue 2027 (Date to be confirmed)

- *Expected Outputs:*
  - Unified messaging guides.
  - Public statements and educational materials.
  - Strengthened collaboration across CSOs.

- *Governance/Roles and Responsibilities:*
  - Coordination across all partner organisations.
  - Content development and public engagement.

TABLE 4_4: PROPOSED PROJECTS_PROJECT 2 AND PROJECT 3

• *MEL Framework:* - Track public attitude shifts. - Assess message uptake and effectiveness.
• *Strategic Linkages/What's Needed:* Cross-sector alignment and amplifying advocates' voices.
• *Call to Action:* Strengthen joint advocacy and coordinated messaging across Malaysia.
RESEARCH WORKING GROUP
MEDIUM RISK **Project 3: Deputy Coordinator's Special – Southeast Asia FGM/C Research & Advocacy Summit**
• *Medium Risk Rationale:* Risk level due to moderate financial investment, multi-country coordination, and engagement with diverse stakeholders, including policymakers, religious scholars, and healthcare providers. While the topics may attract public sensitivity, the controlled workshop environment and research framing help mitigate reputational or political risks. Logistical complexity and cross-border participation increase operational demands, but they remain manageable with structured committees and clear planning.
• *Purpose:* Strengthen regional research and collaborative action on FGC in Southeast Asia.
• *Target Participants/Beneficiaries:* Researchers, CSOs, healthcare providers, policymakers, midwives, youth leaders, students, activists.
• *Key Challenges/Rationale:* FGC in Southeast Asia is under-researched, medicalised, and frequently framed as religious.
• *Project Overview:* Three-day hybrid workshop in Penang, 150–200 participants.
• *Objectives:* - Build ethical, participatory research skills. - Strengthen regional collaboration. - Develop a joint regional position statement.
• *Activities/Programme Components:* - Day 1: Regional framing + survivor perspectives - Day 2: Laws, Islamic discourse, methods - Day 3: Policy lab + joint statement - Additional: Survivor Voices Corner, poster gallery, lightning talks, publication track.
• *Expected Outputs:* - Regional joint statement. - Abstract book and proceedings. - Recorded sessions. - Strengthened research network.

TABLE 4_5: **PROPOSED PROJECTS**_PROJECT 3 AND PROJECT 4

- *Governance/Roles and Responsibilities:*
  - Executive Committee
  - Organising Subcommittee
  - Scientific Subcommittee
  - Communications Subcommittee
- *MEL Framework:* Embedded through documentation, feedback, and network tracking.
- *Strategic Linkages/What's Needed:* Supports research capacity and regional collaboration; feeds into future advocacy.
- *Call to Action:* Join committees, volunteer, contribute expertise, and support regional statement(s).

RESEARCH WORKING GROUP

HIGH RISK
Project 4: Group Proposal – Future Leaders' Programme

- *High Risk Rationale:* Risk level due to its substantial financial requirements, intensive multi-phase structure, and the need for sustained mentorship, organisational capacity, and cross-sector partnerships. It also engages early-career professionals in sensitive research and advocacy areas, creating potential reputational and safety considerations. The six-month duration, leadership training components, and regional scope add further operational and coordination complexity, making this the most resource- and management-intensive initiative in the portfolio.
- *Purpose:* Develop emerging leaders capable of bridging research, advocacy, policy, lived experience, and ethical leadership.
- *Target Participants/Beneficiaries:* Medical students, junior doctors, early career researchers, SRHR professionals (<5 years' experience).
- *Key Challenges/Rationale:* Lack of regional leadership on complex, under-researched gender issues.
- *Project Overview:* Six-month fellowship combining research residency + advocacy internship.
- *Objectives:*
  - Build ethical, research-informed advocacy leadership.
  - Integrate clinical and scientific nuance into policy spaces.
  - Strengthen emotional literacy and long-term sustainability.
- *Activities/Programme Components:*
  - Phase 1: Research Residency
  - Phase 2: Advocacy & Grassroots Internship
  - Parallel Leadership Series:
    - > Ethics labs
    - > Narrative communication
    - > Self-care and sustainability
    - > Mentorship dialogues
    - > Networking events

TABLE 4_6: PROPOSED PROJECTS_PROJECT 4

- *Expected Outputs:*
  - Context-sensitive research contributions.
  - Strengthened advocacy credibility.
  - Cohort archive and institutional legacies.
- *Governance/Roles and Responsibilities:* Programme managed by Working Group with academic and NGO partners.
- *MEL Framework:* Outputs, leadership competencies, and partner feedback evaluated throughout.
- *Strategic Linkages/What's Needed:* Builds regional leadership; supports research and advocacy pillars.
- *Call to Action:* Recruit fellows, mentors, and partner organisations across Asia.

6.5 PROPOSAL ALIGNMENT

FIGURE 3: ALIGNMENT OF PROJECT PROPOSALS WITH THE ASIA NETWORK TO END FGM/C TOC.

Figure 3: Illustrates how each proposed project contributes to the four policy levers within the TOC. Mapping the projects against these levers shows the strategic coherence of the portfolio and highlights how different initiatives reinforce one another. Low-risk community programmes, medium-risk research activities, and high-risk leadership development efforts all feed into complementary pathways—strengthening evidence, improving public and professional understanding, shifting social norms, and clarifying the relationship between law, ethics, and religion.

This visual alignment demonstrates that the projects are not standalone activities, but interconnected components designed to build momentum across multiple systems simultaneously, ultimately supporting a more comprehensive national response to FGC.

Alignment with Research Needs. The Research Working Group's proposals directly support the **Research Opportunities identified in Section 7.3**, translating those priorities into practical, implementable programmes:

- The **Southeast Asia FGM/C Research & Advocacy Summit (Project 3)** aligns with the need for stronger multidisciplinary capacity and improved methodological quality by creating a platform for researchers, clinicians, CSOs, and scholars to develop shared skills and research agendas.
- The **Future Leaders' Programme (Project 4)** addresses the long-term need for sustained national research capacity, developing emerging researchers who can integrate clinical, social, legal, and community perspectives into high-quality FGC research.
- **National FGC Awareness & Advocacy Programme (Project 2)** supports the opportunity to reduce fragmentation in the research landscape by promoting common MEL indicators, shared ethical standards, and coordinated data practices.
- Finally, community-based initiatives such as **Women First KL (Project 1)** complement opportunities for participatory and survivor-centred research by enabling trust-building and grounded data collection within affected communities.

Taken together, these proposals operationalise the key research needs outlined in **Section 7.3** and provide a coherent pathway to strengthen Malaysia's FGC research ecosystem.

Ensuring alignment among education, advocacy, and research is critical to an effective national response to FGC. Advocacy must be anchored in credible evidence to maintain trust and avoid misinformation. Conversely, research priorities should be shaped by questions emerging from community work and advocacy practice. When evidence generation and advocacy reinforce one another, programmes remain relevant, responsive, and grounded in lived realities, enhancing policy influence and overall national impact.

Alignment of Proposed Projects with the Legal Options Matrix. The proposed projects collectively reinforce the policy pathways outlined in the **Legal Options Matrix (Section 7.4)** by generating evidence, strengthening institutional capacity, and building the public and professional understanding necessary for low- and medium-sensitivity reforms to succeed.

- **Women First KL (Project 1)** and the **National FGC Awareness & Advocacy Programme (Project 2)** directly support Options 1–6 by generating community-level evidence, improving public literacy, and enabling culturally grounded communication that reduces backlash when MOH, MMC, or JKM issue circulars, SOPs, or professional guidance.
- **The Southeast Asia Research & Advocacy Summit (Project 3)** advances Options 4, 7, 9, and 10 by strengthening ethical research capacity, developing regionally coordinated methodologies, and building expert networks that inform treaty reporting, harmful practices frameworks, and Sharia-civil coordination.
- **The Future Leaders Programme (Project 4)** enhances long-term institutional readiness for reform by cultivating ethically grounded, research-literate practitioners who can bridge clinical settings, policy interpretation, community engagement, and inter-agency collaboration– all core to implementing CPD requirements, counselling guidelines, and cross-ministerial strategies.

Together, these projects create the social mandate, technical expertise, and evidence infrastructure needed to operationalise high-feasibility, low-sensitivity reforms, while also laying the groundwork for medium-sensitivity policy options without triggering the political risks of legislative change.

Alignment of the Latest Policy Briefs. The four proposed projects directly operationalise the recommendations in the ***Medicalisation of Female Genital Mutilation/Cutting in South and South-East Asia: Policy Brief*** (2025) and the ***Addressing Female Genital Cutting in Indonesia and Malaysia: Policy Brief*** (2025). Both documents prioritise reducing medicalisation, strengthening monitoring systems, enhancing public understanding, and improving cross-sector coordination.

- **Women First KL (Project 1)** advances community-centred prevention and targeted engagement with B40 households, generating baseline data critical to health-sector reporting reforms.
- **The National FGC Awareness & Advocacy Programme (Project 2)** implements the briefs' recommendations on coordinated national messaging, addressing medical, legal, and religious misconceptions while supporting low-sensitivity regulatory interventions such as MOH and MMC guidance.
- **The Southeast Asia Research & Advocacy Summit (Project 3)** fulfils recommendations on building regional research capacity, generating ethical and comparable data, and strengthening policy coherence–prerequisites for integrating FGC into harmful practices frameworks and treaty reporting.
- **The Future Leaders Programme (Project 4)** aligns with the briefs' call to develop multisectoral leadership capable of managing institutional reform across health, legal, religious, and social welfare systems.

Collectively, these projects provide a practical, high-feasibility pathway for implementing the policy briefs' recommendations and advancing Malaysia's progress toward a coordinated, evidence-based national approach to ending FGC.

CHAPTER 7
PRACTICAL TOOLS AND RESOURCES

OVERVIEW:
This Chapter translates the toolkit's analysis into concrete, ready-to-use tools for advocates, clinicians, researchers, and policymakers. It is designed as the "hands-on" section of the document, providing practical resources that can be deployed immediately within Malaysian settings.

7.1 ADVOCACY MESSAGING TEMPLATE

TABLE 5_1:
ADVOCACY MESSAGING TEMPLATE FOR MEDIA, POLICYMAKERS, RELIGIOUS AUTHORITIES, AND MEDICAL PROFESSIONALS.

MEDIA

Key Principles – Media reporting on FGC in Malaysia should:
- Focus on facts, science, and child wellbeing, not sensationalism.
- Avoid framing FGC as a "religious obligation" — it is not required by Islam.
- Clarify that "minor" or "symbolic" cutting is still unnecessary, painful, and non-therapeutic.
- Emphasise that parents act out of tradition, not malice.
- Present medicalisation as a clinical ethics concern, not a "safer" version.
- Use accurate, Malaysia-specific language.

Recommended core messages for media:
- *Primary message:* Female circumcision is medically unnecessary and provides no health benefits. Even minor cutting causes pain, poses risks and is not required in Islam. Families often continue the practice out of tradition, rather than obligation. Accurate, evidence-based reporting helps protect children and supports informed public discussion.
- *Secondary message:*
  - > "FGC in Malaysia is typically performed on infants who cannot consent."
  - > "Medical professionals worldwide agree that no form of FGC is medically justified."
  - > "Islam does not mandate female circumcision, and many Muslim-majority countries do not practice it."
  - > "Parents often request FGC because they believe it is a harmless cultural norm—accurate information helps them make safer choices."
  - > "Medicalisation does not remove risk; it reinforces a practice with no clinical benefit."

Suggested media-friendly paragraphs:
- *On harm and necessity:* "Female circumcision is unnecessary. Even when described as a minor cut or 'just a prick,' it causes pain in infants, exposes them to risk, and provides no medical advantage. Leading international medical bodies—and Malaysian clinicians—agree that no form of genital cutting on girls is medically justified."

TABLE 5_2: ADVOCACY MESSAGING TEMPLATE

- *On tradition vs religion:* "Although FGC is often associated with Muslim identity in Malaysia, it is not required by Islam. The practice predates religion and is rooted in cultural tradition. Many Muslim-majority countries do not practice it at all. Reporting with this nuance prevents misconceptions and reduces stigma."
- *On medicalisation:* "Some families seek out doctors or nurses, believing the procedure will be safer. However, medicalisation does not make the practice harmless. The issue is not who performs it, but that the procedure itself is unnecessary and violates clinical ethics."
- *On protecting parents from stigma:* "Parents who choose FGC usually do so out of a sincere belief that it is culturally expected or beneficial. Accurate reporting can help them understand the medical facts without judgement or blame."

Do's and Don'ts for journalists:

✓ Use "female genital cutting (FGC)" or "female circumcision."
✓ Emphasise child health and well-being.
✓ State that FGC is not required by Islam.
✓ Differentiate Malaysia's Type IV practices from African Type 3 (no conflation).
✓ Focus on science, ethics, and the child-protection lens.
✓ Highlight expert voices (paediatricians, O&G, Islamic scholars who clarify non-obligation).

✗ Don't imply that Malaysian FGC is equivalent to African Type 3 mutilation.
✗ Don't portray parents as abusive or imply they are sexual abusers.
✗ Don't present the topic as a religious conflict.
✗ Don't imply that "medical FGC is safer."
✗ Don't rely on outdated or non-Malaysian data.

Short soundbites for headlines/social media:

- "Experts: Female circumcision unnecessary and not required in Islam."
- "Doctors: Even minor genital cutting carries risks and offers no medical benefits."
- "Clarifying the difference between tradition and religion can help protect infants."
- "Medical bodies: No form of FGC is ethical or clinically justified."

One-sentence message for sensitive media contexts:

"Female circumcision in Malaysia is a cultural practice, not a religious requirement. Even the mildest forms are medically unnecessary and cause avoidable pain to infants."

POLICY MAKERS

Key messages:

- FGC is fully addressable under existing Malaysian law—no religious conflict.
- The Federal Constitution (Articles 5, 8, and 75) already mandates the protection of children.
- Medicalisation is a patient-safety and clinical-governance problem.
- A federal directive or an MMC guideline can clarify the law without controversy.

Suggested language: "FGC involves non-therapeutic injury to infants, and the Federal Constitution prioritises their safety and bodily integrity. Clarifying existing law through MOH or MMC guidelines will strengthen child protection, enhance clinical governance, and align Malaysia with our commitments under CEDAW, CRC, and SDG 5.3–without touching theological matters."

TABLE 5_3: ADVOCACY MESSAGING TEMPLATE

Do's and Don'ts for policymakers:

✓ Frame FGC as:
> child protection
> medical governance
> regulatory clarity
> low-cost, high-impact reform

✓ Emphasise federal supremacy (Art. 75).
✓ Highlight alignment with UN treaty obligations.
✓ Provide simple policy options (e.g., MMC directive, MOH circular).

✗ Don't frame it as a religious ban.
✗ Avoid emotional appeals—policymakers respond better to evidence.
✗ Don't suggest criminalising parents (not feasible politically).

Short version:

- "FGC is a child-safety issue. A national guideline would protect infants and support clinicians."
- "Malaysia can clarify policy without alteringreligious positions."

RELIGIOUS LEADERS

Key messages:

- Islam does not mandate female circumcision; the Qur'an does not mention it.
- FGC is cultural, not *ibadah*.
- Federal law protects children and overrides conflicting interpretations.
- Scholars can guide the community toward safer, evidence-based practices.

Suggested language: "Our shared goal is the well-being of children. Islam emphasises protection from harm. Because medical evidence shows that even light cutting can cause pain and complications, many Muslim communities worldwide are re-evaluating the practice. Religious leaders in Malaysia are uniquely positioned to guide families with compassion and clarity."

Do's and Don'ts for religious leaders:

✓ Use a respectful, non-confrontational tone.
✓ Emphasise Maqasid al-Sharia (protection of life and health).
✓ Focus on the principle of "avoiding harm" (darar).
✓ Highlight that the fatwa is not a criminal law.
✓ Acknowledge religious diversity.

✗ Don't call the *fatwa* "wrong."
✗ Don't say "Islam bans FGC" (not universally accepted).
✗ Avoid comparing Malaysian practice to African FGM.

Short version:

- "Islam emphasises protecting children from harm, and FGC is not required by the Qur'an."
- "Religious guidance can help families make safe, informed decisions."

TABLE 5_4: ADVOCACY MESSAGING TEMPLATE

HEALTHCARE PROFESSIONALS
Key messages: • FGC has no medical benefit and is considered harmful even in minor forms. • WHO, FIGO, RCOG, and ACOG all prohibit medical involvement. • MMC ethics require avoiding unnecessary, harmful procedures. • Parental request does not justify non-therapeutic genital injury. • Doctors risk professional misconduct and legal liability.
Suggested language: "There is no clinical justification for any form of female genital cutting. As healthcare professionals, we have a duty to avoid unnecessary procedures that cause pain or injury, even if minor. WHO and FIGO prohibit medical involvement, and MMC ethics require us to decline parental requests while offering clear, respectful counselling. A national guideline would help standardise practice and protect both clinicians and children."
Do's and Don'ts for healthcare professionals: ✓ Emphasise ethical duty ("do no harm"). ✓ Use WHO, FIGO, MMC, and RCOG positions. ✓ Provide scripts for declining requests. ✓ Highlight the medico-legal risk. ✓ Stress an infant's inability to consent. ✗ Avoid framing parents as "ignorant" or "wrong." ✗ Do not imply the clinician may face criminal prosecution (focus on professional risk). ✗ Don't accuse colleagues—focus on system-level guidance.
Short version: • "No form of FGC has any medical benefit. WHO and MMC ethics prohibit it." • "Clinicians must decline requests and counsel families with care."

7.2 CLINICIAN REFUSAL SCRIPTS FOR FGC REQUESTS

TABLE 6_1: SAMPLE REFUSAL SCRIPTS
Short and simple script (for busy clinic settings): "I understand this is a common tradition, but medically it is not necessary, and it does cause pain to the baby. Because there is no health benefit and some risk, we do not perform this procedure in our clinic. Your daughter is healthy as she is."
Gentle, empathetic script (for parents who believe it is *wajib*): "Many families ask about this, and I appreciate that you want to do the best for your daughter. Islam does not require female circumcision, and most Muslim countries do not practice it. As doctors, we must avoid procedures that cause pain without any medical benefit. Even a small cut is still painful, and infants cannot consent. For these reasons, we cannot perform it. Your daughter is already perfect and healthy."

TABLE 6_2: SAMPLE REFUSAL SCRIPTS

Culturally sensitive script (for families motivated by tradition):
"I understand this is something your family or community has always done. Nowadays, we know from medical evidence that even a tiny cut causes pain and has no health benefits. Because of this, doctors in Malaysia and around the world have agreed it should not be done in a medical setting. Out of care for your baby, we do not offer the procedure, but we are happy to talk through any questions you have."

Clinical ethics script (for medically informed parents or private clinics):
"Female circumcision has no therapeutic purpose and exposes the infant to unnecessary pain and risk. According to medical ethics and WHO/FIGO guidance, clinicians cannot perform non-beneficial genital procedures on children. MMC's Code of Conduct also requires us to avoid unnecessary harm. Therefore, we cannot proceed with this request. We recommend no cutting, as your daughter's genital anatomy is already normal and healthy."

Script emphasising the Doctor's Duty of Care (helps when parents insist "just a small cut is fine"):
"Even a small cut is still an injury to sensitive tissue, and is painful for the baby. As your doctor, I have a responsibility to avoid causing harm when there is no medical benefit. Although I respect your cultural practice, I cannot perform it. My duty is to ensure your daughter's health and comfort."

Religious sensitivity script (for parents citing *fatwa*):
"I understand that some families cite the 2009 *fatwa*. It allows female circumcision only when there is no harm. Medically, however, any cut to genital tissue does cause pain and carries some risk, and Islam emphasises avoiding harm, especially to children.

There are also differing views among Islamic authorities. For example, the Perlis Mufti Department has stated that female circumcision should only be considered after consultation with medical experts, and only if there is a genuine medical need. They also note that there is no evidence that uncircumcised women face any disadvantage in religion or daily life. Many scholars similarly regard this as a cultural practice rather than *wajib*.

Because there are no health benefits and some risk of harm, doctors cannot perform the procedure. Your daughter is already healthy and does not need this procedure."

Alternative reassurance script (to reduce parental anxiety):
"Some parents worry that if they don't do this, their daughter will miss something important. I can assure you that omitting the procedure has no effect on hygiene, religious identity, or future health. There is truly no advantage to doing it, and your child will be completely fine without it."

Script for nurses/midwives who need to decline firmly but kindly:
"We understand why some families request this. However, we cannot perform female circumcision because it has no medical benefit and is painful for the baby. As healthcare providers, we follow national ethics guidelines that require us to avoid unnecessary procedures. We kindly advise against it."

TABLE 6_3: SAMPLE REFUSAL SCRIPTS

Optional scripts for special situations:

- *When parents say: "But the cut is very small."*
  "Even a small cut is still a cut, and infants feel pain more intensely. Since it does not improve your daughter's health in any way, we should avoid hurting her unnecessarily."
- *When parents say, "Can you at least do a symbolic one?"*
  "Symbolic practices that don't involve cutting aren't medical procedures. But we cannot perform any form of genital injury, even small pricks."

Patient Information Leaflet:

A patient information leaflet has been designed by the Malaysian Doctors for Women & Children and Monsters Among Us (MAU) to address some of the common myths about FGC. The content draws on the *Empowering Healthcare Professionals* leaflet and *Ending FGC: A Toolkit on Engaging Medical Practitioner*, ensuring that the information provided is medically accurate, culturally sensitive, and aligned with current professional guidance.

English

Bahasa Melayu

7.3 RESEARCH OPPORTUNITIES

Despite growing documentation of the prevalence and medicalisation of FGC in Malaysia, significant research gaps continue to hinder the development of evidence-based policy and effective legal reform. These gaps present clear opportunities for multidisciplinary research that can strengthen national understanding of the practice and inform culturally grounded interventions.

1. **Clinical and longitudinal health outcomes.** Malaysia currently lacks systematic studies examining short- and long-term physical, sexual, psychological, and obstetric outcomes associated with both traditional Type 4 and medically performed Type 1 FGC. Research grounded in clinical assessment rather than self-report data is essential to clarify health impacts, challenge persistent misconceptions about harmlessness, and guide medical regulatory reform.

2. **Infant anatomy, procedure variability, and risk pathways.** Given evidence that medicalisation has introduced cutting techniques involving visible clitoral tissue, further anatomical and procedural research is needed to map how different methods correlate with injury patterns. Clinical audits, observational studies, and practitioner-reported data can help identify risk pathways and support safer health-system responses.

3. **Policy, legal, and governance analysis.** There is limited scholarly work assessing how Malaysian statutory law, child-protection frameworks, medical regulations, and Islamic governance structures intersect with FGC. Opportunities exist for legal scholarship to apply comparative analysis, regulatory mapping, and doctrinal

interpretation to clarify obligations, identify gaps, and outline pathways for reform.

4. **Sociocultural and religious drivers.** While broad motivations are known, deeper ethnographic and sociological research is needed to understand variations in beliefs, decision-making, gender norms, and intergenerational transmission across regions, socioeconomic groups, and religious communities. This includes examining how religious authority, digital information flows, and intra-community debates shape contemporary attitudes.

5. **Health-system dynamics and professional behaviour.** Research is needed to understand why healthcare providers continue to perform FGC despite ethical conflicts, unclear regulatory guidance, and a lack of formal training. Studies exploring professional norms, institutional decision-making, and the informal transmission of cutting techniques within clinical settings can provide critical insights for policy and training reform.

6. **Community attitudes and behavioural change pathways.** Few studies have used behavioural science frameworks to examine the drivers of change, resistance, or ambivalence toward FGC within Malaysian communities. Mixed-methods work, particularly in collaboration with community-based organisations, can help identify leverage points for stigma reduction, norm change, and support for parent decision-making.

7. **Data systems and national monitoring.** Malaysia lacks routine surveillance, health-system reporting, and/or institutional data on FGC. Research exploring the feasibility, acceptability, and design of national monitoring systems can inform policy while respecting privacy, ethics, and community sensitivities.

8. **Comparative regional research.** FGC in Southeast Asia remains understudied relative to African contexts. Malaysia is well-positioned to lead regional collaborative research comparing prevalence, religious interpretations, medicalisation patterns, and policy responses across Brunei, Indonesia, the Philippines, Singapore, and Thailand.

9. **Survivor-centred and participatory research.** There is limited documentation of the lived experiences o women and girls affected by FGC, especially as medicalisation shifts the age of cutting to infancy. Survivor-led and participatory research can illuminate memory, embodiment, sexual health, and emotional impacts in ways that conventional surveys cannot.

These opportunities underscore the need for coordinated, multidisciplinary research that integrates clinical science, social science, law, public health, and religious studies. Addressing these gaps will not only strengthen Malaysia's evidence base but also support culturally sensitive, rights-aligned policymaking and advance regional leadership in understanding Type 4 and medicalised FGC. Crucially, this work must also include Malaysia's diverse migrant and refugee communities, who remain significantly underrepresented in existing research and policy discussions.

Research Challenges and Corresponding Solutions. Table 7: Key challenges encountered in conducting research on FGC in Malaysia, along with corresponding solutions aimed at strengthening methodological rigour, community access, institutional collaboration, and data quality.

TABLE 7: KEY CHALLENGES IN CONDUCTING RESEARCH

1. **Limited access to communities and gatekeepers:**
   - Build partnerships with trusted community-based organisations (CBOs).
   - Use participatory research methods that engage local facilitators.
   - Secure early engagement with community leaders and women's groups.

2. **Sensitivity around religion and cultural identity:**
   - Employ culturally respectful framing and non-confrontational language.
   - Involve Islamic scholars, ethicists, or culturally literate intermediaries.
   - Use anonymous interview methods to reduce hesitation.

3. **Institutional hesitancy and lack of collaboration from government bodies:**
   - Seek formal research MOUs with universities or medical associations.
   - Leverage existing CSO-government dialogues (e.g., child protection, SRHR).
   - Provide policymakers with summary briefs and early findings to build trust.

4. **Inadequate research funding and low prioritisation:**
   - Integrate FGC research within the broader SRHR, GBV, or child health grants.
   - Partner with regional bodies (UNFPA, UNICEF, ARROW, Spotlight Initiative).
   - Develop multi-year donor proposals rather than one-off studies.

5. **Lack of clinical and health-system data:**
   - Advocate for standardised documentation and ICD coding in the health system.
   - Conduct clinical audits and hospital-based observational studies.
   - Train healthcare staff to identify and record cases ethically.

6. **Ethical constraints of research involving minors:**
   - Develop robust ethics applications with clear safeguards and parental consent pathways.
   - Use non-invasive methods (parent interviews, anonymised clinician reports).
   - Collaborate with paediatric ethicists.

7. **Stigma, privacy concerns, and disclosure barriers:**
   - Use confidential, trauma-informed interviewing techniques.
   - Increase representation of female researchers and facilitators.
   - Offer anonymous surveys to complement qualitative work.

8. **Reluctance of healthcare providers to participate:**
   - Emphasise confidentiality and non-punitive research aims.
   - Engage professional bodies (MMA, O&G societies, nursing councils) as intermediaries.
   - Use neutral phrasing around “clinical practices” rather than “FGM harm.”

8. **Fragmented research environment and lack of interdisciplinary collaboration:**
   - Establish a national or regional FGC research network.
   - Develop shared protocols, ethics templates, and data standards.
   - Host annual research convenings to align agendas and reduce duplication.

7.4 LEGAL OPTIONS MATRIX

Policy Pathways to Address Female Genital Cutting (FGC) in Malaysia. This matrix categorises possible legal and regulatory reforms by feasibility, political sensitivity, institutional lead, and expected impact, helping policymakers choose the most realistic pathways without legislative overhaul.

Table 8: These options for policy pathways require NO law reform and can be implemented immediately. They avoid religious controversy and political resistance.

TABLE 8_1: LOW SENSITIVITY, HIGH FEASIBILITY OPTIONS FOR POLICY PATHWAYS TO ADDRESS FGC

LEGAL OPTION 1: MOH CIRCULAR PROHIBITING MEDICALISED FGC			
Description: Clarifies FGC is a non-therapeutic, non-permissible procedure in clinics; prohibits public-sector involvement.			
Lead Agency: MOH	**Feasibility** ★★★★★	**Sensibility** ★☆☆☆☆	**Expected Impact:** ***High*** Stops medicalisation in the public sector
LEGAL OPTION 2: MMC PROFESSIONAL GUIDANCE NOTE			
Description: Declares FGC a breach of medical ethics; provides refusal scripts; disciplinary actions apply.			
Lead Agency: MMC	**Feasibility** ★★★★★	**Sensibility** ★☆☆☆☆	**Expected Impact:** ***High*** Shifts norms in the private sector
LEGAL OPTION 3: CHILD PROTECTION SOP INTEGRATION			
Description: Add FGC risk, referral, and protection steps to JKM guidelines under ss.17–18 Child Act.			
Lead Agency: JKM	**Feasibility** ★★★★★	**Sensibility** ★☆☆☆☆	**Expected Impact:** ***High*** Empowers social workers
LEGAL OPTION 4: HEALTH SECTOR DATA & REPORTING			
Description: Add FGC to Patient Safety Reporting System; create "Never Event" classification.			
Lead Agency: MOH	**Feasibility** ★★★★★	**Sensibility** ★☆☆☆☆	**Expected Impact:** ***High*** Builds evidence base
LEGAL OPTION 5: OFFICIAL GUIDANCE ON FATWA LEGAL LIMITS (ART. 75)			
Description: Issue a BHEUU/AGC clarification: *fatwas* do not override the Child Act, Penal Code, and Constitution.			
Lead Agency: PMD Legal Affairs Division	**Feasibility** ★★★★☆	**Sensibility** ★★☆☆☆	**Expected Impact:** ***High*** Resolves misinformation

TABLE 8_2: OPTIONS FOR POLICY PATHWAYS

LEGAL OPTION 6: NATIONAL CLINICAL GUIDELINE ON FGC COUNSELLING			
Description: Counselling scripts, risk explanation, documentation, and referral.			
Lead Agency: MOH + MMC	**Feasibility** ★★★★★	**Sensibility** ★☆☆☆☆	**Expected Impact:** ***Medium-High*** Builds evidence base

MOH: Ministry of Health; **MMC:** Malaysian Medical Council; **JKM:** *Jabatan Kebajikan Masyarakat* (Department of Social Welfare Malaysia); **BHEUU:** *Bahagian Hal Ehwal Undang-Undang* (Legal Affairs Division), AGC: Attorney General's Chambers *(Jabatan Peguam Negara)*, PMD: Prime Minister's Department

NB: Acknowledging the challenges of direct MOH engagement, the Strategic Workshop identified professional medical associations—such as OGSM (see Chapter 5)—as key intermediaries capable of strengthening institutional influence and facilitating a more constructive engagement process with MOH.

Table 9: These options require moderate political will but no legislative amendment; effective for scaling reform.

TABLE 9: MEDIUM SENSITIVITY, MEDIUM FEASIBILITY OPTIONS FOR POLICY PATHWAYS TO ADDRESS FGC			
LEGAL OPTION 7: NATIONAL HARMFUL PRACTICES FRAMEWORK (FGC, CHILD MARRIAGE, VIRGINITY TESTING)			
Description: A cross-ministerial roadmap aligned with CEDAW/CRC.			
Lead Agency: KPWKM + MOH + AGC	**Feasibility** ★★★★☆	**Sensibility** ★★★☆☆	**Expected Impact:** ***High***
LEGAL OPTION 8: CPD REQUIREMENTS FOR ALL CLINICIANS			
Description: Mandatory modules on ethics and refusal of non-therapeutic genital procedures.			
Lead Agency: MMC + Nursing Board	**Feasibility** ★★★★☆	**Sensibility** ★★☆☆☆	**Expected Impact:** ***Medium-High***
LEGAL OPTION 9: ALIGNMENT IN TREATY REPORTING (CEDAW, CRC, UPR)			
Description: Explicitly report FGC as a harmful practice; outline progress.			
Lead Agency: MOFA + AGC	**Feasibility** ★★★★☆	**Sensibility** ★★☆☆☆	**Expected Impact:** ***Medium***
LEGAL OPTION 10: SHARIA–CIVIL COORDINATION NOTE			
Description: Quiet alignment between JAKIM + MOH emphasising harm avoidance (darar) and non-obligation.			
Lead Agency: JAKIM + MOH	**Feasibility** ★★★☆☆	**Sensibility** ★★★☆☆	**Expected Impact:** ***Medium***

KPWKM: *Kementerian Pembangunan Wanita, Keluarga dan Masyarakat* (Ministry of Women, Family and Community Development); **MOFA:** Ministry of Foreign Affairs; **JAKIM:** *Jabatan Kemajuan Islam Malaysia* (Department of Islamic Development Malaysia).

Table 10: These options involve statutory reform or direct challenge to religious norms; not needed now and politically difficult.

TABLE 10: HIGH SENSITIVITY, LOWER FEASIBILITY OPTIONS FOR POLICY PATHWAYS TO ADDRESS FGC			
LEGAL OPTION 11: AMEND THE CHILD ACT TO EXPLICITLY BAN HARMFUL TRADITIONAL PRACTICES			
Description: Includes FGC within the statutory definition of harm.			
Lead Agency: Parliament + KPWKM	**Feasibility** ★★☆☆☆	**Sensibility** ★★★★☆	**Expected Impact:** ***Very High***
LEGAL OPTION 12: AMEND PENAL CODE TO SPECIFICALLY CRIMINALISE FGC			
Description: Similar to the UK Female Genital Mutilation Act.			
Lead Agency: AGC	**Feasibility** ★☆☆☆☆	**Sensibility** ★★★★★	**Expected Impact:** ***Very High*** But high risk
LEGAL OPTION 13: STATE-LEVEL REPEAL/AMENDMENT OF THE 2009 *FATWA*			
Description: Politically improbable; unnecessary due to Art. 75.			
Lead Agency: State Mufti Offices	**Feasibility** ★☆☆☆☆	**Sensibility** ★★★★★	**Expected Impact:** ***Moderate***
LEGAL OPTION 14: GAZETTE A PROHIBITION UNDER SHARIA ENACTMENTS			
Description: Not aligned with current state authority preferences.			
Lead Agency: State Islamic Departments	**Feasibility** ★☆☆☆☆	**Sensibility** ★★★★★	**Expected Impact:** ***Moderate***

CHAPTER 8
CONCLUSION

Malaysia stands at a critical juncture in its efforts to safeguard the rights, health, and dignity of girls and women. This report demonstrates that eliminating FGC requires a coherent, multisectoral approach grounded in scientific evidence, aligned with international human rights standards, and responsive to the lived realities of communities nationwide. While the practice remains reinforced by longstanding social norms and institutional gaps, it is neither medically indicated nor aligned with ethical, legal, or child-protection principles.

A strengthened national response must therefore integrate four critical pillars:

- **First, strengthening the evidence base,** by sustained investment in high-quality, Malaysia-specific research, is essential to inform policy, strengthen clinical understanding, and dispel persistent misconceptions.
- **Second, expanding education and public awareness** with accurate, culturally sensitive, and context-specific education ensures that families, youth, healthcare providers, and religious institutions have access to clear information.
- **Third, supporting advocacy and social norm change** with strategic advocacy, which is necessary to translate evidence into public understanding and social norm change.
- **Fourth, strengthening legal and protective mechanisms** to ensure a supportive legal and policy environment anchored in gender equality, child protection, and professional accountability is necessary to ensure that national institutions act consistently with international obligations and best practices.

Collectively, these pillars form the basis for a comprehensive, rights-based strategy that places girls and women at the centre of policy and practice. The proposals outlined by the Working Groups offer practical pathways to operationalise this strategy through coordinated research, community engagement, institutional leadership development, and policy reform.

Ending FGC is not only a matter of public health or cultural dialogue; it is about ensuring that every girl in Malaysia can grow up free from harm, discrimination, and violence. Sustained collaboration among government agencies, civil society, healthcare providers, religious leaders, researchers, and affected communities will be essential to achieving this shared objective.

FGC requires a coherent, multisectoral approach grounded in scientific evidence, aligned with international human rights standards, and responsive to the lived realities of communities nationwide.

These pillars—strengthening the evidence base, expanding education and public awareness, supporting advocacy and social norm change, and strengthening legal and protective mechanisms—form the basis for a comprehensive, rights-based strategy that places girls and women at the centre of policy and practice.

8.1 CALL TO ACTION

Accordingly, to accelerate national progress toward eliminating FGC in Malaysia, we call on all relevant ministries, professional councils, religious institutions, CSOs, researchers, and community leaders to take coordinated action on the following priorities:

1. **Strengthen national commitment.** Government ministries, statutory bodies, and state religious authorities are encouraged to reaffirm their commitment to protecting girls and women from harmful practices and to actively engage with civil society, experts, and affected communities to shape evidence-based policy.

2. **Institutionalise evidence-informed decision-making.** National and state agencies should adopt mechanisms that ensure scientific evidence, clinical expertise, and community insights directly inform policy, programming, and law reform processes.

3. **Expand and support research.** Universities, research institutions, and development partners are urged to invest in interdisciplinary research that addresses critical national gaps–including health outcomes, motivations, legal frameworks, and dynamics of medicalisation.

4. **Advance public education and professional training.** Education sector partners, health institutions, and religious schools should integrate accurate, rights-based content on FGC into curricula and professional development programmes, ensuring all stakeholders have with reliable information.

5. **Promote multisectoral collaboration.** Government bodies, CSOs, healthcare providers, youth networks, and community organisations should strengthen coordination to ensure consistent messaging, shared data, and unified strategies that support national coherence.

6. **Prioritise survivor-centred approaches.** All interventions, including research, service provision, and advocacy, must uphold the dignity, agency, and confidentiality of women and girls, ensuring that their voices guide programmatic and policy directions.

7. **Advance legal and policy reform.** Malaysia is encouraged to review and strengthen legal frameworks to ensure clear protection against FGC, in line with constitutional guarantees, child-protection principles, and international human rights obligations.

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