

The logo for Sahiyo, featuring the word "sahiyo" in a bold, lowercase, sans-serif font. The letter 'i' has a black dot above it. Below the word, the tagline "United Against Female Genital Cutting" is written in a smaller, black, sans-serif font.

sahiyo
United Against Female Genital Cutting

**Understanding
Female Genital Cutting
in the Dawoodi Bohra Community:
An Exploratory Survey**

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For more information on Sahiyo and this study, please contact info@sahiyo.com or visit sahiyo.com.

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Abstract

Female Genital Cutting or FGC (also known as female genital mutilation and female circumcision) comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for cultural, religious, traditional and other non-medical reasons. FGC is primarily known to be practiced in sub-Saharan African countries, but its prevalence is found globally, including within Asian and Asian diaspora communities. Currently, little to no representative data has been collected on the practice within these communities.

This study attempts to understand the views, beliefs and rationales of the practice held by women belonging to the Dawoodi Bohra community to enable policymakers, donors, program developers, health professionals, and other key stakeholders to have a clearer insight into ending this human rights violation.

The Dawoodi Bohras are a sub-sect of Ismaili Shia Islam, whose administrative headquarters are located in Mumbai, India. The majority of Dawoodi Bohras reside in India and Pakistan, but over the last few decades there has been a rapid and significant migration of Dawoodi Bohras to the Middle East, East Africa, Europe, North America, Australia, and other parts of Asia. Three hundred and eighty-five women, affiliated with the Dawoodi Bohra community, living in the above mentioned disparate geographic locations, participated in this study by filling out an online survey. Findings indicated that 80% of the survey respondents had undergone FGC, and that various rationales were given for the continuation of FGC, including for 1) Religious purposes (56%), 2) To decrease sexual arousal (45%), 3) To maintain traditions and customs (42%), and 4) Physical hygiene and cleanliness (27%).

Regardless of the justifications given by the Dawoodi Bohra community, the findings demonstrate that FGC is deeply rooted in the community's culture. Understanding the complex social norms and cultural value systems that shape the meaning and significance of the practice within this community is critical to the work of anti-FGC advocates. On a constructive note, despite the high prevalence of FGC within the survey participant population, 82% stated they would not continue FGC on their daughter(s), indicating a window for change and abandonment of FGC among future generations of Dawoodi Bohras.

Introduction and Purpose

Introduction and Purpose

For the first time ever, the United Nations has prioritized the elimination of Female Genital Mutilation/Cutting (FGM/C) under the goal of achieving gender equality as part of the Sustainable Development Goals (SDG) – a 15-year plan to help guide global development and funding in the areas of critical importance for humanity and the planet.

Since 2015, Sahiyo has been working with the Dawoodi Bohra community to advocate for the abandonment of the practice of ‘khatna’ or Female Genital Cutting (FGC). In June 2015, Sahiyo introduced an online survey to gather data on FGC and gain insight into the prevalence of FGC amongst the Dawoodi Bohra communities in India and around the world. The study was done with the intention to establish strategies that can bring the practice to an end. Such strategies could include the establishment of a hotline for girls seeking assistance; the provision of education and resources to help those on the frontlines, such as educators, healthcare workers, and law enforcement; implementation of public awareness campaigns; and appropriate funding to support these efforts.

Prior to this survey, little to no data existed about khatna or Type I FGC within the Dawoodi Bohra community. Yet, as more and more women are publicly speaking about FGC within this community – as can be attested to by increased media attention on the topic in the year 2016 – understanding how to engage with the community to tackle this issue becomes of paramount importance. This document summarizes findings from the exploratory study.

About Sahiyo

Sahiyo (the Bohra Gujarati word for ‘saheliyo’, or friends) began in 2014 as a conversation between five women who felt strongly about the ritual of ‘khatna’ or Female Genital Cutting (FGC) in the Dawoodi Bohra community. The group includes a social worker, a researcher, two filmmakers and a journalist, who had all been speaking out, in their own ways, against the practice of khatna. As their collaboration grew, they realized the need for an organized, informed forum within the community that could help drive a movement to bring an end to khatna. The mission of Sahiyo is to empower Dawoodi Bohra and other Asian communities to end Female Genital Cutting and create positive social change through dialogue, education and collaboration based on community involvement.

Report Overview

The report will focus on the following points mentioned below:

- Literature review on the topic of female genital cutting
- Survey project’s methodology
- Findings of the research
- Analysis of key findings followed by recommendations

What is FGC?

Female Genital Cutting (FGC) (also known as female genital mutilation and female circumcision) comprises all procedures that involve the partial or total removal of external genitalia or other injury to the female genital organs for cultural, religious, traditional and other non-medical reasons. According to the World Health Organization (WHO) (2016), the procedure has no known health benefits and the removal of or damage to healthy genital tissue may cause several immediate and long-term health consequences. Further, FGC violates a series of well-established human rights principles, including the principles of equality and non-discrimination on the basis of sex, the right to life when the procedure results in death, and the right to freedom from torture or cruel, inhuman or degrading treatment or punishment, as well as the rights of the child. The abandonment of FGC has been listed as a target under Goal 5 of the United Nation's Sustainable Development Goals (Sustainable Development Goals, 2016).

A Brief History of Dawoodi Bohras

The Dawoodi Bohras are a sub-sect of Ismaili Shia Islam, who trace their roots back to the Fatimid dynasty of Yemen in the 11th century. The Dawoodi Bohras believe that the religious or spiritual leader of the community is the Da'i al-Mutlaq, referred to with the title of 'Syedna'. The post originated in Yemen but moved to Gujarat, India, in the 1500s. Today, the Dawoodi Bohras are predominantly a Gujarati-speaking business community with their own distinct culture and a population estimated to be between one and two million. The majority of Dawoodi Bohras reside in India and Pakistan, but over the last few decades there has been a significant migration of Dawoodi Bohras to the Middle East, East Africa, Europe, North America, Australia, and other parts of Asia. The administrative headquarters of the Dawoodi Bohras as well as the office of the current (53rd) Da'i are in Mumbai, India.

Due to the diverse roots of the Dawoodi Bohras, the community has a mixture of Yemeni, Egyptian, Indian, and African elements, and thus differs from other Shia Muslims in certain beliefs and practices. For example, the Dawoodi Bohra language, called Lisan al-Dawat, is written in Arabic script, but is derived from Urdu, Gujarati and Arabic (Dawoodi Bohra's, 2016). The Dawoodi Bohras also stand out because of their distinct attire, their food and their reputation as a largely wealthy and well-educated community. In western India, Dawoodi Bohras are known for having a more "progressive" attitude toward women – most Dawoodi Bohra women are educated, work in various professional fields and are also known to run home-based businesses even if they do not work outside.

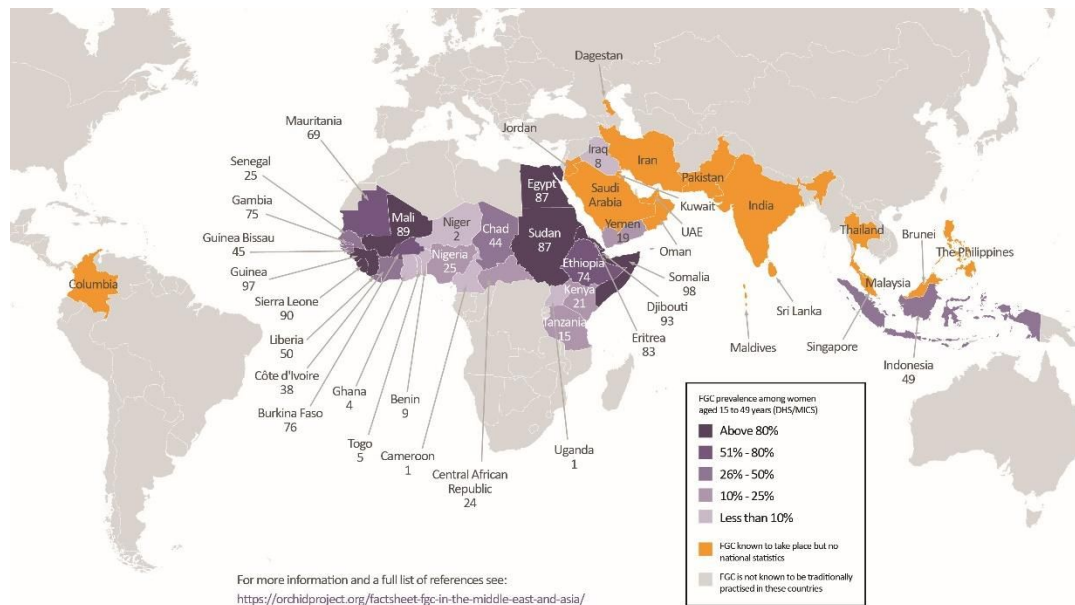
The Practice of Khatna or FGC among the Dawoodi Bohras

Dawoodi Bohras are the most well-known Muslim community in India to practice FGC, known as 'khatna' or 'khafd' in the community – a ritual that many Islamic scholars around the world do not endorse. In most instances, the process involves the removal of a pinch of skin from the clitoral hood at the age of seven, or between the ages of six and twelve. While the Quran, Islam's holy book, does not sanction FGC, the *Daim al-Islam*, a religious text followed by this community, does endorse the practice. It is likely that the practice came down to the Dawoodi Bohras from Yemen, where Dawoodi Bohras trace their roots

and where FGC is widely practiced in several provinces. As the Dawoodi Bohras have immigrated to other parts of the globe, this tradition has migrated with them and is known to be performed in secret behind closed doors in countries where legislation banning FGC exists. Although the practice is considered widespread, the topic was, until recently, rarely spoken about and/or mentioned in open discussions. The outcome of this research is focused on understanding the nature of this practice within the community, thereby contributing knowledge to the field of gender violence, public health, and social work.

Significance of Research

According to the United Nations, at least 200 million women in 30 countries have been subjected to FGC. However, these statistics are largely restricted to sub-Saharan Africa and ignore the global scope of the issue. In Indonesia alone, half of girls under the age of 14 have gone through FGC (UNICEF, 2016). The practice has been cited to occur in South America, as in various countries in Asia and the Middle East including, Oman, Yemen, United Arab Emirates, Pakistan, Iraq, Iran, Malaysia, Singapore, Thailand, Sri Lanka, Maldives, Brunei, Russia (Dagestan) and Bangladesh. Owing to global migration patterns, FGC has spread to Europe, North America and Australia as well. The map below depicts a few countries where FGC has been cited to occur.



Map 1: Provided by Orchid Project

The National Association of Social Workers (NASW) in the United States points out that the key to ending this form of social oppression is to understand the religious, cultural, ethical, mental and physical aspects of FGC among populations where it is practiced (Social Work Policy Institute, n.d.). According to WHO guidelines released in 2016, there is an urgent need for more research on FGC prevention and intervention programs to learn how to help women and girls who have undergone FGC.

Abdulcadir (2014) concludes in his research paper that additional studies focusing on “the diversity of women with FGM: different types of cutting, origins, cultures, experience, complications, and migration” are also needed. He further suggests that “future studies should be multicenter and prospective, and should involve countries where FGM is practiced as well as countries of migration”.

The purpose of this research project is to understand the perceptions, beliefs and rationales of FGC among the global Dawoodi Bohra population. As global migration increases, and as the Dawoodi Bohra community continues to migrate to new parts of the world, the number of women and girls who have undergone FGC or who will be at risk of it will continue to increase in every country. This increase makes it crucial for front line workers, including activists, health workers, social workers, legal professionals, etc. to understand the cultural, ethical, mental, and physical aspects of FGC as they encounter it in practice.

Aims and Objectives of the Study

The aims and objectives of the study are as follows:

- To obtain credible statistics about the nature of Dawoodi Bohras who have undergone FGC and the numbers who continue to practice it.
- To obtain objective data on the perceived harmful and/or beneficial physical, psychological and sexual effects of FGC.
- To examine the various justifications given within the Dawoodi Bohra community to continue the practice of FGC.
- To determine community-based interventions that can lead to the abandonment of FGC based on findings of the study.

Literature Review

Literature Review

Introduction

To study the prevalence of FGC amongst the Dawoodi Bohras, an extensive review of literature focusing on multiple facets of Female Genital Cutting (FGC) was conducted. A theme worth noting in the literature is the overarching plethora of academic papers about FGC as it occurs in Africa and in Western societies where African immigrants from FGC-practicing countries are settled (Shell-Duncan, 2008; Boyle et al., 2001; Prazak & Coffman, 2006). Meanwhile, the occurrence of FGC in other countries, such as India, is mentioned in brief, in just two or three sentences (Monahan, 2007; Jaeger et al., 2008; Burson, 2007). Ghadially (1991) also notes that literature on the 'sunnah' version of FGC (the form more often performed in Asia) was lacking in comparison to the available literature on forms like clitoridectomy and infibulation. The literature thus reveals an underlying assumption that the number of cases reported in those "other countries" is too low to suggest a real social problem.

This literature review, then, attempts to highlight the nature of FGC from a global perspective and is broken into the following categories: 1) terminology related to FGC, 2) history of FGC, 3) justifications given for FGC, 4) physical consequences of FGC, and 5) interventions used to end FGC.

Terminology Related to FGC

The World Health Organization (WHO) has grouped the types of FGC into four broad categories with subdivisions to indicate the differences in genital cutting that might occur within an FGC-practicing community.

WHO FGC Categories	WHO Definitions
Type I	<p>Partial or total removal of the clitoris and/ or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I cutting, the following subdivisions are proposed:</p> <ul style="list-style-type: none"> · Type Ia - removal of the clitoral hood or prepuce only · Type Ib - removal of the clitoris with the prepuce
Type II	<p>Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed:</p> <ul style="list-style-type: none"> · Type IIa - removal of the labia minora only · Type IIb - partial or total removal of the clitoris and the labia minora · Type IIc - partial or total removal of the clitoris, the labia minora and the labia majora
Type III	<p>Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed:</p> <ul style="list-style-type: none"> · Type IIIa - removal and appositioning of the labia minora · Type IIIb - removal and appositioning of the labia majora
Type IV	<p>All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.</p>

The World Health Organization's categories of FGC have been consistently used to define the type of cutting occurring within practicing communities. However, the same cannot be said when it comes to the terminology chosen to discuss the practice. Academics, NGOs, activists, and communities carrying out the practice have intensely debated the correct terms to refer to this practice, a debate that is informed by an even larger debate of cultural relativism versus universalism (Healy, 2007).

For example, terms like female circumcision are considered more culturally accepted within practicing communities, and researchers using those terms appear to be more culturally relativistic. Proponents of the term Female Genital Mutilation (FGM), however, state that FGM accurately reflects the invasiveness of the procedure and the violation of human rights that is incurred (Jaeger, Caflisch, & Hohlfeld, 2008). Those who choose the term FGM believe that

a more universal term must be used that disregards cultural contexts. However, critics of terms like FGM consider it to be an insulting and pejorative Western construct, which is insensitive to the traditional value implied in the practice.

This may help to explain why Ghadially (1991), a researcher from Mumbai, India, who conducted a small exploratory study using a convenience sample of Bohra Muslims in India, used the term "Female Circumcision" or FC. Islamic Relief Canada (2013-2016) also

found in their research on FGC in Indonesia that certain terms can add to the traumatization of survivors:

Experiences from community-based interventions may indicate that the term ‘mutilation’ can, in some instances, actually add to the traumatising of an individual. Girls and women who have undergone FGC can feel victimised, stigmatised and offended by the word ‘mutilation’ and its derogatory connotations (p. 8).

Throughout academic discourse, the term “female circumcision”, “female genital cutting”, “female genital surgery”, “ritual genital surgery”, “sexual mutilation”, and female genital mutilation” have been used to describe the practice (Rahman and Toubia, 2000). Lastly, Christoffersen-Dev (2005) used the term “female genital practices” to capture “the spectrum of body-altering practices involving the female genitals”. He refuted the acronyms of FGC and FGM, stating that meaning is lost in the acronyms and that they objectify the practice as a rare medical syndrome.

For purposes of this literature review and to ensure no additional harm is caused to survivors, the term Female Genital Cutting (FGC) is used, as it appears to be a compromise between the two warring viewpoints. And as Dustin & Davies (2007) stated, “the term FGC is a more neutral, non-blaming term, which still graphically represents the injuries that girls suffer.”

History of FGC

Today, although the procedure is associated primarily with Muslims, it is also carried out amongst other religious groups including Christians (Cameroon, Egypt, Mali, Senegal, Nigeria, Niger, Kenya, Sierra Leone and Tanzania). The only Jewish group known to have practiced it is the Beta Israel of Ethiopia (El-Damanhoury, 2013).

The time period when FGC first originated is uncertain, but it is widely acknowledged that this practice predates both Christianity and Islam (J.A. Black, 1995) and may be over 2,000 years old. Herodotus wrote about FGC being practiced in Egypt as early as 500 BC and the Greek geographer, Strabo, reported while visiting Egypt in 25 BC that one of the Egyptian customs was “to circumcise the males and excise the females” (Knight, 2001). Some scholars, citing evidence of FGC found on Egyptian mummies, have noted that FGC was practiced in ancient Egypt as a sign of distinction among aristocracy (Momoh, 2005). Greek physicians visiting Egypt believed FGC was performed to reduce a woman’s sexual pleasure, thereby controlling her sexual behavior. The Romans performed a technique involving slipping of rings through the labia majora of female slaves to prevent them from becoming pregnant, and the Scoptsi sect in Russia performed FGM to ensure virginity (Momoh, 2005). In the 19th and 20th centuries, within Europe and the United States, FGC was performed because it was believed to cure nymphomania, hysteria, masturbation and other “female disorders” (Momoh 2005).

Justifications Given for FGC

Literature reveals that various justifications are given for the continuation of FGC by practicing communities. Commonly cited justifications include: 1) Religion, 2) Hygiene, 3) Sexual Control, 4) Culture (Identity & Marriageability)

Religion

WHO (2001) states that religion is proclaimed by some Muslim, Christian, Jewish and animist communities as a reason for the continuation of FGC. Islamic Relief Canada (2013-2016) also states that religion is falsely used to encourage the practice within Islam, and that FGC has no religious or cultural justification.

Amongst Islamic scholars, there is a dichotomous difference of opinion on the matter, with some claiming the practice is obligatory and others claiming it is acceptable, but not mandatory. Other Islamic scholars claim that the practice has no basis in Islam; there is no mention of a direct call for practicing FGC in the Quran. However, amongst Dawoodi Bohras, FGC is often considered to be an unspoken tradition mandated by the religious clergy.

Islamic Relief Canada (2013-2016) notes that despite fatwas by leading scholars to condemn the practice, there are also numerous rulings that condone the so-called 'sunnah' form of FGC that may be roughly equated with Type I or Type IV. For instance, the Majelis Ulama of Indonesia (MUI), Indonesia's largest Muslim clerical body, which comprises leading Indonesian Muslim groups such as Muhammadiyah and Nahdlatul Ulama, does not entirely endorse or forbid FGC, and advocates that it is a religious and constitutional right for Indonesians to decide for themselves. Interviewees in their study indicated that the MUI fatwa was the primary reason for the continuation of the 'sunnah' version of FGC in their country.

Health & Hygiene

Although no medical benefits of FGC have ever been proven in the academic literature, some proponents of FGC believe that there are positive health benefits such as FGC producing a clean and healthy genital area (Islamic Relief Canada, 2016).

In some communities, female genitals are offensive to men and being infibulated is considered more beautiful. These justifications of aesthetics also relate to the notion that female genitals lack cleanliness and must therefore be removed. Myths that encourage the practice of FGC are that the clitoris will grow to the size of a penis or that the clitoris is a "man's organ" needing to be removed. Other perceived health benefits include the idea that FGC cures infertility, that a woman's uncut genitalia has the power to cause blindness and that if the woman conceives a child, the uncut genitalia could cause physical harm, madness, and lead to the death of her child and husband (WHO, 2001). These justifications hint at the idea that FGC, even though perpetuated mostly by women on other women (Mackie, 1996), may in fact be a patriarchal tradition, used to separate women and encourage them into a submissive gendered role within the community.

Sexual Control

The literature shows that sexual control is a highly common response given for the continuation of FGC amongst practicing communities. According to this belief, a woman's honor is connected to her sexuality and thus FGC helps maintain that honor. For instance, it is believed that FGC minimizes a woman's sexual behavior prior to marriage, and ensures that she remains a virgin (WHO, 2001). Thus, FGC intends to define a woman's role in her society by way of her sexuality, which is a form of gender discrimination (Rahman and Toubia, 2000).

Interestingly, justifications of enhanced sexual relations have also been used to promote the practice. Islamic Relief Canada (2013-2016) found in their study that individuals who agreed with FGC believed that FGC enhanced sexual relations between a man and woman as part of the intimacy of marriage.

Culture (Identity and Marriageability)

Literature shows that a community's culture also plays a significant role in the decision to continue FGC. For instance, in Ethiopia, 80% to 100% women and girls undergo FGC as a means of loyalty to their culture and faith (Ethiopian Society of Population studies, 2008). The maintenance of FGC preserves the cultural identity of the group.

Social pressure by family and friends can also turn the practice into an informal or formal requirement for social acceptance. Some researchers also emphasized FGC's role in the social construction of a woman's identity (Dustin & Davies, 2007), stating that in some communities girls who are not cut are looked down upon by society. Al-Krenawi & Graham (1999) highlight gender construction as well, stating that social pressures created by notions of family honor contribute to the identity of women. It can then be understood why FGC is also seen by some as a marriageability requirement – a practice that raises a woman's status and makes her eligible to be a wife (Mackie, 1996, 2000).

Interestingly, however, Islamic Relief Canada (2013-2016) found that women and girls in Indonesia who did not undergo FGC were seen as 'unclean', but they did not suffer from negative repercussions such as difficulties in getting married or being employed.

Physical Consequences of FGC

Literature on FGC is steeped with information on its harmful physical effects. Medical complications associated with FGC have been widely documented for Type II and Type III. Short-term medical complications such as "severe pain, injury to the adjacent tissue of urethra, vagina, perineum and rectum, hemorrhage, shock, acute urine retention, fracture, infection and failure to heal" have been cited, whereas long-term complications such as "difficulty in passing urine, recurrent urinary tract infection, pelvic infection, infertility, keloid scar, abscess, cysts and abscesses on the vulva, clitoral neuroma, difficulties in menstrual flow, calculus formation in the vagina, Vesico-Vaginal Fistula, Recto-vaginal Fistula, problems in childbirth and failure to heal" have been noted (WHO, 2001).

Long-term effects on the mental well-being of women and girls have also been noted, such as fear, submission, inhibition and the suppression of feelings. Sexual complications such as painful sexual intercourse due to “scarring, narrowing of the vaginal opening, obstruction of the vagina due to elongation of labia minora and complications such as infection” have been noted as well (WHO, 2001). Some studies have also demonstrated that there is an increased risk of transmission of the Human Immunodeficiency Virus (HIV) due to contaminated instruments being used during the cutting; as well as due to damaged and disrupted tissue, wound infection, repeated reproductive tract infections, dyspareunia, and dry sex” (Thein, 1995). FGC can also increase infant mortality rates; death rates among infants increased by 15% for mothers with Type I, 32% for Type II, and 55% for Type III (Sanctuary for Families, 2013).

However, little data exists on the harmful physical effects of Type I FGC as is reported to be practiced within the Dawoodi Bohra community – a type considered to be common amongst Asian FGC-practicing communities.

The information that does exist regarding harmful medical complications of the least severe forms of FGC comes from anecdotal evidence and small-scale case studies. These reports cite bleeding, pain, discomfort, burning sensation while urinating, swelling, and infection as short-term complications. Long-term effects are cited as partial or total absence of sexual arousal during intercourse, fear of intimacy and the act of sex, as well as psychological concerns such as post-traumatic stress disorder, depression and anxiety (Ghadially, 1991 & Srinivasan, 1991).

Islamic Relief Canada (2013-2016) suggests that the absence of demonstrable evidence on the negative impact of FGC amongst Indonesian women and girls could be related to the notion that FGC is not discussed freely in Indonesian society or amongst its women. They urge for further investigations into the “reported incidences of pain, fevers, and – most importantly – long term traumas, such as the loss of sexual satisfaction within marriage” (p. 22).

Interventions Used to End FGC

Many different interventions have been attempted to stop the practice from continuing onto the next generation, but few have been successful.

Health Issues Framework

During the 1960s and 70s, women’s groups in many African nations held awareness campaigns regarding the harmful effects of FGC. Moreover, doctors in Nigeria, Sudan and Somalia began reporting in medical journals about the harmful consequences of FGC (Rahman & Toubia, 2000), thus beginning intervention strategies to end FGC based on the health issues framework.

The framework discusses medical complications such as severe pain and bleeding, chronic infections, infertility, pregnancy problems, and pain during sexual intercourse (Jaeger et al., 2008 & Burson, 2007) as a persuasion tool against FGC. Many activists who adhere to a health issues framework argue that a wish for good health is recognized

among all communities and is therefore, a good persuasion tactic. The health issues framework is also considered important when practicing communities believe there are medical benefits associated with the practice.

However, advocacy efforts using a health issues framework come with challenges. In fact, medical “facts” about the consequences of FGC are hard to obtain, and in some cases a discrepancy has occurred between these negative medical “facts” and what women experience in real life due to FGC. As Monahan (2007) highlights, “Critics of the strong rhetoric regarding the negative health outcomes of FGC point out that there is not enough existing data to support negative health outcomes including the impact on sexuality” (p. 22). The potential risks of genital cutting assumed to be true in much of the literature are based on conclusions from data which are purely anecdotal. As a result, some researchers, aware of the potential falsity of the previously held health beliefs are now depending on new research from more methodologically sound studies to back up their health claims (Prazak & Coffman, 2006).

The collection of data surrounding the health consequences of FGC has and will oftentimes be hampered by methodological and ethical constraints (Monahan, 2007), which can be expected, considering the very private nature of Female Genital Cutting. Most researchers have been unable to find large populations of ‘cut’ women willing to participate in studies. Most data in this field continues to be drawn from case studies and small samples. Even within these small-scale research projects, little to no research has been collected on the long-term health consequences of Type I or the ‘sunnah’ variety of FGC practiced most often in Asia (Ghadially, 1991).

Another challenge with using the health issues framework draws on the universalism versus cultural relativism argument. For instance, Islamic Relief Canada’s study (2013-2016) found that interventions using the health framework proved most successful when the research and awareness campaigns came from members within the communities themselves, rather than from outside influences, which falls in line with the belief that practicing communities are wary of outside interventions not being sensitive to their cultural traditions.

An additional barrier to the health issues framework, as depicted by Islamic Relief Canada’s study (2013-2016), includes religious leaders and groups condemning the more severe types of FGC (Types II and III) based on negative health consequences, yet supporting ‘sunnah’ (Type I and/or Type IV) because they differentiate between ‘sunnah’ and the more severe forms of FGC. The following interviewee quotes indicates just such a division:

The FGC here is not the same with the one in Africa...I wonder why people make it into an issue...If this is about pain and human rights, the males can protest because they too are cut. For us, the resistance against FGC is unreasonable especially considering how FGC has helped those women with a very high libido who feel difficult to concentrate in their activities because they get aroused easily (Islamic Relief Canada, 2013-2016, p. 16).

The literature therefore demonstrates that a more thorough understanding of the medical implications of Type I and/or Type IV FGC is needed to combat this growing notion that some forms of FGC are acceptable.

Medicalization

FGC is usually performed by traditional practitioners. However, the literature shows there is a growing trend amongst some FGC-practicing communities toward having health-care providers perform FGC in a sterile environment, which gives the impression that FGC is safe.

In 1979, in Khartoum, the capital of North Sudan, the World Health Organization financed the first seminar on Harmful Traditional Practices Affecting the Health of Women and Children. Those in attendance opposed the continuation of FGC, including attempts at medicalization of the practice (Rahman & Toubia 2000). In 1993, the World Medical Association and several other medical professional associations including the International Federation of Gynecology and Obstetrics (FIGO) strongly disapproved medicalization of FGC. In 1997, WHO/UNICEF/UNFPA released an Interagency Statement on the Elimination of FGC, also condemning the medicalization of the practice. In 2016, WHO released guidelines on the management of health complications arising from Female Genital Cutting, and reiterated firmly that:

Medicalization of FGM (i.e. performance of FGM by health-care providers) is never acceptable because this violates medical ethics since (i) FGM is a harmful practice; (ii) medicalization perpetuates FGM; and (iii) the risks of the procedure outweigh any perceived benefit (p. 3).

Despite strong condemnation of FGC by international communities, countries like Indonesia have institutionalized and legitimized the practice by allowing health-care professionals to perform FGC. This medicalization of the practice by the government has given the appearance that FGC is harmless. In other words, medicalization has allowed communities to use biomedicine to reconstitute their traditions locally, and make sense of health concerns held by the international community (Christoffersen-Dev, 2005). In fact, in the last few years, a growing debate has occurred amongst some health professionals who urge that minor forms of FGC be recognized as culturally acceptable.

In June 2016, *The Economist* (2016) – a prestigious British news magazine – entered this debate by publishing a controversial editorial condoning “mild” FGC. The editorial argued that since global campaigns to completely ban FGC have been unsuccessful for the past 30 years, governments should try a “new approach” in which the “worst forms” of genital cutting are banned in favor of “a symbolic nick from a trained health worker”. *The Economist’s* editorial was met with both praise from FGC practitioners who felt validated, and firm condemnation from survivors, activists and international organizations who recognize even “mild” FGC as a form of gender-based violence.

Human Rights Framework

The shortcomings of the health issues framework has paved the way for a human rights framework (Shell-Duncan, 2008 and Christoffersen-Dev, 2005) based on the UN Declaration of Rights that states women and children have the right to health and bodily integrity and freedom from torture (Dustin & Davies, 2007). In fact, FGC has increasingly been discussed within the framework of girls' and women's rights (Rahman and Toubia, 2000) and since 1997, WHO has issued multiple joint statements with the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), and other agencies denouncing the practice of FGC (Sanctuary for Families, 2013).

However, this framework also has a criticism, in that, proponents of FGC consider human rights to be a Western construct that refuses to take into account cultural relativism (Shell-Duncan, 2008). As Monahan (2007), Burson (2007) & Healy (2007) discuss, a growing debate over universal values versus cultural relativism ensues over use of this framework. Islamic Relief Canada (2013-2016) also noted in their study that activist groups campaigning from a women's rights angle would be ineffective, as gender rights were often seen as "secular and pro-Western."

Government & Legislation

In 2012, the United Nations General Assembly passed a landmark resolution, "Intensifying Global Efforts for the Elimination of Female Genital Mutilations", calling on all states to enact legislation banning FGC. In fact, over the years, FGC has been explicitly and implicitly prohibited by an evolving framework of international and governmental laws. Yet, for communities who cling to FGC as a necessary cultural tradition, viewing FGC as a human rights violation – one that is equivalent to child abuse or sexual assault – is deemed incompatible.

For instance in India, FGC could fall under the Indian Penal Code (Section 326 - causing grievous hurt). However, practicing communities often do not see FGC in that manner, and thus ignore or are ignorant of criminal laws regarding assault and physical harm under which FGC could fall. Thus, several countries have enacted legislation that specifically makes FGC a criminal offense.

Time and time again, the literature has discussed the use of legislation as a method to deter the continuation of FGC within practicing communities. And it has shown that criminalization of FGC is considered a contentious issue, since a spectrum of opinions exist on the effects of legislation (Shell-Duncan, 2008). Jaeger et al., (2008) explained that legislation can be a useful tool to deter communities away from the practice. Mackie (1996), on the other hand, notes that criminalization has had no effect on reducing or eliminating FGC occurrences.

For instance, the early 20th century brought about the first documented laws against FGC. In the 1900s, in Burkina Faso, Kenya and Sudan, colonial administrations and missionaries tried to end FGC by enforcing laws and church rules, but these initiatives proved unsuccessful. Instead, communities were fueled with anger at what they saw as foreign interference in their cultural affairs. Similarly, in the 1940s and 50s, the Sudanese and

Egyptian governments put forth laws criminalizing FGC which also failed (Rahman & Toubia 2000).

Legislation has not had the desired effect of eliminating the practice altogether. In Indonesia where FGC is legal and medicalized, one study found that 99% of interviewees believed that government intervention to cease the practice would be ineffective because FGC is viewed as a religious requirement, a social norm that is performed for the good of the girl (Islamic Relief Canada, 2013-2016).

In fact, repressive enforcement of anti-FGC laws have led to some communities continuing the practice in secret, and/or performing the practice on girls at much younger ages to avoid detection, as has occurred amongst the Maasai tribe in Kenya (Matueshi, 2016). The ineffectiveness of legislation to cease the practice indicates that behavior change based on fear is not sustainable in bringing about social change.

Additional unintended consequences noted by researchers include fear of seeking medical care because friends and family members could be deported if health workers report FGC to authorities (Monahan, 2007), and stigmatization or marginalization of women from FGC practicing communities because they are under constant surveillance (Swensen, 1995).

The effects of FGC legislation need to be studied more carefully. Legislation must be created in such a way that unintended consequences will be minimized, which is why a theme of caution emerges in the literature regarding the creation of anti-FGC legislation (Dustin & Davies, 2007).

Compensation for Cutters

In some societies, performing FGC is a source of income for the cutter and their family (UNFPA 2007). Thus, one method of intervention – compensating cutters to not cut girls – has been used to deter midwives from performing the operation. The rationale behind this method was that since cutters earn a livelihood by getting paid for performing the operation, anti-FGC agencies should pay the midwives not to cut at a higher price (Mackie, 2000).

Modernization Theory

The modernization theory argues that through increased urbanization, education, mass communication, and economic development, the tradition will naturally be abandoned on its own (Mackie, 2000).

Alternative Initiation Rites

Another intervention, based on the supposition that FGC is an initiation into adulthood, suggests creating alternative “harm-free” initiations for young girls. Unfortunately, these intervention strategies have shown little to no result in the reduction of Female Genital Cutting because they disregard the significance FGC has for a community. For instance, Prazak & Coffman (2006) conducted a study on alternative initiations, the results of which showed a failure in retaining long-term cessation of FGC, and then stated that a closer inspection of the transformation of community ideology and social norms needed to be studied to provide an alternative ritual that could replace genital cutting.

Social Norm Theory

For some communities, FGC is considered a practice that must continue for the good of the girl. Given this reasoning, FGC can be viewed as a social norm within a practicing community. In short, social norms play a prescriptive role: whoever does not follow what the majority of people within that community are practicing is considered strange or deviant. Durkheim, in his work entitled 'The Rules of Sociological Method', argues "it is possible to gain exhaustive knowledge of the 'social constraints' of a society through a purely statistical study of customs, which allow one to state what majority of the people do". (Dubois 2003: p.1-2).

The practice of FGC operates as a self-enforcing social convention or social norm. The communities who follow FGC consider it to be a socially upheld behavioral rule and girls who have not undergone FGC might feel stigmatized for not having undergone it (WHO, 2010). This reasoning helps explain why Islamic Relief Canada (2013-2016) found that 40% of their interviewees claimed that even if FGC Type 1 ('sunnah') was found to be medically harmful, the community would still continue it because it was a religious requirement.

Finding Holistic Interventions

The literature reveals that FGC interventions must be approached through multi-sectoral, coordinated efforts at both the grassroots and political level. These approaches must incorporate cultural, religious, human rights, and health perspectives.

The coupling of various intervention strategies ensures that interventions account for cultural considerations (i.e. significance of FGC to a community) through dialogue with the practicing communities. This in turn helps both communities and support programs reach a shared understanding of the community's problems and needs and how to address them (Population Reports, 2007).

The research suggests, then, that a holistic intervention would involve developing a collaborative, coordinated movement that prioritizes education and outreach on FGC, and engages faith leaders, survivors, community members, teachers, service providers and law enforcement in affected communities in efforts to more effectively defend the rights of girls and women at risk of the practice (Sanctuary for Families, 2013; Monahan, 2007; Al-Krenawi & Graham, 1999).

Methodology

Methodology

Creating the Questionnaire

This exploratory study was conducted using an online survey instrument via Google Survey Forms that consisted of a mixture of quantitative and qualitative questions to understand the meaning behind the continuation of the practice of FGC.

The survey was divided into three sections: 1) General Information, 2) Personal Experience, and 3) Social Experience. The full list of questions can be found in Appendix A.

The General Information section contained questions concerning the demographic data of participants such as age, education level, religion, country of residence, etc. These questions were asked to determine the demographic similarities between research participants. Secondly, questions related to personal and social experience were asked to determine participants' knowledge and experience of FGC within their communities.

In order to develop these survey questions, Sahiyo consulted with various FGC experts and NGOs, as well as reviewed the sources referenced in the literature review and created questions based on surveys/questions used within these studies. Other resources were referenced too, such as Sahiyo co-founder Mariya Taher's Master's thesis at San Francisco State on the topic of FGC in the Dawoodi Bohra community within the United States. Her thesis was consulted to guide the wording of specific questions pertaining to the practice of khatna within the Dawoodi Bohra community. Additionally, the researchers, as natives in the Dawoodi Bohra community, had knowledge of the population which helped shape some of the questions.

This survey was not translated into another language. However, some of the questions included words that were more familiar to the target population, such as 'khatna', a more culturally sensitive word for the term Female Genital Cutting. Though no translation services were needed, some participants chose to respond to qualitative survey questions using words in Gujarati or Lisan al-Dawat (the language spoken by Dawoodi Bohras). In these situations, the researchers, being able to speak Gujarati or Lisan-al-Dawat, translated the words when collecting the data. (Refer to the glossary for meanings of Gujarati or Lisan-al-Dawat terms.)

In order to test for reliability and validity of the instrument, Sahiyo asked fellow FGC experts and NGOs to read through the set of questions to assess for bias and to make sure the questionnaire was a culturally acceptable tool for the exploratory study. Additionally, to check for clarity of wording and bias in wording, the survey was first tested on ten people. After making necessary changes based on their feedback, the survey was released to the Dawoodi Bohra community through snowball sampling methodology.

Ethics and Confidentiality

There were no physical or psychological risks related to this study, however there was the possibility that some questions in the survey would make participants feel uncomfortable.

Participants were given written instructions regarding what participation in the survey meant before beginning the survey. Only women who identified as belonging to or having grown up in the Dawoodi Bohra community, and were 18 years or older, were allowed to participate in the survey. Survey participants were also reminded that the survey was anonymous and completely voluntary. They were not obligated to answer any questions and were free to stop the survey at any time. Participants read through instructions and checked “yes” to questions asking if they understood these instructions and gave permission to use their responses in our study (See Appendix A).

Another potential risk was loss of privacy. This risk was minimized by keeping the research data in a secured database of which only researchers had access. To ensure anonymity of the participants, no identifying information, such as names or email addresses, were asked in the survey.

Sampling

Sampling Strategy & Recruitment Process

Jonah Blank (2001), in his research of Dawoodi Bohra rituals, had great difficulty in gathering information on the practice of FGC. In the passage below, he explains how his position of being outside the community affected his access to this information.

Whether the custom is extinct, extremely rare, or still widely practiced, it is a topic on which no male researcher (particularly one outside the community) can speak with real authority. An issue of such seriousness, however, would be an important area for investigation by a sensitive researcher, particularly a female community member (p. 57).

The Dawoodi Bohra sub-sect is a very closely-knit community that generally disapproves of inter-marrying with other ethnic/religious groups because they are considered outsiders. Not surprisingly then, many religious practices are considered private, and outsiders are also not allowed to partake in the knowledge of these traditions. However, as Blank (2001) states, a female researcher from within the community may be able to gather information on the ritual of FGC. Since the Sahiyo researchers are female and were raised in the Dawoodi Bohra community, access to this community was possible as the research in regard to the practice of khatna was conducted in a sensitive manner.

As no large-scale study existed on the practice of ‘khatna’ amongst the Dawoodi Bohra community, purposive sampling and snowball sampling methods were used to recruit participants to take the exploratory, online survey. First, the researcher identified ten members of the community who would be willing to take the survey (purposive sampling). These participants received an email or WhatsApp message describing the research study and asking them to take part. The recruitment script for this e-mail/WhatsApp message is listed in the Appendix B. Then Sahiyo researchers asked those initial survey respondents to identify other women who were 1) 18+ and 2) raised in the Dawoodi Bohra tradition, to take the survey. These women then sent the survey e-mail or WhatsApp message to their own networks. This method of identifying participants continued for six months, from July

25, 2015 until January 25, 2016, and in the end, 408 women had responded to the survey (snowball sampling).

Sample Size

Sahiyo's initial goal was to have 100 women complete the survey. However, as word of the online survey spread through the Dawoodi Bohra community, more and more participants were identified, culminating in 408 women completing the survey during a period from July 25, 2015, until January 25, 2016. After sorting through data for ineligible participants, Sahiyo found a sample size of 385 women from which to extrapolate data and analyze for purposes of this exploratory study. Ineligible participants included those who 1) did not give consent to using their answers in our survey, 2) did not give permission to publish results, 3) stated they did not grow up in Dawoodi Bohra community, 4) identified as male.

Gathering Data

The researchers conducted the study using quantitative methods involving survey research. Data collection involved survey information in which demographic questions as well as both open- and close-ended questions were asked of participants. Sahiyo researchers worked with a population that spoke English, therefore, no interpreter was needed for the survey tool. All survey questions asked to participants were in English. In instances when participants reported using Lisan-al-Dawat or Gujarati words, researchers were able to translate them since they are natives in the community and speak the language. No other persons were involved in the collection of survey materials. However, since the researchers did employ a snowball method to obtain research participants, the participants themselves helped in gathering data by referring the researchers to additional members of the community willing to participate in the study. In order to record data from the survey, Google Survey Forms was used to capture survey results and to transfer to a Google Spreadsheet with a timestamp date of when the survey was taken by the participant.

An online method of data collection was deemed appropriate, as (Blank, 2001) observed, the Dawoodi Bohras, "have become Internet pioneers uniting members of their far-flung denomination into a worldwide cyber congregation" (p. 178) and "the latest technological device in the Bohra toolbox is the Internet" (p. 178). Blank found that computer ownership, use and literacy were far more prevalent in the Dawoodi Bohra community than in most other segments of Indian society (2001).

Organizing and Interpreting Data

Researchers analyzed the data using both quantitative and qualitative content analysis methods.

Quantitative data analysis presented in this report was performed using R, a free statistical computing software package. Differences in estimates were calculated using chi-squared tests of independence, with an alpha of 0.05. Given small sample sizes for subpopulations, exact Fisher test were also employed. All estimates are unweighted.

Qualitative data analysis helped answer the following research questions: 1) Why FGC is practiced among Dawoodi Bohra women, and 2) What were the physical, psychological, and sexual impacts of undergoing FGC. After survey data was collected, Microsoft Word was used to conduct content analysis by way of coding and subcoding recurring themes found within open-ended questions. First, to generate open codes, the researcher conducted a line-by-line analysis to identify key words from survey participants' responses. Then, sentences that appeared to form part of a meaning unit were identified and codes were developed. Next, key ideas/themes were identified and codes were refined and/or additional codes were created. Once a final set of coding was completed and similar codes were grouped into broader categories, theoretical constructs were identified, from which emerging theories were developed (Grinnell & Unrau, 2008).

Survey Limitations

Limitations of the study include participants being gathered via the snowball method, which eliminates the possibility of participants being randomly chosen from a sampling frame. While this limits the ability to generalize about 'khatna' within the wider Dawoodi Bohra community, these results provide the first look into a hard-to-reach population. Based on the unique population studied, snowball sampling was deemed most appropriate (Heckathorn, 1997).

Additionally, only those with computer, mobile or Internet access and capability, and knowledge of English, were able to take part in the survey. This reduces the generalizability of study findings across socio-economic levels, particularly amongst Dawoodi Bohras in the lower income brackets who do not speak English or have no access to computers or the Internet. Both of these issues – the snowball sampling technique and the web-only administration – introduce bias into the results.

Conclusions made in this report are best considered as suggested trends that warrant further research and more sophisticated data collection techniques, including respondent-driven sampling to estimate representative weights.

Key Findings

Key Findings

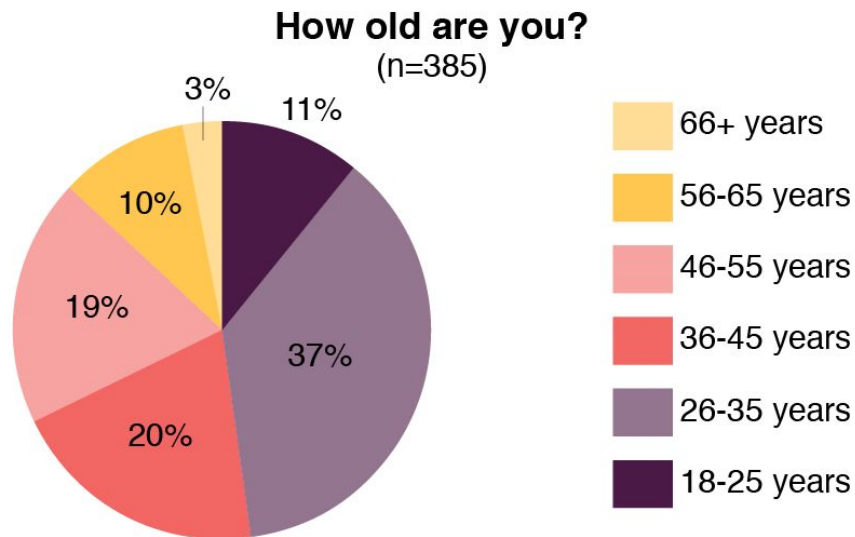
This exploratory study consists of a mixture of quantitative and qualitative questions to understand the practice of Female Genital Cutting. The survey was divided into three sections: 1) General Information, 2) Personal Experience, and 3) Social Experience. The full list of questions can be found in the Appendix.

General Information

Toward the start of the survey, demographic information was collected to establish commonalities and differences between survey participants and to ensure eligibility according to study guidelines. In addition, the information was collected to determine if demographics correlated with participants' view on FGC and its continuation. Sample size consisted of 385 women who identified as having grown up in the Dawoodi Bohra community. Demographic information is depicted by the following charts:

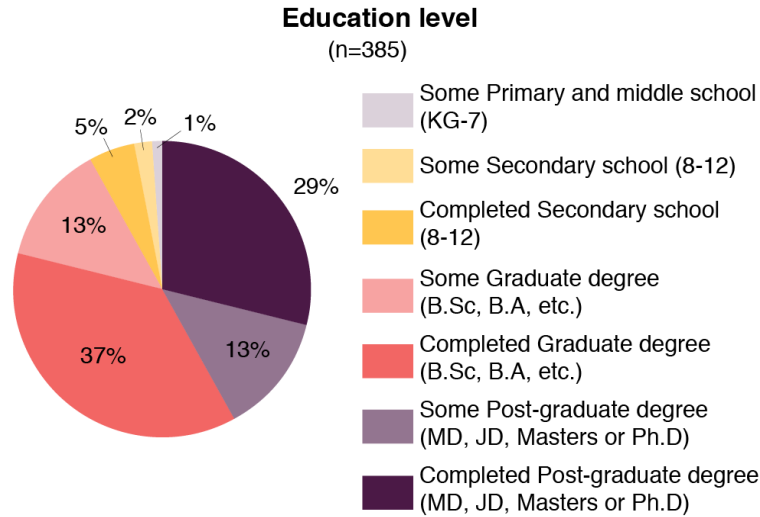
Q1: Ages of Participants

The majority of our participants fell between the ages of 18- 45 (87%). The remaining 13% of participants were 56 years and older.



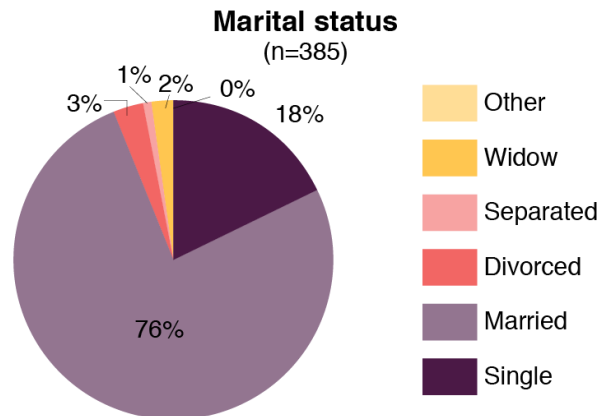
Q2: Education Level

Nearly 80% of respondents have earned at least a bachelor's degree, which is not representative of the general education levels worldwide (or even in the countries represented in the survey). This may be affected by the methodology – 80% of those surveyed have earned at least a bachelor's degree as compared to 22% among countries belonging to OECD countries.¹



Q3: Marital Status

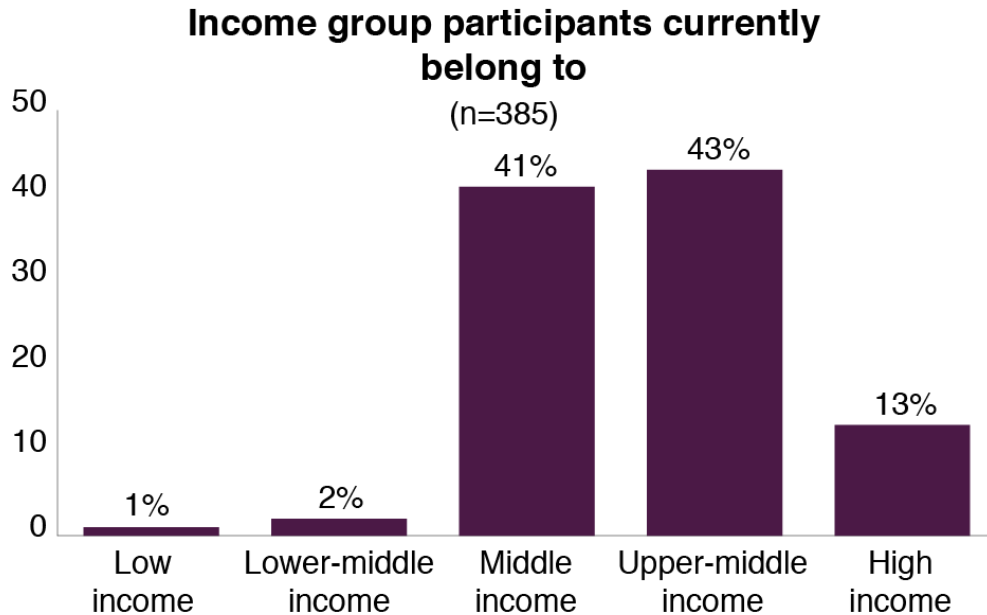
The majority of participants were married at 76%. The second largest group was 18%, single.



¹OECD countries are those 35 member countries who have signed onto the Convention on the Organisation for Economic Co-operation and Development. Countries include: Australia, Austria, Belgium, Canada, Chile, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Japan, Korea, Latvia, Luxembourg, Mexico, Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, Turkey, United Kingdom, United States.

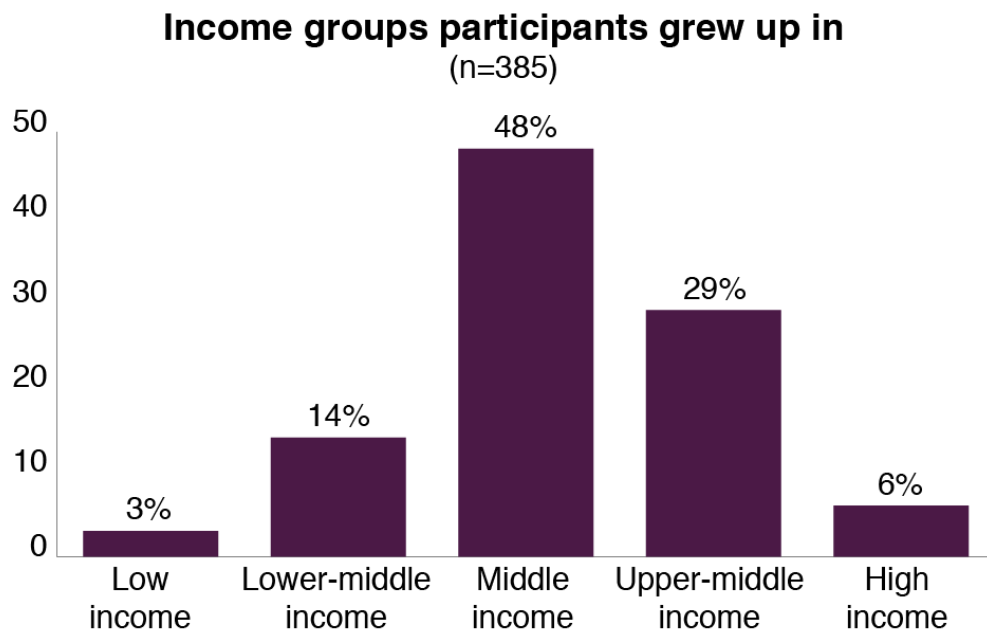
Q4: Current Income Level

As the survey was distributed globally and income levels vary country to country, participants were asked to self-report their income levels.



Q5: Previous Income Level

Survey participants were asked to self-report the income level of the household they grew up in as children.



Q6: Previous Religion

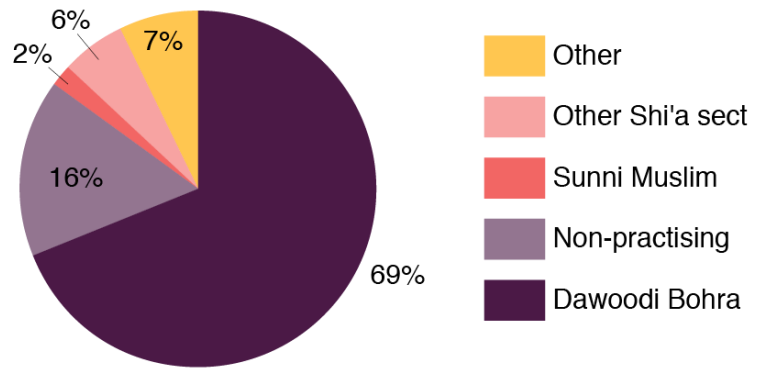
Survey eligibility requirements included that all participants grew up in the Dawoodi Bohra community, thus only participant responses from those who indicated they had grown up in this community were used for data analysis.

Q7: Current Religion

Sixty-nine percent of participants still identified as Dawoodi Bohra. Twenty-six participants choose the “other” category and responses included Muslim, Islam, Bahai, Spirituality, None, Agnostic, Atheist, Humanitarian, Sahaj Yoga, “practice with all sects”, and “following the teaching of my grandparents”.

Religion participants identify with now

(n=385)

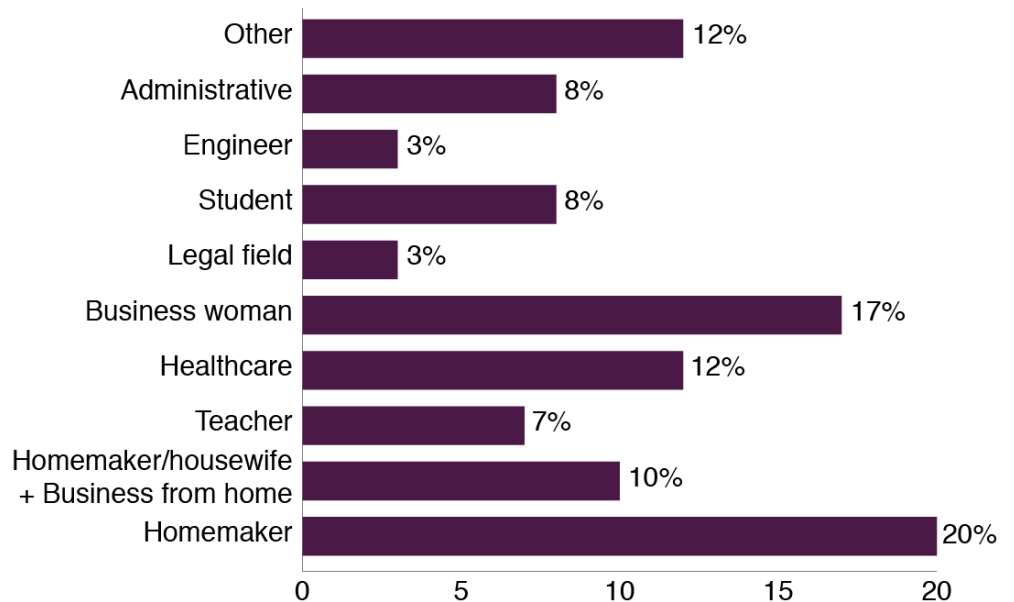


Q8: Profession

In line with their high education levels, most survey participants held a profession or worked part-time (80%). Twenty percent of survey participants indicated they did not work, marking the homemaker/housewife category.

Of the 46 participants or 12% of survey respondents who indicated the “other” category, all indicated belonging to a profession outside of the home. Other categories included social work/NGO, academia/teacher, marketing, writing, finances, human resources, counselor, IT, journalism/media, conservator, event

Profession



planning, graphic design, artist, architect, city planner, life coach.

Q9: Current Country of Residence

Majority of participants resided in India (131 participants or 34%), followed by the United States (119 participants or 31%), United Arab Emirates (9%), United Kingdom (8%), Pakistan (6%), Canada (5%), Australia (3%).

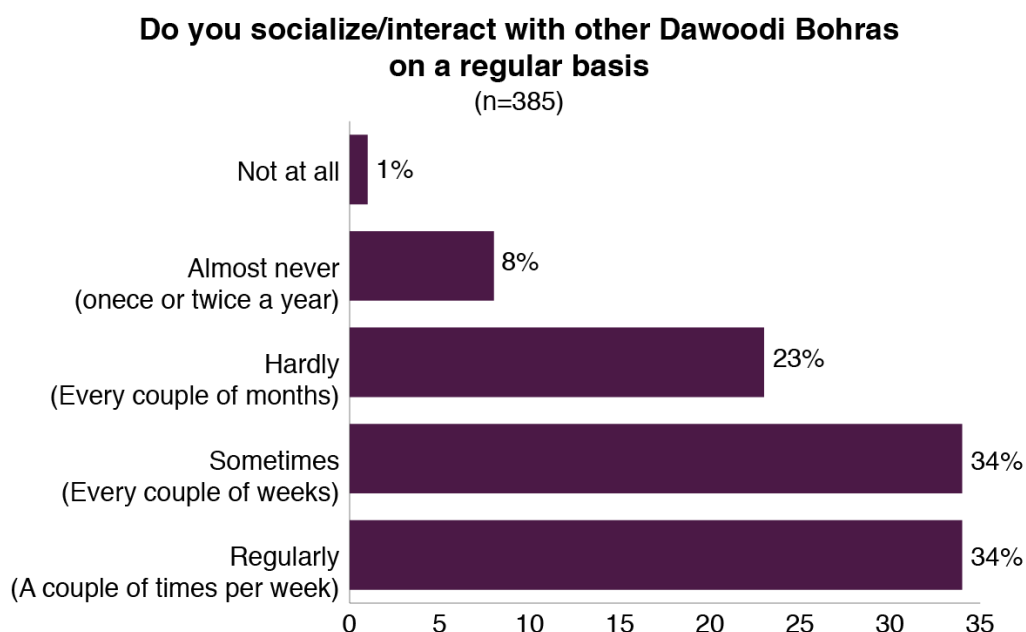
Countries participants currently reside in (n=385)	
Country	Number
India	131
United States	119
United Arab Emirates	36
United Kingdom	29
Pakistan	22
Canada	18
Australia	10
Tanzania	4
Kuwait	3
Malaysia	3
Kenya	2
Oman	2
Bangladesh	1
Uganda	1
Bahrain	1
New Zealand	1
Qatar	1

Personal Experience - Part 1

The next set of questions represent participants' own experience with the Dawoodi Bohra community and awareness of FGC within the community.

Q10: Socializing With Other Dawoodi Bohras

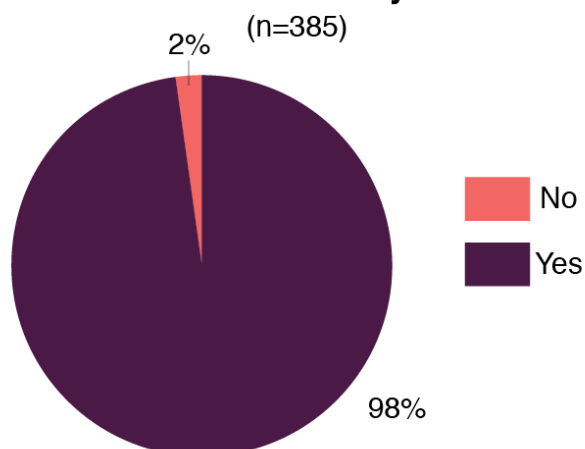
Participants were asked to indicate how often they socialized with other Dawoodi Bohras to determine if socialization had influence on whether or not a person underwent FGC or continued FGC on their daughters. The majority of participants indicated they socialized with other Dawoodi Bohras at least every couple of weeks.



Q11: Awareness of Khatna

Survey participants were overwhelmingly aware of the continuation of FGC in the community with 377 survey participants (98%) stating “yes” and 8 survey participants (2%) stating “no”.

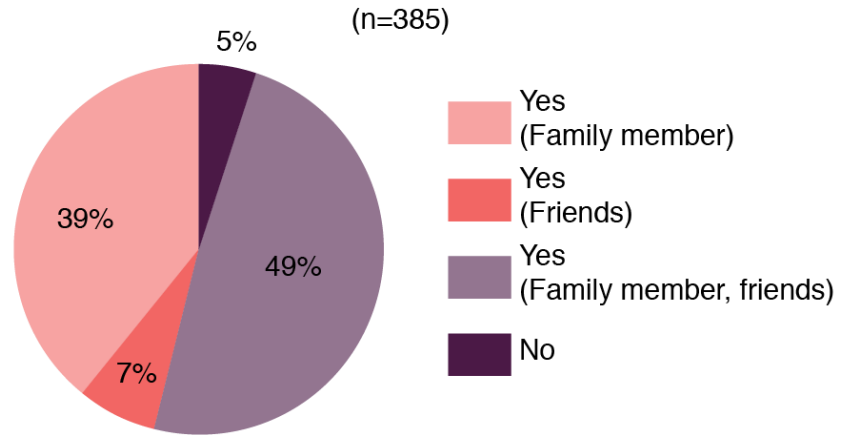
Are you aware of prevalence of FGC in DB community?



Q12: Friends or Family Members Who Underwent Khatna

Of the 385 survey participants, only 19 women or 5% were unaware of FGC occurring amongst their friends or family members. In total 88% knew a family member on whom FGC was performed and 56% knew a friend on whom FGC was performed.

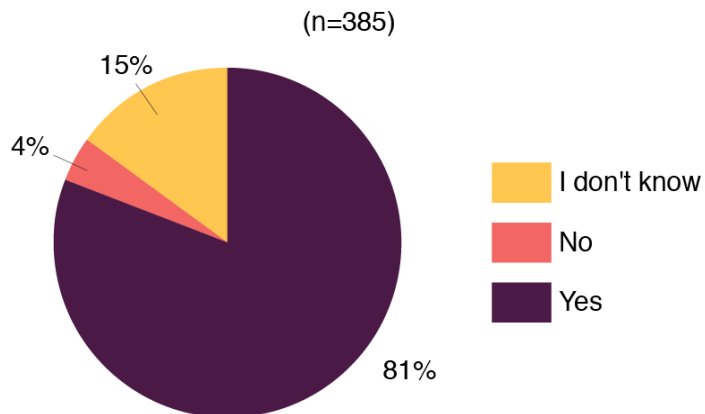
Do you have friends or family members on whom Khatna was performed?



Q13: Khatna Performed on Mother

Eighty-one percent or 311 survey participants responded that their mother underwent FGC and 4% responded that FGC had not happened to their mother.

Was Khatna performed on your mother?

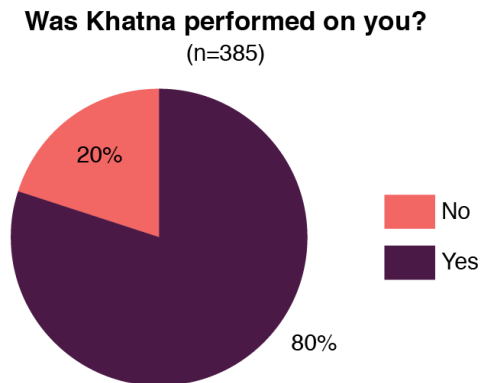


Fifteen percent do not know whether FGC was performed on their mother. Knowledge of mother's FGC procedure was found to be related to whether the respondent personally had FGC performed on them. Quantitative analysis revealed that those who had experienced FGC were more likely to know if their mother had undergone the procedure - 88% versus 51%.

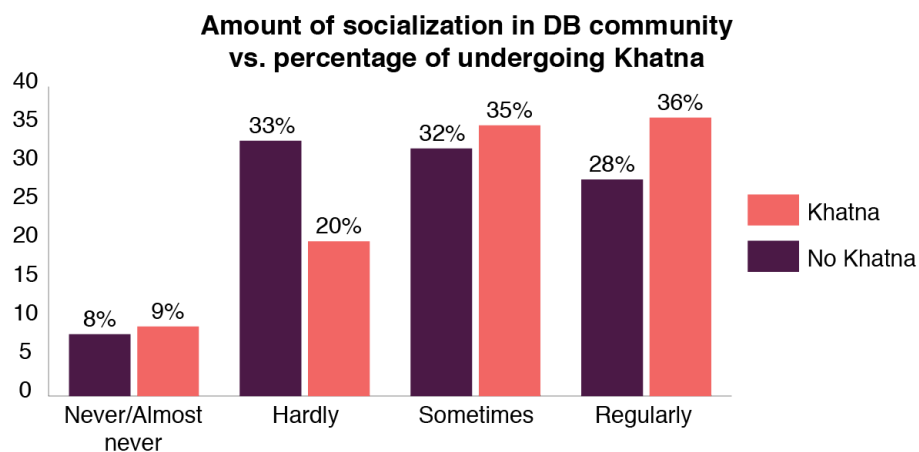
Q14: Khatna Performed on Survey Participants

Eighty percent or 309 survey participants responded that they had undergone FGC. While 20% or 76 survey participants reported they had not undergone it.

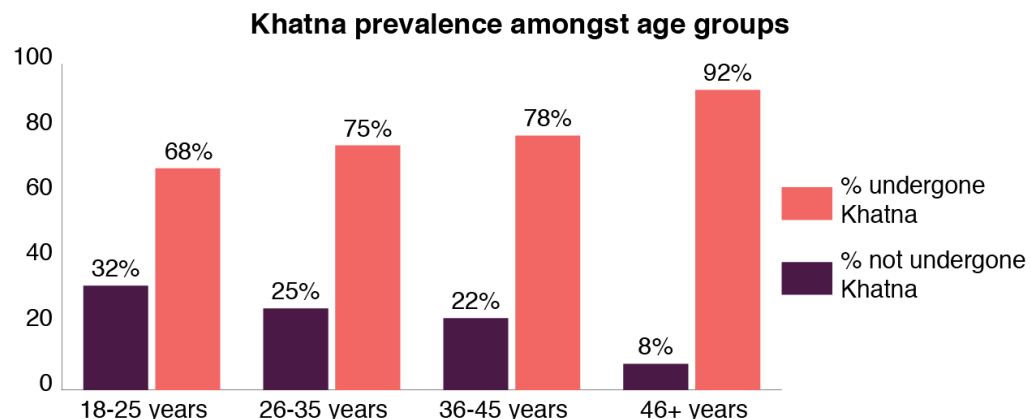
No relationship was found when the data was analyzed to determine if a relationship existed between income levels (Question #4) and having undergone FGC, nor was a relationship found when comparing education levels (Question #2) to having undergone FGC.



Additionally, no significant statistical difference was found when the amount of socialization within the Dawoodi Bohra community (Question #10) was compared to whether or not a person had undergone FGC. Results are shown below.



However, data analysis did reveal significant differences between the reported FGC rates across age groups (Question #1). Ninety-two percent of those 46 years or older reported undergoing FGC, compared to 68% of those 18-25 years of age.



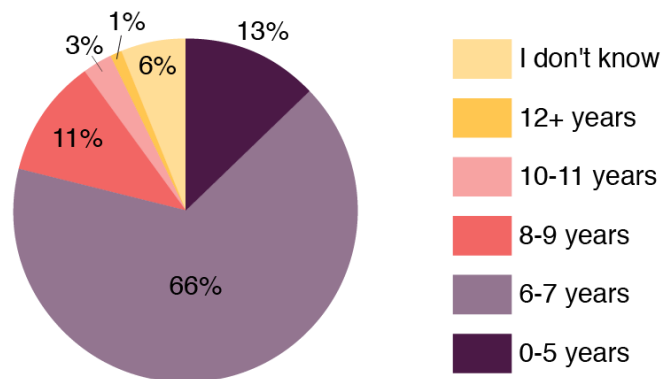
Personal Experience - Part 2

The following questions were asked of the 309 survey participants who indicated they underwent FGC, so that we could gauge their own understanding of what had occurred to them.

Q15: Age of Khatna

Two hundred and five or 66% of respondents stated they underwent FGC between 6 to 7 years of age which is the considered the normal age to undergo it by the Dawoodi Bohra community. Eighteen survey participants or 6% could not recall how old they were when they underwent FGC.

Age of participants at the time of Khatna
(n=309)

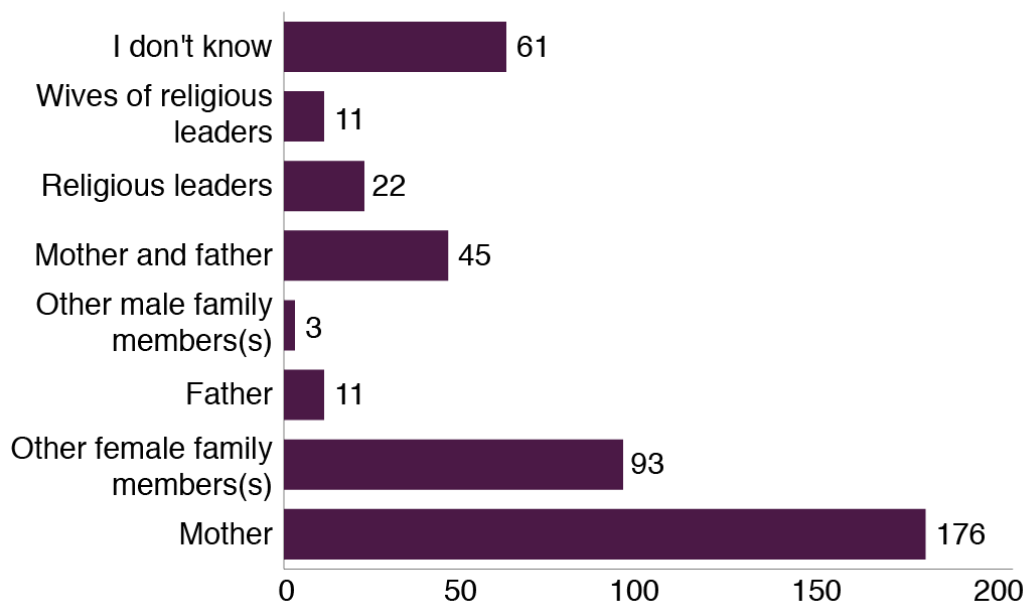


Q16: Decision Maker of Khatna

Survey Participants were asked to mark all choices that applied to Question #16. The Table below represents all answers marked by participants.

With respect to who made the decision to have FGC done, which was a multiple response question, 67% of respondents indicated that their mother made the decision. Thirty-two percent indicated that another female family member was also involved in the decision making, such as a grandmother. And 23% indicated some other decision maker was also involved, such as fathers, religious leaders, and their wives.

Who made the decision?



Where the FGC was performed?

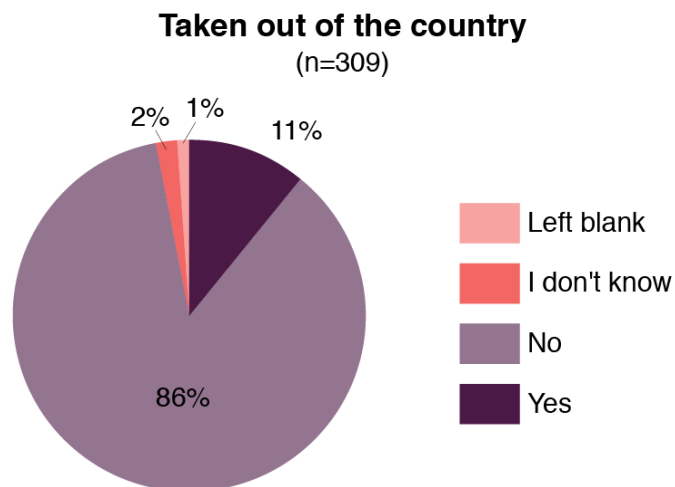
Country	Number
India	217
Pakistan	44
United States	10
Tanzania	9
United Kingdom	7
Kenya	6
United Arab Emirates	5
Kuwait	3
Sri Lanka	2
Canada	2
Bangladesh	2
Bahrain	1
Malaysia	1

Q17: Country Khatna Occurred In

Most survey respondents reported that they underwent FGC in India (70%). Forty-four respondents stated that they underwent FGC in Pakistan (14%).

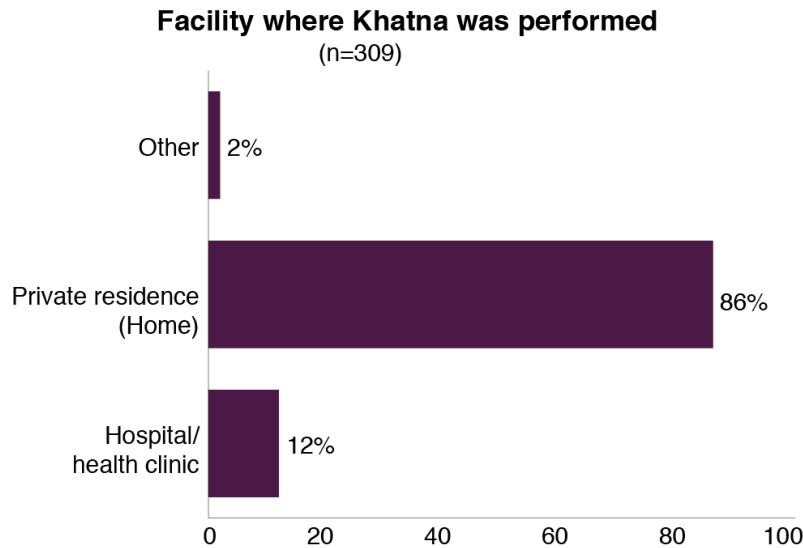
Q18: Taken Out of Country to Have Khatna Done

The majority of respondents (86%) reported that they had FGC done to them in their country of residence. Eleven percent or 34 respondents reported being taken out of their country to have FGC done. Data analysis was unable to compare 'where FGC was performed' (Q17) with whether the woman was outside her native country (Q18) due to a low number of participants or cell sizes (i.e., under 5 participants) for some of the countries listed in Q17.

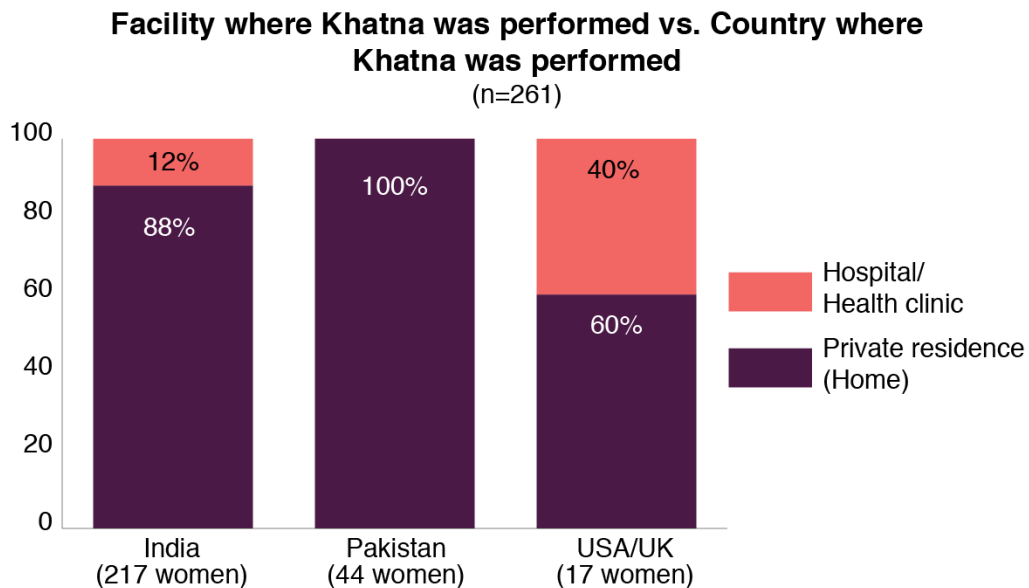


Q19: Location of Khatna

The majority of respondents (86%) had FGC done in a private residence, while 12% reported having undergone it in a health facility.

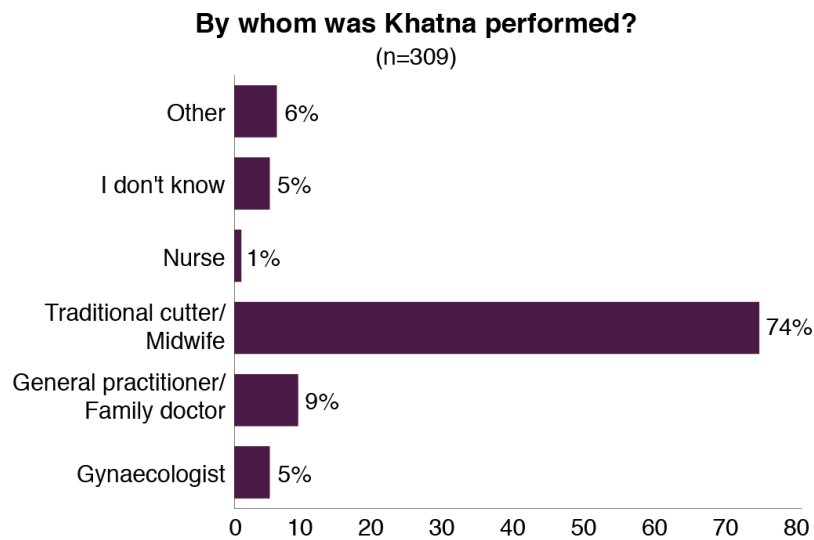


Data analysis also revealed that there were significant differences in regard to what facility FGC was performed in according to the country where the survey participant underwent the procedure. In Pakistan, 100% of survey participants had the procedure done at a private residence. In India, 88% of survey participants had the procedure at a private residence. Because of the small sample cell size, the United States and the United Kingdom were combined (17 women), and data analysis here revealed that 60% of survey participants had the procedure done at a private residence.



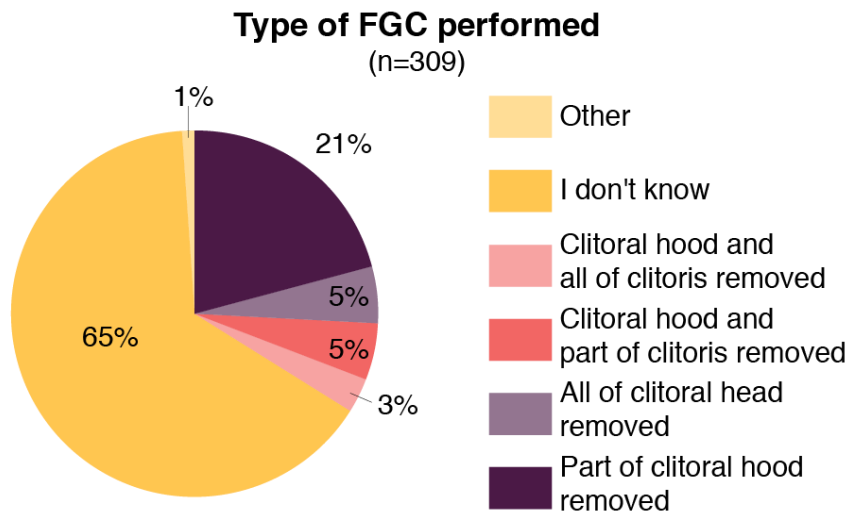
Q20: Who Performed Khatna?

Seventy-four percent of women reported being cut by a traditional cutter. Fifteen percent in total reported being cut by a health professional. (Breakdown: 9% general practitioner/family doctor; 5% gynecologist, 1% nurse.) Another 5% were unsure who cut them. The remaining 6% of participants marked the 'other' category, and their elaborations indicated that they were cut not by health professionals, but other women belonging to the Dawoodi Bohra community.



Q21: Type of "Cutting" Performed

Typically, in the Dawoodi Bohra community, the practice of FGC entails that only part of the clitoral hood is removed. The World Health Organization has classified this type of cut as Type 1 genital cutting, which includes the removal of the prepuce with partial or total removal of the clitoris (2016).



The majority of survey respondents, however, were unsure of what had occurred to them, with 65% or 202 participants answering 'I don't know'. Among the rest, 21% responded that part of their clitoral hood had been removed. Five percent reported that all of their clitoral hood had

been removed, and another 5% reported that their clitoral hood and part of their clitoris had been removed. Three percent reported that their entire clitoris had been removed. The other category includes three responses in which two participants did not respond and one participant reported that her labia was cut as well.

Table 1: Elements of Story (FGC experience)

# of participants	Story element
112	Taken to cutter's house/cutter came to their house
60	Taken by Mother/grandmother/ other female relative
45	Underwear taken off
50	Pinned down by women
41	Razor/blade/knife/scissors/wire used
12	Black powder/turmeric/something put on afterwards/red color antiseptic (known as Lal Dawa)/ diluted dettol
12	Wore a pad/cloth afterwards
10	Given a treat afterwards
6	Rested in bed afterwards
12	Had it done with a friend/cousin
10	Health professional did it/ medicalization
8	Social Pressure to have it done to daughter

Q22: Narrative Question - Experience about their Khatna

Participants were asked to describe the details surrounding their FGC. To analyze the responses, content analysis was carried out and recurring themes were coded and sub-coded. Charts below depict the coding system. Of the 385 survey participants, 309 women had undergone FGC. Within this group, 131 women provided details on their FGC experience.

Four themes emerged from participant responses: 1) Discussing the elements of their FGC experience, 2) Discussing what they were told was going to happen to them, 3) Discussing their physical reactions, and 4) Their emotional reactions. Breakdowns of each theme are depicted by the tables below.

Of the most significant narrative themes, the following figures stood out.

- 86% of women described being taken to a cutter or a cutter coming to their house.
- 98% of women described experiencing pain immediately after FGC.

Table 2: What they were told was going to happen to them

	Deception about what was going to happen	Secretive	No explanation provided	Removing a worm/insect	All bohra girls go through it	Genitals being dirty
# of participants	50	26	28	20	6	2

Table 3: Physical reactions

	Pain	Don't remember (not completely clear)/blacked out at some point	Blood	Screamed	Couldn't walk afterwards/ sit for toilet/pain while urinating
# of participants	50	26	28	20	2

Table 4: Emotional reactions

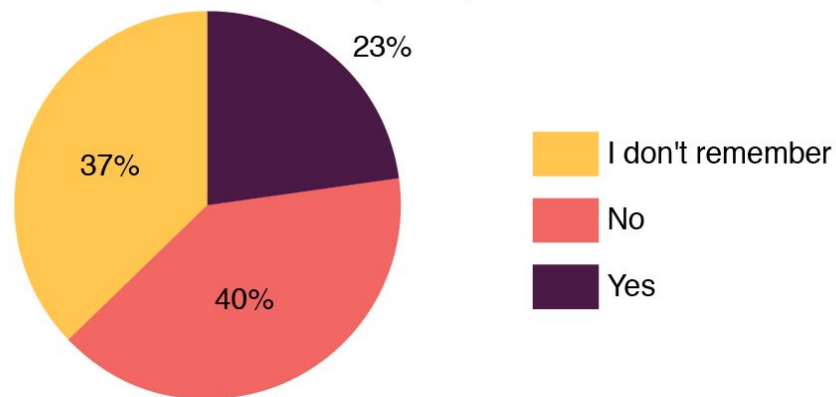
	Traumatized	Terrible/horrible/ scary experience	Realizing what happened to them later in life	Anger	Mention that they didn't want it for daughter
# of participants	49	41	19	16	12

Q23: Physical or Health Complications

Participants were divided between not having any health issues immediately after FGC (40% or 123 participants stated as such) and not being able to remember if they faced any physical or health issues (37% or 112 participants). Twenty-three percent responded that they had undergone physical and health issues immediately after undergoing FGC.

Did you face any physical or health issues immediately after Khatna?

(n=309)

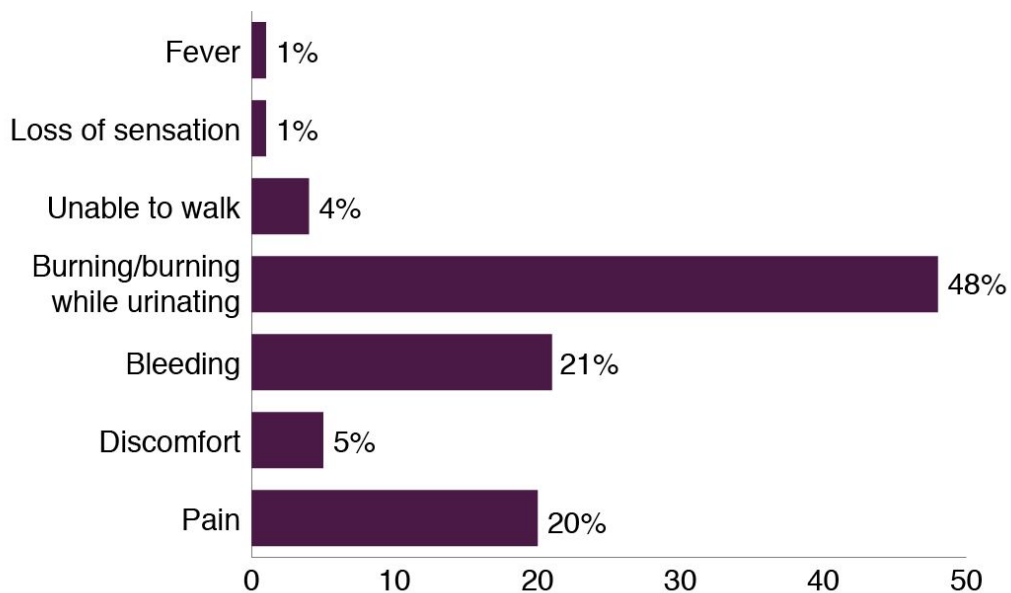


Of those who reported undergoing physical or health issues immediately after FGC, 71 respondents provided information regarding what physical/health effects they immediately encountered. Their information is depicted by Chart 23b.

Immediate health effect after Khatna

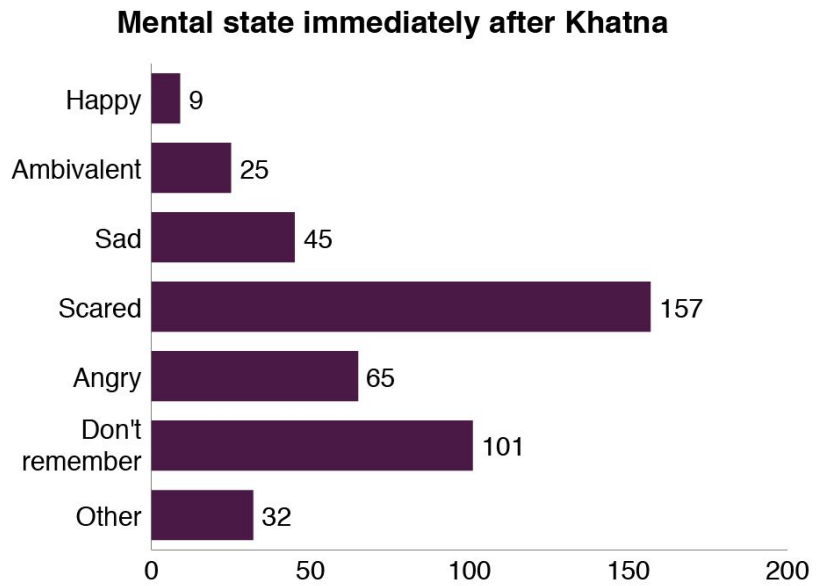
Respondents who said "Yes"

(n=71)



Q24: Mental State Immediately After Khatna

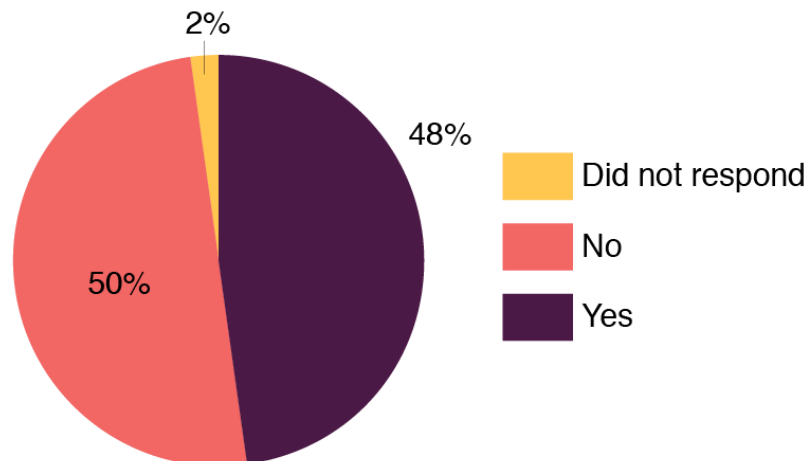
Survey participants were asked to mark all answers that applied to them. Overall, 29% (101 respondents) did not remember what they were feeling following the procedure. The most common emotions were scared (51% or 157 respondents), angry (21% or 65 respondents), and sad (15% or 45 respondents). Three percent or 9 respondents felt happy and 8% (25 respondents) marked ambivalent. Other responses included confusion, shame, numbness, humiliation, despair, mistrust or betrayal, normal, and traumatized.



Q25: Emotional Impact on Adult Life

About half of the 309 participants responded that FGC had left an emotional impact on their adult life (48% or 149 participants). The other half (50% or 154 participants) reported not having experienced an emotional impact on their adult life.

Did FGC leave emotional impact on adult life?
(n=309)



Of the 149 survey participants who stated that undergoing FGC had created an emotional impact on their adult life, 77 people provided descriptions of that impact. Their responses were coded in the following way as depicted by Chart 25b.

Emotional impact on adult life
(n=149)

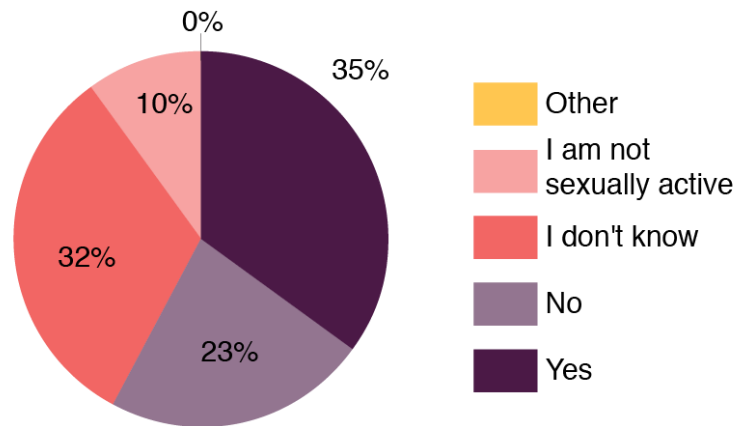
Impact	Percentage of participants
Haunted by FGC memories	8
Betrayed/violated/distrust in family	9
Upset/Disappointed/disturbed	9
Shame/embarassed/humiliated	5
Fear/scared/nervous	5
Feeling incomplete/something missing	9
Don't want others to go through it	5
Too young to consent/understand	8
Anger at parents	6
Anger	19
Sexual frustration	17

Q26: Khatna and Sex Life

Thirty-five percent of respondents reported that FGC had affected their sex life. Another 23% reported that their sex life had not been disturbed. Thirty-two percent of respondents were unsure if FGC had any impact on their sex life. Ten percent of respondents were not sexually active at the time of taking the survey.

Has Khatna affected your sexual life?

(n=309)



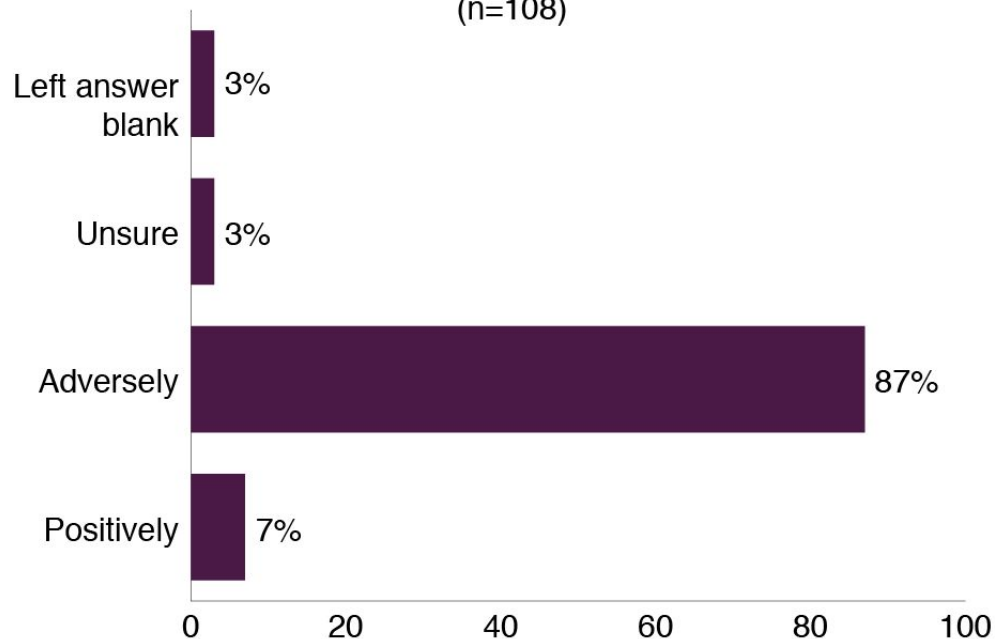
Q27: Khatna and Sex Life - Positive or Negative

Of the 108 participants who responded in Question #26 that FGC had affected their sexual life, the following question of if FGC had affected their sexual life positively or adversely was asked. Ninety-four participants (87%) indicated that their sexual life had been impacted negatively. Eight participants (7%) responded that their sexual life had been positively affected.

If Khatna affected sex life, is it positively or adversely?

Respondents from Q26

(n=108)



Q28: Narrative Question - Khatna and Sex Life Details

Participants were asked to describe the details surrounding the effects of FGC on their sex life. To analyze questions, content analysis was carried out and recurring themes were coded and subcoded. Eighty-three people responded to this question with more description. Chart below depicts coding system.

If you wish to elaborate on the effects of Khatna on your sexual life, please describe below (n=83)	
Effects	Percentage of participants
Heightened physical stimulation	3
Increase in sexual desire	3
Didn't affect sexual life	3
Unsure if related to procedure	10
Negatively affected relationship	7
Low libido	10
Discomfort/pain	17
Lack of physical stimulation	19
Difficulty/inability to reach an orgasm	29

Social Experience

What would DB relatives and friends think if a woman did not undergo Khatna?

	Participants who responded	
	Number	Percentage
Other	17	6
I don't know	74	19
We don't discuss Khatna	198	45
The woman is not a "true" Dawoodi Bohra	102	27
They would think that the woman was unclean	41	11
Wouldn't want that woman to marry their son	45	11
They would be upset	42	11
They would be very surprised	79	21
They would think nothing of it	63	16

Q29: Perception of Not Undergoing Khatna

Participants were asked what their relatives and friends would think of women who have not undergone FGC, and were allowed to mark more than one answer to the question. The graph below depicts the overall number of times an answer was selected by a participant. Seventeen participants also selected “other”, and of these seventeen “other” responses, eleven individuals indicated that different groups (family vs. friend, educated vs. uneducated, religious vs. not religious) would think different things of a woman who hadn’t undergone FGC. Additionally, this graph depicts the overall percentage of selection for an answer response by survey participants. The leading response selected by participants was, “We don’t discuss Khatna”.

Explanations heard for Khatna

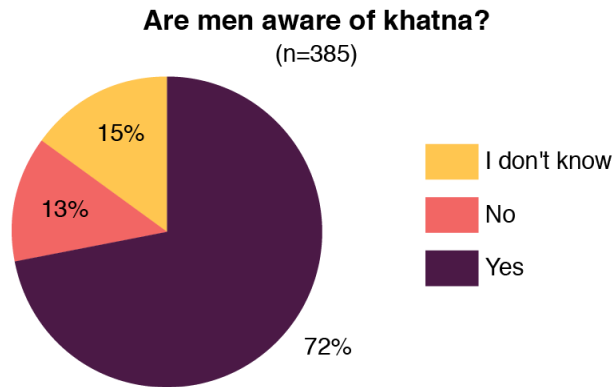
Explanations	Number
Other	12
As a necessary requirement for a good marriage	36
To gain respect from the community	32
To increase sexual arousal	8
To decrease sexual arousal	178
To maintain traditions and customs	161
For reasons of physical hygiene and cleanliness	103
For religious purposes	222

Q30: Explanations Given to Perform Khatna

Multiple explanations were given as to why FGC continued in the community. Participants were able to mark all of the explanations they had heard for the continuation of FGC. The most common answer was that FGC was continued for religious purposes. Those who marked “other” indicated that they had heard no explanation for FGC.

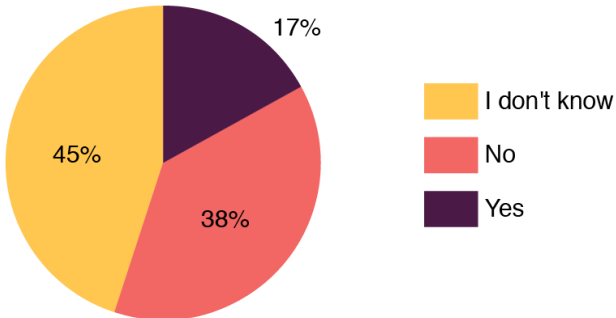
Q31: Men's Knowledge on Khatna

Participants were asked if men (fathers, brothers, sons, etc.) were aware of FGC. The majority (72%) reported yes.



Men's expectation on Khatna occurring

(n=385)



Q32: Men's Expectation of Khatna Occurring

The majority of survey respondents (45%) were unsure if men expected FGC to be performed on Dawoodi Bohra women. Thirty-eight percent believed that men did not expect FGC to happen to women.

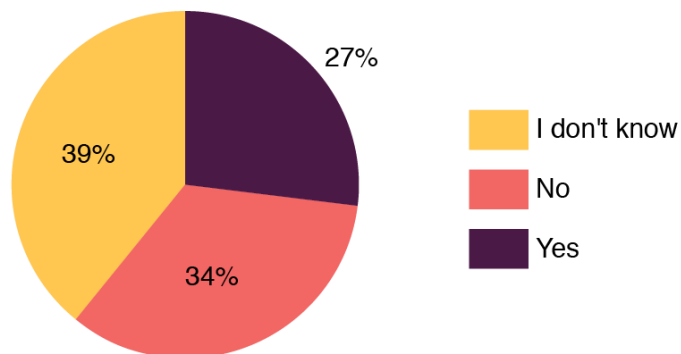
Khatna When Female Relatives Undergo It

Though 72% of participants responded that they believed men are aware of FGC in Question 31, 39% were unsure if men were told of the practice when it occurred to a female relative, and 34% believed that men were not told when it occurred to a female relative.

Q33: Men's Knowledge of

Are men told of the practice when it happens?

(n=385)

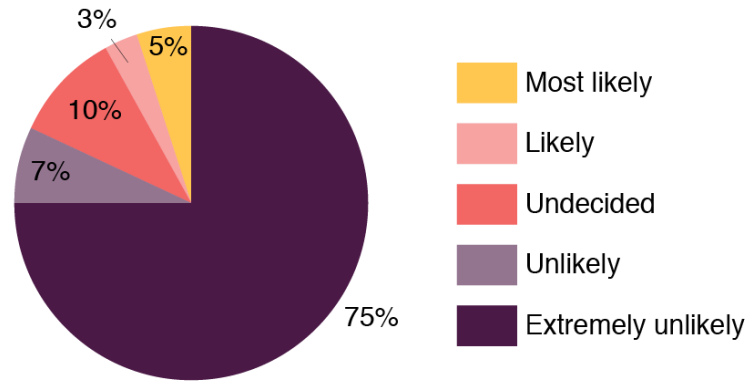


Q34: Continuing Khatna on Their Daughter

Eighty-two percent of participants overwhelmingly responded that they would not continue FGC on their daughter.

Would you continue Khatna on your daughter?

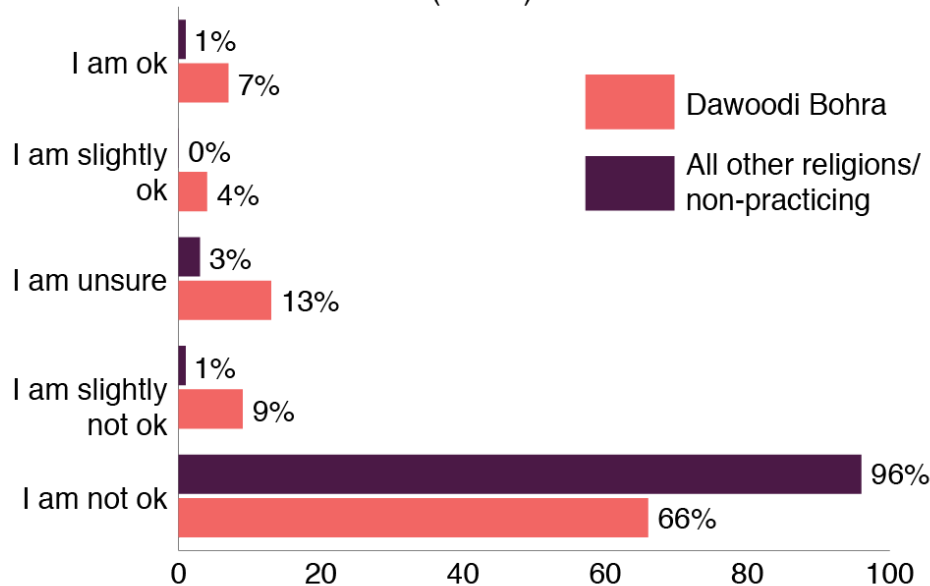
(n=385)



Data analysis also revealed a significant statistical difference between respondents' reporting they are OK with khatna continuing and whether they identified with being a Dawoodi Bohra in their adult life. Those most likely to continue khatna were also more likely to still identify as Dawoodi Bohra. The same relationship was found when analyzing the question on if they would continue the practice on their own daughters. Chart 34a shows, two-thirds of those still identifying as Dawoodi Bohra were extremely unlikely to continue the practice with her daughter, while 96% of those who have left the religion say the same.

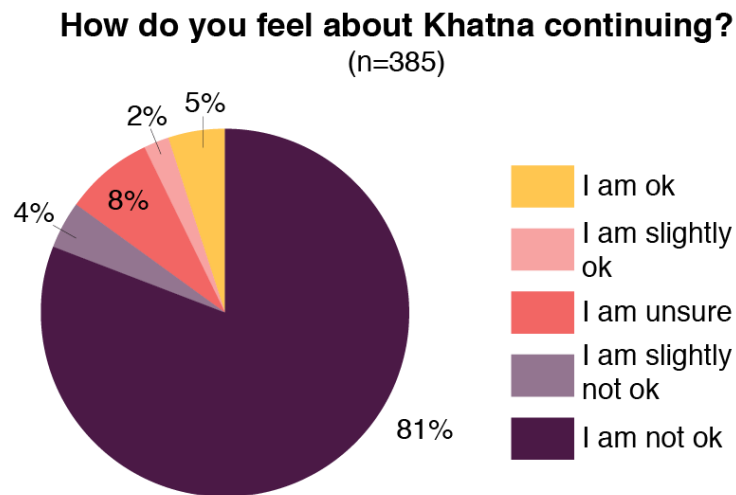
Identification with DB vs. being okay with Khatna continuing

(n=385)



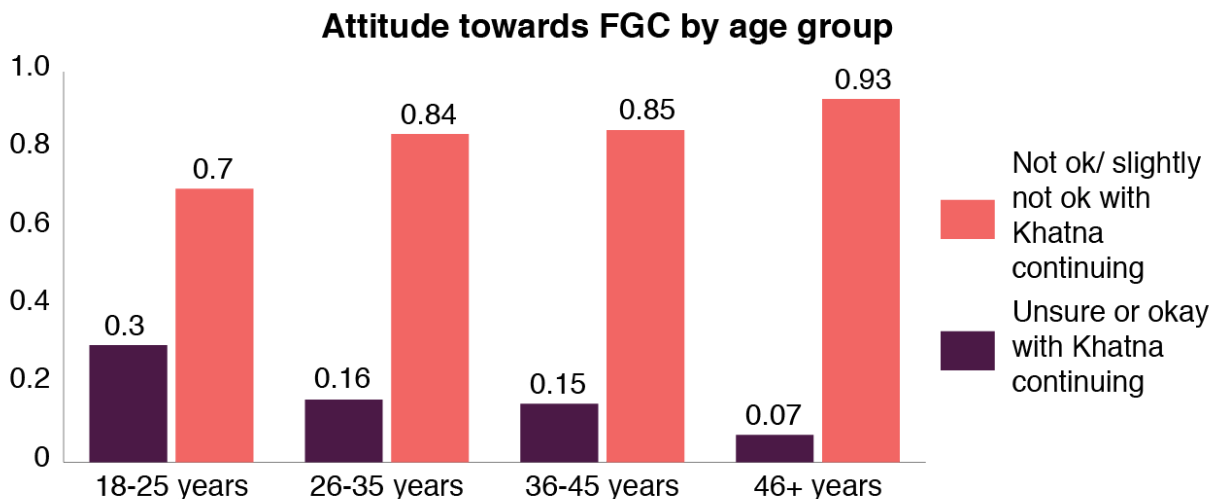
Q35: Khatna Continuation in the Community

Participants were asked to depict how they felt about the practice of FGC continuing using a scale. Three hundred and twenty eight or 85% of participants reported not being okay with FGC continuing. Only 28 participants or 7% reported being ok with the practice continuing.



The data showed that there was a relationship between FGC prevalence and the intention to continue the practice with one’s offspring (Question #34) and also in general in the community. Among those who had not undergone FGC, no one stated that they were “OK or slightly OK with the practice continuing”; only 10% of those who had experienced FGC reported being OK or slightly OK with continuing the practice in the community (and 9% reported being OK or slightly okay with continuing FGC on their own daughter).

Data was also analyzed to see if survey participants’ attitudes toward abandoning FGC changed with participant’s age group. Coincidentally, older women, 46+ years were more likely to express a negative view of FGC continuing (93%) compared to women 25 years and younger (70%).

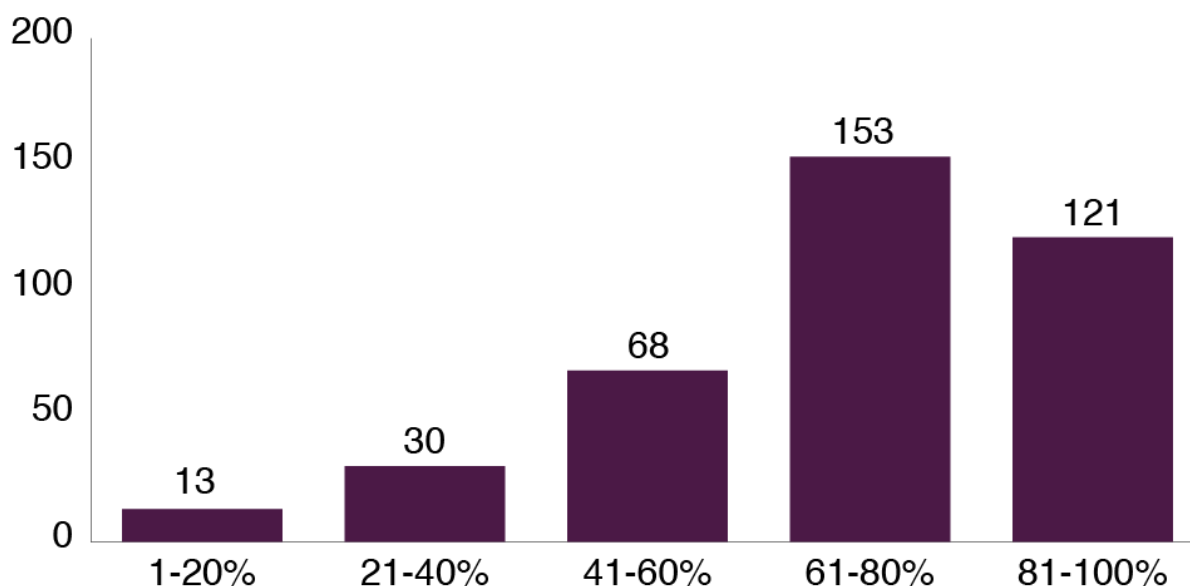


Q36: Belief around Prevalence of FGC in Community

Participants were asked to estimate the percentage of females who had undergone FGC in the entire Dawoodi Bohra community. The chart below indicates that the majority of respondents believe FGC to be prevalent at a rate of 61% to 100% within the Dawoodi Bohra community.

How prevalent is Khatna in DB?

(n=385)



Q37: Khatna Performed Amongst Other Communities in India

Survey participants were asked if they were aware of FGC happening in other Indian communities. The majority reported no. Fifty-nine respondents responded yes, and few respondents provided names of religious communities in India, including Memon, Agha Khanis, other Shia Muslims, Sunni Muslim, Hindus, Christians, Sulaimani Bohras, Alvi Bohras, and the Siddi tribe in Pakistan.

It is important to note that this information in regard to other South Asian communities practicing FGC has not been confirmed independently by Sahiyo. However, Ghadially (1991) interviewed cutters from the Dawoodi Bohra community who stated they had clients from Aliya and Sulemani Bohra Muslim communities as well. The Dawoodi Bohras, the Aliyas and the Sulemanis were considered one Bohra sect before they split into sub-sects in the 1600s. All three claim their roots in Ismaili Shia Islam.

Discussion

Discussion

Currently, no representative data on FGC exists for India or amongst Dawoodi Bohra communities worldwide. However, the practice of female genital cutting (FGC) among Dawoodi Bohras has been the subject of small-scale research and documentation for more than two decades. One case study published in April 1991 by Sandhya Srinivasan, depicted a young mother living in an extended household who, because of pressure from her mother-in-law, took her seven-year-old daughter to a traditional cutter to have her undergo FGC. Another well-known study of FGC in the community is 'All for Izzat' by Rehana Ghadijally (1991). Her study was based on oral interviews with 50 Dawoodi Bohra women from Mumbai, as well as two traditional cutters. A more recent small scale study based on ethnographic interviews of six women who underwent FGC and resided in the United States was conducted by MSW student and Sahiyo co-founder, Mariya Taher (2010). Though limited in scope, these case studies help corroborate results found by Sahiyo's 2015-16 study, providing for the first time an evidence-based understanding of how FGC has continued within the Dawoodi Bohra community on a global level.

Sahiyo's 2015-16 study also supports findings by Shell-Duncan, Reshma, Feldman-Jacobs (2016), who produced a state-of-the-art synthesis on FGC by combing through nationally representative data on the prevalence of the practice among girls and women ages 15-49 in 29 countries (Yemen, Iraq and 27 African nations). Lastly, the analysis looked at findings from Islamic Relief Canada's (2016) qualitative study on FGC in Indonesia to help demonstrate similarities between varying Asian countries in regard to the type of FGC performed.

Type of FGC

Ghadijally reported that the Dawoodi Bohras practice the 'sunnah' variety of FGC in which the prepuce or the hood of the clitoris is removed. However, Sahiyo's study showed that the majority of survey participants (65%) were unsure of what occurred to them, indicating that the exact type of cut was not revealed to them at the time they underwent FGC. Only 21% of survey respondents indicated that a part of their clitoral hood had been removed.

Islamic Relief Canada (2016) indicated a similar finding amongst their survey population in Indonesia regarding a lack of knowledge on the female anatomy amongst survey participants, indicating that 60% of their interviewees in Lombok had limited knowledge of the anatomy of the female body and its reproductive organs – and were therefore unaware of what FGC entailed and how it affected their bodies.

Age of FGC

Consistent with Ghadijally's findings that khatna was performed on girls at the age of seven, 66% of Sahiyo's survey respondents indicated that they underwent FGC between six to seven years of age. Sahiyo's survey did not inquire as to why girls were cut at this age, but Ghadijally postulated that it was perhaps because the girl was considered too young to understand what was being done to her but "at the same time was considered sufficiently mature to continue the tradition when she had a daughter of her own".

Who Performs FGC on Girls?

According to Ghadially, khatna is carried out by *mullanis*, midwives and doctors. Sahiyo's survey respondents support this claim, as 74% of women reported being cut by a traditional cutter and 15% reported being cut by a health professional.

Physical Health Consequences of FGC

Interviewees from Ghadially's study reported no serious health or reproductive repercussions due to khatna, although a Dawoodi Bohra doctor she interviewed attested to seeing cases of girls with "infection, swelling, severe bleeding, shock, tetanus". Sahiyo's survey found that 23% of the respondents reported undergoing physical health issues immediately after FGC, which included pain, bleeding, and burning during urination. (Thirty-seven percent could not remember if they faced any physical health issues).

Interestingly, while only 71 women or 23% reported experiencing physical health complications after FGC in the objective component of the question, a larger group of women, 128 women, or 98% mentioned experiencing pain in the subjective or narrative component of the question.

Islamic Relief Canada (2013-2016) found that amongst their Indonesian study, there was no evidence of major physical complications due to FGC, but, interviewees did depict incidences of pain, fever and bleeding.

Narrative Elements of the FGC Survey

Ghadially's (1991) study includes a description of khatna by a cutter within the Dawoodi Bohra community. This description contains elements similar to what respondents in Sahiyo's survey recalled of their own FGC experience. Of the 385 survey participants, 309 women had undergone FGC. Within this group, 131 women provided details on their FGC experience. The similar elements included the use of 1) a razor or sharp object, 2) a powder mixture to put over the clitoris for healing purposes, and 3) the girl being held down by her mother or another woman during the procedure. The following survey participant's quote exemplifies these story elements:

'I remember my mum whispering with my granny and aunties that time had come now. Then she mentioned to my dad who said do what's needed. She told me we were going to buy a doll, took me to a woman's house in a Bohra community housing set up. We were told to wait in the sitting area, another friend of mine was sitting with her mum. She was called in first, I heard screaming and then she came out supported by her mum. I was taken in next, the lady told my aunt to lay me on a table, remove my undies. My mum had left because she said she couldn't watch. My aunt held me down tightly, the lady removed a new razor blade in front of me and then bent down between my legs. I felt a sharp cut, heard myself scream and cry. The lady then gave

me cotton wool and my aunt put it in my undies to absorb the blood. We were then led out of the room. For a week after, my mum washed my vagina with diluted dettol and the matter was hushed up and never talked about.’ (sic)

The cutter in Ghadially’s study also explained that the girl is told not to speak of what happened to her to anyone. This response was given by respondents in Sahiyo’s survey as well.

‘I didn't know anything. My mum told me to come lie on the bed and it was performed. Afterwards mum explained a little that every girl has to go through this and not to tell anyone, meaning brothers and friends.’

The cutter also noted that some girls were told a worm was removed from their stomach. This, too, was stated by some respondents in Sahiyo’s survey, as highlighted in this next quote:

‘I hardly remember the happenings around it, all I remember is that I was taken there by my mum and my caretaker to this strange, poor and dungy home of a (Katchi) woman who was probably a midwife and there I was forced to open my legs and was told there was a worm that needed to be removed. I remember coming home padded with cotton wool and in a lot of pain. I was made to rest and sleep in bed all day! Don't remember anything after.’ (sic)

Sahiyo’s survey results differ, however, with respect to the physical reaction of the girl experiencing khatna. According to the cutter in Ghadially’s 1991 study, there were no immediate consequences of khatna:

There is no bleeding unless the girl is difficult to manage. She [the cutter] recommends to the mother that the genital area be washed with warm water and antiseptic and the girl be given coconut water to drink to help in the discharge of urine. The wound is healed in a day or two. Post circumcision complaints are rare. Occasionally mothers come saying that the girl won't permit them to wash the circumcised area (p. 19).

But in Sahiyo’s survey, of the 131 women who provided details of their FGC experience, 98% described experiencing pain immediately afterward. Survey respondents also mentioned experiencing bleeding, screaming, being unable to walk, sit on the toilet, pain during urination, and blacking out due to the experience. Survey respondents recalled the experience as horrible or scary and stated that they felt traumatized, or were angry about having to undergo the experience. The following two quotes illustrate the trauma felt by the survey participants immediately after they underwent FGC.

‘Awful experience, painful beyond belief, lifelong emotionally and psychologically scarring. I was taken to a tiny apartment, told to take off my underwear and cut with a knife that was heated up on a stove. There was ample blood and excruciating pain.’ (sic)

‘It was the most horrific experience of my childhood and something that I will remember for the rest of my life. I was taken to some random shack in some random village and a lady that I had never met in my life held me down and took a knife to me. I just remember screaming and crying through the entire thing and being in pain for the next week or so. I would absolutely never have my child ever go through such an experience in her life.’

The difference in opinion between the cutter and the reported experiences by Sahiyo’s survey respondents clearly indicates a disconnect in the understanding of the various physical and emotional reactions faced by a girl who undergoes FGC.

Emotional Impact on Adult Life

None of the earlier Dawoodi Bohra case studies discussed the emotional impact of undergoing FGC in the woman’s adult life. Sahiyo’s study found that about half – 48% of the 309 participants who had undergone FGC – stated that their FGC had left an emotional impact (Question #25). Survey participants were given the opportunity to provide more details in narrative form regarding the emotional impact FGC had on them as demonstrated by the response below.

‘As the years rolled by, I attained puberty, and after experiencing my first menstruation, I became aware of my sexuality. At this point of time, my second eldest sister, in order to give me an understanding of sexual knowledge, gave me a book to read - 'Encyclopedia of Sexual Knowledge' authored by Dr. Van de Velde. After reading that book, the full impact and realization of that awful, painful and life-changing procedure which I was made to undergo at the innocent age of seven years, dawned on me. I was privately distraught and enraged to learn that I had been robbed of my basic feminine rights to sensuality and sexuality, and forever, deprived of any clitoral sexual stimulation. This feeling disturbs and traumatizes me even today. I feel robbed and cheated of my sexuality, and feelings of inadequacy and incompleteness remain with me till today, even at the age of 61. The emotions of impotent rage and anger refuse to leave my mind or my spirit. After making a private self-examination, I found that the prepuce or the entire foreskin of my clitoris had been cut off.’

Of the 309 respondents, 35% of the women stated that the FGC had impacted their sex life as adults, the majority implying that their sex life had been affected negatively

(Question 28). However, as mentioned earlier, 65% of survey participants were unsure of what had physically occurred to them. Thus Sahiyo's study was unable to conclude if FGC had caused their sex life to be unfulfilling. Survey participants' narrative responses reflected both 1) the negative impact on their sex life, and 2) the uncertainty of whether or not their sex life had been impacted by FGC. The following quotes demonstrate these varied experiences:

'I am unable to reach a clitoral orgasm. If much stimulation of my clitoris is attempted, I experience soreness and a burning sensation. I also very rarely experience vaginal orgasm because of lack of sufficient arousal and stimulation of my genitalia particularly the clitoris.'

'Given that my circumcision was done more for symbolic reasons to merely satisfy the religious decree, the procedure didn't have any adverse physical implications (thankfully) in my life. Having said this, since I was obviously not sexually active at the age of 6-7 years, I am unaware if the procedure has positively or negatively affected my sexual life!'

'I was not comfortable in allowing penetrative sex. I felt anxious, nervous and would start to shiver, until my husband would give up seeing my strange behaviour. I would normalise immediate after he would withdraw. He would be normal but I would suffer the guilt pangs.'

'The khatna has not left any obvious physical evidence. No gynecologist or other medical doctor has ever remarked or even noticed that my genitalia looked at all different. There have been issues with my inability to properly enjoy sexual intercourse, however I don't believe that these are linked to the khatna. Rather medical professionals have said these are due to other factors. Frankly, as confused and angry as I was as a young girl, and as much as I think this abhorrent and unnecessary practice should end, I don't believe that it had a lasting physical impact on my sexual health.'

Despite the varied experiences relating to the emotional and sexual life of survey participants, the overall negative reactions of the women points to the need for support services for survivors who have faced emotional trauma/psychological trauma due to FGC – more so, perhaps, than the need for physical health-related support services.

Men's Knowledge of FGC

Ghadijally (1991) claimed that a girl's FGC was kept an absolute secret not only from outsiders, but also from men in the Dawoodi Bohra community. Yet, when respondents from Sahiyo's survey were asked if men were aware of FGC in the community, an overwhelming majority reported "yes" (72%). Considering Ghadijally's case study was

conducted in 1991, and with the advent of the internet, social media, and the fact that the media in India has highlighted the issue of FGC within the last two years, Sahiyo's findings might reveal that the topic of FGC is no longer considered a guarded secret amongst men from the community, or even for that matter, the general public. However, when asked if men were aware of when a female relative underwent FGC, 39% were unsure and 34% believed that men were not told about it.

Reasons for Continuing FGC

Muteshi (2016) stated that "FGM/C is a sensitive practice that is embedded within complex socio-cultural systems. Reasons vary across countries and cultures". She explains that one community might provide several reasons or even contradictory reasons for the continuation of the practice, a statement that is corroborated by the earlier Dawoodi Bohra case studies and Sahiyo's study within the Dawoodi Bohra community.

In April 1991, Srinivasan stated that FGC was not explicitly required by the Dawoodi Bohra religion, but that families continued the tradition out of fear that they would incur the disapproval of religious leaders if they abandoned it. In contrast, Ghadially (1991) indicated that khatna was endorsed by the clergy, who often provided permission and support to traditional cutters (who are Dawoodi Bohra women mostly from low-income families). Taher's study also found that the clergy recommended FGC be continued (2010). Additionally, participants in Taher's study reported that though their mothers were responsible for making the decision to have them cut, this decision was heavily influenced by religious leaders (2010). These findings suggest that because the practice is linked to religion, it may be more strongly connected to the need for culture-based social inclusion. The following survey participant quotation from Sahiyo's study highlights the idea that FGC for the Dawoodi Bohras is in fact a must for social inclusion into the community, as the survey participant noted that other Muslims don't perform the practice.

'I vividly remember this painful procedure. Before we realized my cousin and me were taken to a old maasi [elder woman]. The event was painful and I cried with pain and even questioned my mother about this. She had no answer except just told me that it was religiously required. I bled for a couple of days, it scared me so much that i was afraid of passing urine. Even enquired from my other Muslim friends whether they had undergone this khatna, to which they nodded in refusal.' (sic)

Yet, religion emerges as only one of the reasons for the continuation of FGC. In Ghadially's study, the most commonly cited reasons for practicing khatna were that it is a religious obligation, a tradition, and that it curbs a girl's sexuality (1991). These findings are consistent with Sahiyo's survey results, in which respondents cited multiple reasons for performing FGC, including for religious purposes (56%), to decrease sexual arousal (45%) and to maintain traditions and customs (42%). Ghadially reported that a less commonly cited reason for FGC was cleanliness, a finding that fell in line with Sahiyo's study results: only 27% of the participants listed physical hygiene and cleanliness as a reason for FGC.

Taher's study also reported several different reasons for FGC within the Dawoodi Bohra community, including hygiene and cleanliness, religion, sexual control, and tradition (2010). All three studies suggest that the continuation of FGC is deeply rooted in the community's culture.

The Dawoodi Bohra community can also be viewed as an ethnic community within South Asia. FGC can therefore be seen as a practice that helps solidify the community's identity. Shell-Duncan et al., (2016) have stated that FGC is a practice that is "more strongly associated with ethnicity than any other personal characteristic". Ethnicity, they explain, serves as a proxy for shared norms or values concerning family honor, factors related to marriageability, sexual restraint, coming of age, or other codes of conduct. Given that FGC is a marker of these norms, the practice can become highly valued by some members of the community and thus strongly protected. Several survey participants remarked on the reinforcement of the practice of FGC by their family members in the narrative section regarding their khatna experience (Question 22). The following quote is one such example.

'I don't recommend doing it to our children however, I had done it to my daughter due to pressure from my mom but did it at the hospital by a doctor. I regret it though' (sic)

This reasoning helps to explain the ideology behind why FGC is performed for sexual control. While Sahiyo's study did not delve into asking why sexual control of women was necessary within the community, Taher's study suggested that the purpose behind controlling a woman's sexuality was religion:

'Those women who mentioned FGC was done to decrease a woman's sexuality stated that within Islam, women were not supposed to be sexually aggressive and by removing a piece of the clitoris' foreskin, a woman's aggressiveness towards sex is curbed. Yet, within the Dawoodi Bohra strain, one participant explained that the actual procedure of removing a piece of the foreskin, no bigger than your pinky fingernail, exposes a woman's clitoris more and that the religious teachings or taweel behind this practice claims that by having both the male and female circumcised, a certain kind of knowledge or ilm is passed between those engaged in the act of sex, and this ilm makes the sex more pleasurable' (2010, p. 37).

Ghadijally (1991) further clarified that the need to curb female sexuality was closely related to the fact that women safeguarded the *izzat* (honor) of the family. She stated,

'Indian Muslim society, like many other traditional societies, uses double standards for judging men and women and demands from women complete adherence to these double standards. Any deviance from the codes of morality prescribed for women threaten the izzat of her kin group. Unlike other Muslim women in India, the sexual desire of Bohra women is curbed both physically and

culturally. The task, as expected, is accomplished by enforcement from older women of the family' (p. 18).

Srinivasan (1991) also claimed that FGC was done amongst the Dawoodi Bohras to control the sexuality of women, and that family structure played a part in continuing FGC from generation to generation. She suggested that FGC was a status symbol among wealthy, orthodox families and that because Dawoodi Bohras typically lived with their extended family, the elder women in the family ensured their family's honor was continued through strict adherence to customs. Although Sahiyo's survey did not include questions relating to family structure, a lack of adherence to customs and tradition has commonly been cited by Dawoodi Bohra community members as reasons for excommunication from the community (Johari, 2015). This fear of social ostracism indicates that for the Dawoodi Bohras, not participating in the continuation of FGC might lead to stigmatization from the society because women who had not undergone FGC would not be the norm. Thus, families who abandon FGC can face high social costs, including exclusion from social support, events, and opportunities (Shell-Duncan, 2016).

Educational Level of those who Undergo FGC

Shell-Duncan et al., (2016) indicated that there was a strong link between women's education and the continuation of FGC. Eighty percent of Sahiyo's survey respondents had earned at least a Bachelor's degree. Yet, data analysis did not reveal a relationship between education level and having undergone FGC.

Shell-Duncan et al., (2016) also suggested that the connection between a mother's education level and her tendency to continue FGC on her daughter could be that more educated women participated less in social networks where female relatives are able to exert a strong influence on whether a child should undergo FGC.

Yet, considering the high education level of Sahiyo survey participants, and that there was no statistical difference in the amount of socialization within the Dawoodi Bohra community and whether or not a person had undergone FGC, "socialization" within the community may not be an important factor in determining whether or not a girl is at risk of FGC. The question of a person's ideological preference (stated religion) however, might provide clues as to whether this influences a person's decision to continue FGC on their daughter. In fact, Sahiyo's survey found that those who were most likely to continue 'khatna' were also more likely to still identify as Dawoodi Bohra in their adult life.

Continuation of FGC

Shell-Duncan et al., (2016) reported that both men and women believed the practice should end. Results from Sahiyo's study also suggested that men and women want the practice to end in the Dawoodi Bohra community.

According to Taher's study of six participants, 83% of participants indicated FGC to be a widespread practice in the Dawoodi Bohra community living in the United States (2010). Sahiyo's survey also indicated FGC to be a widespread practice among the global

Dawoodi Bohra community, the majority of respondents believing FGC to be prevalent at a rate of 61% to 100% in the Dawoodi Bohra community. These high figures indicate FGC to be a social norm within this community.

However, looking at trends of continuation of FGC onto the next generation, Sahiyo's survey results differed from Ghadially's case study. More than 70% of the Dawoodi Bohra women Ghadially interviewed had continued khatna on their daughters without questioning it (1991). Sahiyo's survey suggested that 82% of survey participants would not continue FGC on their daughter. Taher's study (2010) also found the number of women who would continue FGC on their daughters to be small – only 33%.

These results suggest that though FGC is considered a widespread practice in the Dawoodi Bohra community, trends toward abandonment of the practice have perhaps begun.

Shell-Duncan et al., (2016) proposed that one way to track the rate of abandonment over generations included comparing the difference between the youngest and oldest age groups, as it could give a clearer indication of any changes that have occurred recently among the younger cohorts.

Yet, when Sahiyo analyzed data to see if survey participants' attitudes toward abandoning FGC changed with participant age group, it was revealed that older women ages 46 and above were more likely to want FGC to discontinue (93%) compared to women 25 years or younger (70%). A possible reason for this contradictory conclusion could be that older women, who have more privacy/agency in traditional family structures, hold more of an influence over the decision to continue FGC on a child.

Conclusion

Conclusion

Implications for Ending FGC

It is imperative to have a clear understanding of the scale and scope of the practice of FGC around the globe so that policymakers, donors, program developers, health professionals, and other key stakeholders know how to contribute to ending this form of gender violence. Muteshi (2016) stated that a challenge to ending FGC is that there has been a lack of adaptation to the local context. The purpose of this report was to understand the perceptions, beliefs and rationales of the practice among Dawoodi Bohras globally in order to create policies and programs that aid in the abandonment of FGC amongst South Asian populations.

Shell-Duncan et al., (2016) indicated that FGC is a practice that is intricately woven into the fabric of social networks and tied to important cultural norms and values. Sahiyo's study demonstrates that regardless of the justification given for the continuation of this practice, FGC is deeply rooted in the Dawoodi Bohra community's culture. Therefore, understanding the complex social norms and cultural value systems that shape the practice's meaning and significance within this community is critical to the work of anti-FGC advocates. For instance, understanding the age at which girls typically undergo FGC in this community can help child protection professionals identify when a girl might be a risk. Or, recognizing that a large percentage of Dawoodi Bohra survey participants lacked basic understanding of the female anatomy, and thus the subsequent physical harm incurred by FGC, could point to a vital need for more sexual health education in schools to counter any beneficial perceptions of FGC that Dawoodi Bohras misguidedly believe in.

Similarly, Sahiyo's study demonstrates that the justification given for FGC can vary over time. Anti-FGC advocates should acknowledge this fluidity and lack of uniformity in rationales for why FGC occurs as an opportunity to understand which community-based strategies would be most effective for facilitating the abandonment of the practice.

For instance, in 2016, as the topic of khatna within the Dawoodi Bohra community gained media attention, for the first time, religious authorities provided public statements regarding the continuation of the practice. The head of the religious community, Syedna Mufaddal Saifuddin, made a public speech in April 2016 stating that "the act" must continue, 'discreetly for girls', implying that Dawoodi Bohras must secretly practice it even in countries where it may be illegal (Das, 2016).

However, in an official press statement in June 2016, the religious authorities clarified that FGC must be performed in countries such as India where the practice has not been made illegal, and must not be performed by diaspora Dawoodi Bohra communities who live in countries where it is illegal (Chari, 2016). Meanwhile, a separate faction of the Bohras, under the leadership of Syedna Taher Fakhruddin, condemned FGM, calling it "an un-Islamic and horrific practice". Yet, this religious leader also maintained that 'khatna', as mentioned in the Dawoodi Bohra religious book *Daim al-Islam*, is different from FGM and should be done 'electively' after a girl reaches adulthood. Fakhruddin stated that khatna is

akin to the clitoral unhooding procedure which is medically and legally sanctioned in many countries and is done to enhance the sexual pleasure of women, not to suppress it (Ashar, 2016). This variance in justification for why FGC should continue has allowed for public dialogue within the community, which advocates have been able to use to nurture public debate.

Keeping abreast of systematic changes within the community's culture is important for anti-FGC advocates who are looking for windows of opportunity in which the abandonment of this harmful practice can be encouraged.

Future Research

The snowball sampling technique used for this study was deemed most appropriate, since those who have undergone FGC within the Dawoodi Bohra community are considered to be a hidden population and thus difficult to access. By utilizing an online system of gathering data, the researchers were able to cater to the global nature of the Dawoodi Bohra community as well. As shown in Question 2, 80% of respondents stated they had earned at least a bachelor's degree, which falls in line with findings given by Jonah Blank (2001) in *Mullahs on the Mainframe*, and with anecdotal evidence collected by Sahiyo that the community is highly educated and prides itself on the use of technology to convey information to Dawoodi Bohra religious congregations globally.

Yet, biases do exist in this survey. It is possible that due to the secretive nature of the topic, women who may be in favor of continuing FGC may have chosen not to participate in the survey, increasing the likelihood that survey participants would only include those women who have chosen to discontinue the practice. Future research should include looking at methods of collecting quantitative data in a systematic manner in which participants are randomly chosen from a sampling frame.

Findings from this report also indicate that future studies should include surveying various other stakeholder groups connected to FGC, such as social service providers, religious leaders and men within the community. Healthcare professionals (pediatricians, gynecologists, nurses) should also be interviewed as they may come into contact with FGC survivors in their professional capacity, and their experiences can build knowledge on the physical effects of the least severe forms of FGC practiced globally.

After reviewing the literature, it is clear that there is a dearth of knowledge about the physical, psychological, and sexual ramifications of Type I FGC as it is performed amongst the Dawoodi Bohras. In fact, both Sahiyo's study and the Islamic Relief Canada (2013-2016) study indicated that there was a lack of awareness regarding the female anatomy amongst survivors who underwent the practice, thus making it challenging for survivors themselves to indicate if they were having physical challenges relating to their FGC. Ghadially (1991) also pointed out this drastic lack of literature on Type I FGC: most literature on FGC is concentrated on the more severe types, including clitoridectomy and infibulation, practiced in Africa, while there is an apparent lack of literature on the 'sunnah' version of FGC noted to occur in many Asian countries.

Data collected from Question 31 in the survey indicated that contrary to anecdotal evidence collected by Sahiyo, most of the survey participants believe that men were aware of the practice of FGC. Considering FGC is often thought to be a symbol of patriarchal oppression of women, future research should include surveys of men to see if they are actually aware of FGC occurring amongst their female relatives. According to Shell-Duncan et al. (2016), existing data demonstrates that the majority of men in many countries do not support the continuation of FGC. If future research shows that Dawoodi Bohra men do not support FGC, men could become an important ally in ending FGC within this community.

Other future research should include comparative studies between the practice of FGC within India and amongst diaspora communities, investigations into the effect of outlawing FGC within countries where diaspora communities reside, and the significance of the practice for those choosing to continue it in spite of criminalization.

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Glossary

Glossary

Alavi / Aliya Bohras (popularly called Aliya Vohras, or just Aliyas) – A small Bohra sub-sect that broke away from the larger Bohra sect in the early 1600s. The other two major sub-sects formed around that time were the Dawoodi Bohra and the Suleimani Bohra. Each sect has its own Da'i or religious leader. The Alavis are largely a trading community with their headquarters in Vadodara, in the Indian state of Gujarat. Their population is roughly 10,000.

Bhai-Sahab – Title given to general male members of the religious clergy.

Bohra/Bohras – See 'Dawoodi Bohra'.

Da'i al-Mutlaq (Da'i), Syedna or Maula – The title used for the religious head of the clergy of the Dawoodi Bohra community. The Da'i is the Imam's vicegerent, with full authority to govern the Dawoodi Bohra community in all matters both spiritual and temporal.

Daim al-Islam (The Pillars of Islam) – A book of Islamic jurisprudence followed by many Musta'li Ismaili Shias, including the Bohras. It was written in 960 AD by Qazi al-Numan, the official historian for Fatimid caliphs. The book is divided into two volumes. Volume I deals with matters of faith, devotion, ritual purity, prayer, funerals, fasting, pilgrimage, and *jihad*. Volume II deals with a wide range of subjects such as food, dress, medicine, oaths, marriage, divorce, inheritance, criminal punishments and the etiquette of judges.

Dawoodi Bohra – The 'Bohras' are a Shia Muslim sub-sect of the Tayyabi Mustali branch of the Ismailis, who trace their religious and literary heritage to the Fatimid caliph-imams of North Africa, Egypt and Yemen in the 10th and 11th centuries. In the latter half of the 11th century, Fatimid missionaries also converted numerous indigenous Hindus on India's western coast to this sect of Islam. Bohras believe in the Da'i al-Mutlaq as their religious and spiritual leader.

In the 1500s, facing persecution in Yemen, the seat of the Da'i shifted to Gujarat on India's western coast, where the Bohras eventually flourished as a trading community. In the 1600s, the Bohra sect split into three sub-sects - Dawoodi, Alavi and Suleimani. Of these, the Dawoodi Bohras are the largest sub-sect, with an estimated population of 1.5 to 2 million around the world, of which around half are in India. Dawoodi Bohras have their own distinctive language, dress, food and culture and have developed a reputation for being well-educated and wealthy. For the purposes of this report, 'Bohra/s' refers to the majority Dawoodi sub-sect.

"Fatimid" tradition – Dawoodi Bohras trace their spiritual heritage from Prophet Mohammed and his son-in-law, Moula Ali, and continuing through their successors, the Imams who, functioning first from Medina, spread over to North Africa and Egypt in the succeeding centuries. Imam Al-Mehdi Billah set out for North Africa and established his religious kingdom in Tunisia and the adjacent territories. Three Imams succeeded him and the fourth, Imam Al-Moiz Le-Dinillah, established his seat of authority in Egypt. The kingdoms these Imams founded, the traditions of thought and philosophy they fostered, the immense literature they produced and guarded, the civilization they established and

the way of life they pursued have all come to be called Fatimi or Fatimid after Fatima, the daughter of Prophet Mohammed and the consort of Imam Ali, thus linking two venerable personalities together.

Hadith – Tradition based on the precedent of Muhammad's words that serves as one of the sources of Islamic Law (Shariat).

Imam – Shia Muslims believe that Imams, who are the religious leaders of the community, are chosen by God to be the perfect examples for the faithful and to lead all humanity in all aspects of life. Within the Dawoodi Bohra tradition, the Imam has gone into seclusion, therefore the Da'i serves as the supreme religious head of the community.

Ilm – Urdu word for knowledge

Izzat – Honor, reputation, prestige

Jamaat – Arabic word for gathering or congregation. In the Bohra context, it also specifically refers to a collective of all Bohras within a specific geographic location, akin to a parish.

Khafd / khafz – The specific Arabic term for female circumcision in the Dawoodi Bohra community.

Khatna – The term used for circumcision among Dawoodi Bohras. Although the term is common for both male and female circumcision, in this report it is used specifically to refer to female circumcision.

Lisan al-Dawat– The official language of the Dawoodi Bohra community, written in the Arabic script but derived from Urdu, Gujarati and Arabic

Mullani – A Bohra woman with semi-religious standing, according to R. Ghadially, 'All for Izzat', *Manushi*, 1991

Sabaq / Sabak – Sermons in religious education held at Dawoodi Bohra mosques

Suleimani Bohra – One of the three sub-sects of Bohras that split from the Bohra mainstream in the early 1600s. The community has its headquarters in Mumbai although its population of more than a million is spread out around the world.

Sunnat / Sunnah – In general, the word Sunnah means habit, practice, customary procedure, or action, norm and usage sanctioned by tradition. Specifically, it refers to Prophet Mohammed's sayings, practices, and living habits. The Sunnah may confirm or interpret something that is revealed in the Qur'an.

Syedna – See 'Da'i al-Mutlaq'.

Taweel – Interpretation. The hidden meaning of a practice or scripture, usually very esoteric and requires special permission (raza) to obtain.

Appendices

Appendix A: FGC Online Survey

Khatna Survey

The purpose of this survey is to understand the extent, purpose and impact of khatna** amongst Dawoodi Bohra women.

The sole intention of this research is to shed light on misunderstandings and lack of information surrounding this age-old practice, which is not often talked about in social circles. It is not the intention of the researcher(s) to discredit or malign any particular community, especially the Dawoodi Bohras. However, due to the exclusivity of this practice amongst the members of this group of Shi'a Muslims in India, and elsewhere around the world where they live or have migrated, the present survey is focusing primarily on them.

This is a COMPLETELY ANONYMOUS survey. No identifying information will be asked of the respondents. In other words, NO names, e-mail addresses etc. are required for the purposes of completing this survey.

Please be truthful in answering the questions, as your response will be representative of the larger Dawoodi Bohra women population. Read the questions carefully and answer accordingly, as the survey is a ONE-TIME ONLY document.

For now, we are asking only women 18+ years old, who associate themselves with the DAWOODI BOHRA community or who grew up with the DAWOODI BOHRA traditions and practices to take the survey.

**For consistency purposes, khatna refers to the practice of girl child / female genital circumcision (removal of the hood, the tissue covering the head of the clitoris, with or without partial or total removal of the clitoris) throughout the survey.

If you are interested in receiving the results of the survey or have other information you would like to share, please send an email to khatnasurvey2015@gmail.com

Participant Consent

The researcher(s) requests your consent for participation in a study about understanding the extent, purpose and impact of khatna among Dawoodi Bohra women.

This consent form asks you to allow the researcher(s) to use the data from your online survey to enhance understanding of the subject.

Participation in this online study is completely voluntary. If you decide not to participate there will be no negative consequences.

The researcher(s) will maintain the confidentiality of all the data collected through this survey.

By submitting this form you are indicating that you have read the description of the study and that you agree to the terms as described above. You also confirm that you belong to or grew up in the DAWOODI BOHRA community, are over the age of 18 and of sound mind and health.

If you have any questions, please contact us at khatnasurvey2015@gmail.com.

Thank you in advance for your participation!

I agree to participate in the online survey, being a DAWOODI BOHRA woman over the age of 18 years and of sound mind and health. I understand the purpose and nature of this study, and I am participating voluntarily.

- Yes
- No

I grant permission for the data generated from this online survey to be used in the researchers' publication(s) on this topic.

- Yes
- No

Section 1: General Information

1) How old are you?

- 18-25
- 26-35
- 36-45
- 46-55
- 56-65
- 66+

2) Education Level:

Mark one answer - if your country has less grades/standards than 12, please still indicate if you completed "Some grades/standards in my country" or "All grades/standards in my country"

- None
- Some Primary and middle school (KG-7)
- Completed Primary and middle school (KG-7)
- Some Secondary school (8-12)
- Completed Secondary school (8-12)
- Some Graduate degree (B.Sc., B.A, etc.)
- Completed Graduate degree (B.Sc., B.A, etc.)
- Some Post-graduate degree (MD, JD, Masters or Ph.D.)
- Completed Post-graduate degree (MD, JD, Masters or Ph.D.)
- Other

3) Please describe your individual/marital/civil status.

- Single
- Married
- Divorced
- Separated
- Common Law
- Widow
- Other

4) What income group do you currently belong to or identify with?

- Low income
- Lower-middle income
- Middle income
- Upper-middle income
- High income

5) What income group did you belong to or identify with while growing up?

- Low income
- Lower-middle income
- Middle income
- Upper-middle income
- High income

6) What religion did you grow up with?

- Non-practicing
- Sunni Muslim
- Dawoodi Bohra
- Other Shi'a Sect
- Other

7) What religion do you most identify with now?

- Non-practicing
- Sunni Muslim
- Dawoodi Bohra
- Other Shi'a Sect
- Other

8) Please describe your profession

- Homemaker/Housewife
- Homemaker/Housewife + business from home
- Teacher
- Health Field (Doctor, Nurse, etc.)
- Business woman (outside of home)
- Legal Field (lawyer, law clerk, judge)
- Student
- Engineer

- Administrative
- Other

9) Where do you currently reside?

- India
- United States
- Australia
- United Kingdom
- Pakistan
- United Arab Emirates
- Tanzania
- Kenya
- Uganda
- Egypt
- Canada
- Bangladesh
- Sri Lanka (previously Ceylon)
- Other

10) Do you socialise/interact with other Dawoodi Bohras on a regular basis?

- Regularly (A couple of times per week)
- Sometimes (Every couple of weeks)
- Hardly (Every couple of months)
- Almost never (Once or twice a year)
- Not at all

11) Are you aware of the prevalence of khatna / female genital circumcision in the Dawoodi Bohra community?

- Yes
- No

12) Do you have friends or family members on whom khatna was performed?

Mark all those options that apply

- Yes - Family Member
- Yes - Friends
- No

13) Was khatna performed on your mother?

Please check all that apply

- Yes
- No
- I don't know

14) Was khatna performed on you?

- Yes
- No

~Section 2~

Personal Experience - Please go to Section 3 if your answer to the previous question regarding if you had undergone khatna was "No".

15) How old were you when the khatna was performed on you?

Please skip if the answer to your previous question was "No".

- 0 to 5
- 6 to 7
- 8 to 9
- 10 to 11
- 12 +
- I don't know

16) Who made the decision that the khatna should be performed on you?

Please check/tick mark all that apply.

- Mother
- Other female family member(s)
- Father
- Other male family members(s)
- Mother and father
- I made the decision myself
- Religious leaders
- Wives of religious leaders
- I don't know
- Other

17) In which country was khatna performed on you?

- India
- United States
- Australia
- United Kingdom
- Pakistan
- United Arab Emirates
- Tanzania
- Kenya
- Uganda
- Egypt
- Canada
- Bangladesh
- Sri Lanka (previously Ceylon)
- Other

18) Were you taken out of the country that you reside in to have khatna performed on you?

- Yes
- No
- I don't know

19) In what location was the khatna done?

- Hospital/Health Clinic
- Private residence (home)
- Other

20) By whom was the khatna performed?

- Gynecologist
- General Practitioner/Family Doctor
- Traditional Cutter/midwife
- Nurse
- Other

21) What type of "cutting" or physical modification was performed when you underwent khatna?

- Part of the clitoral hood removed
- All of the clitoral hood removed
- Clitoral hood and part of clitoris removed
- Clitoral hood and all of clitoris removed
- I don't know
- Other

22) If you remember, please describe the details surrounding your khatna.

23) Did you face any physical or health issues immediately after khatna?

For example: excess bleeding requiring a visit to the doctor, discomfort/burning sensation while urinating, wound infection, etc.

- Yes - Please describe what physical or health issues you have faced in the "Other" field.
- No
- I don't remember
- Other

24) What was your emotional or mental state immediately after the khatna was performed?

Please check/tick mark all that apply.

- Happy
- Ambivalent
- Sad
- Scared
- Angry
- Don't remember what I was feeling
- Other

25) Has the khatna procedure left any emotional impact on you in your adult life?

If your answer is "Yes", please describe in a few words under the "Other" field how khatna has left an emotional impact on you in your adult life.

- Yes
- No

- Other

26) Has khatna affected your sexual life?

If you answer is "No", you can skip the next question and proceed to Section 3.

- Yes
- No
- I don't know
- I am not sexually active
- Other

27) If khatna has affected your sexual life (answer to question 26, above), is it positively or adversely?

If you desire, please feel free to elaborate under the "Other" field how khatna positively or adversely affected you.

- Positively
- Adversely
- Other

28) If you wish to elaborate on the effects of khatna on your sexual life, please describe below.

For example: heightened physical stimulation, increase in sexual desire, lack of physical stimulation, inability to orgasm, discomfort while engaging in sexual activity, etc.

~Section 3~

Social Experience

29) What would your Dawoodi Bohra relatives and friends think if they knew a Dawoodi Bohra woman had not undergone khatna?

Please check/tick mark all that apply. If you select "Other", please elaborate.

- They would think nothing of it
- They would be very surprised
- They would be upset
- They would not want that woman to marry their son
- They would think that the woman was unclean
- They would think that the woman is not a "true" Dawoodi Bohra
- We don't discuss khatna
- I don't know
- Other

30) What explanations have you heard as to why khatna is practised by the Dawoodi Bohras?

Please check/tick mark all that apply. If you select "Other", please elaborate on the explanation(s).

- For religious purposes
- For reasons of physical hygiene and cleanliness
- To maintain traditions and customs
- To decrease sexual arousal

- To increase sexual arousal
- To gain respect from the community
- As a necessary requirement for a good marriage
- Other

31) Do you believe men (fathers, brothers, uncles, etc.) are aware of the practice of khatna?

- Yes
- No
- I don't know

32) Do you think that your male relatives expect all Dawoodi Bohra women to do khatna?"

- Yes
- No
- I don't know

33) Do you think men are told of the practice of khatna when their female relatives undergo it?

- Yes
- No
- I don't know

34) If you had/have a daughter/granddaughter would you continue the tradition of khatna with them? Please grade on a scale of 'Extremely unlikely' to carry on the tradition of khatna with them to 'Most likely' to carry on the tradition of khatna with them.

- 1=Extremely unlikely
- 2=Unlikely
- 3=Undecided
- 4=Likely
- 5=Most likely

35) How do you feel about the practice of khatna continuing forward? Please grade on a scale of 'I am not OK' with khatna continuing forward to 'I am OK' with khatna continuing forward.

- 1=I am not OK
- 2=I am slightly not OK
- 3=I am unsure
- 4=I am slightly OK
- 5=I am OK

36) In your opinion, how prevalent do you believe khatna is in the Dawoodi Bohra community?

Please estimate the percentage of females who have undergone FGC in the entire community?

- 0-20%

- 21-40%
- 41-60%
- 61-80%
- 81-100%

37) Do you know if khatna is being performed amongst other communities than the Dawoodi Bohras in India?

If your answer is "Yes", please mention the community names under "Other".

- Yes - Please mention the names of the communities under "Other".
- No
- Other

Appendix B: E-mail Sent to Participants

Draft script to use:

Dear XYX,

I was given your contact by <friend/family etc.>.

As I am from the Dawoodi Bohra community, I am writing on behalf of my friend/colleague who is pursuing research to understand the extent, purpose and impact of the practice of khatna amongst the Dawoodi Bohras.

I understand that this is a very personal and sensitive subject matter that almost no one talks about, and this makes knowledge gathering on this practice even more important. The information you will be providing the researcher will go a long way throwing light on this age-old practice of khatna amongst the Bohra community. It is completely anonymous and you will not be asked for any personal identification in order to complete it. I would also like to reassure you that the purpose of this research is not to malign or discredit any particular community, especially the Dawoodi Bohras.

I humbly request you to take some time out of your busy schedule to fill out this survey - I don't think it will take more than 5-10 minutes of your time.

If you have questions, you can reach me at my email or write to the researcher at info@sahiyo.com.

Thanks for your help!