

# Discourse(s) of Female Genitalia: Mutilation vs. Cosmetic Surgery

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## Abstract

There is a discrepancy between "Western" engagement with female genital mutilation (FGM) and female genital cosmetic surgery (FGCS). Despite a similar ambiguity regarding the outcomes of each, FGM is ultimately condemned, while FGCS is permitted. By unpacking the dominant "Western" discourse(s) of each, this paper accounts for the discrepancy; FGCS is constructed as a medically legitimated option for enhancing the utility of one's genitals and for liberating one's sexuality, while FGM is constructed as a threat to "Western" conceptions of genital utility, sexuality and agency. Such discourse(s) arguably illustrate the tendency to condemn the contextual "other" and take "our" contextual constructions largely for granted.

**Keywords:** agency, female genital cosmetic surgery, female genital mutilation, genital utility, liberal sexuality

The dominant "Western" discourse(s) of female genital mutilation (FGM) and female genital cosmetic surgery (FGCS) is ambiguous, wherein contradicting claims exist about each, and certain dominant stances are either unsupported or contradicted by the available evidence. After unpacking the literature regarding both FGM and FGCS, this paper illustrates how the former is constructed as a threat to "Western" conceptions of genital utility, sexuality, and agency. The latter is constructed as a medically legitimated option for enhancing the utility of one's genitals and for liberating one's sexuality. The intention of this paper is not to discern the moral permissibility of either practice; rather, the aim is to transcend the defend versus condemn dichotomy in this exploration of their construction within dominant "Western" discourse(s). In doing so, perhaps "we" can begin to question the condemnation of the contextual "other" and the taking for granted of "our" own contextual constructions.

According to the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), and the United Nations Population Fund (UNPF), FGM includes all procedures that intentionally alter or cause injury to female genitals for non-medical reasons (UNFPA, 2018; UNICEF, 2018; WHO, 2018). Four categories of FGM are recognized: Type I includes the partial or total removal of the clitoris; Type II includes the partial or total removal of the clitoris, the labia minora, and occasionally the labia majora; Type III includes the partial sealing of the vaginal opening by cutting and appositioning the labia minora or majora; lastly, Type IV refers to all other procedures which are harmful to female genitalia (UNFPA, 2018; UNICEF, 2018; WHO, 2018). Despite the existence of certain ambiguities and contradictions within the literature, the dominant claims made about FGM within "Western" contexts largely situate the procedure(s) within a framework of condemnation.

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FGM is known to result in consequences for the sexual and reproductive health of females, including effects such as haemorrhage, infections (e.g. urinary tract), sexual dysfunction, psychological problems, problems during childbirth, shock, and death (UNFPA, 2018; UNICEF, 2018; WHO, 2018). As such, UNFPA, UNICEF, and WHO issued a joint statement in 1997 condemning FGM as a violation of human rights. Since then, active efforts to eradicate it have been made, including through the creation of anti-FGM policies worldwide and by working within affected communities to educate against the practice (WHO, 2018). As a result, FGM is outlawed in 43 countries, including in the United Kingdom (UK), the United States of America (USA), Canada, Australia, and New Zealand, with penalties ranging from monetary fines to life in prison (UNFPA, 2018). The validity of this dominant anti-FGM stance, however, is continually questioned within the literature.

For example, Obermeyer and Reynolds' (1999) and Obermeyer's (2003) comprehensive reviews of FGM literature suggests that commonly cited claims regarding the prevalence and severity of adverse health effects are largely unsupported and exaggerated. In their most recent review, Obermeyer (2003) concludes the following:

Statistically higher risks are documented for some but not all types of infections; the evidence regarding urinary symptoms is inconclusive; the evidence on obstetric and gynecological complications is mixed: increased risks have been reported for some complications of labour and delivery but not others, and for some symptoms such as abdominal pain and discharge, but not others such as infertility or increased mortality of mother or infant. (p.443)

This conclusion undermines the broad claims made by UNFPA UNICEF and WHO; indeed, it is misleading to cite such "serious implications" as resulting directly from FGM procedures if the evidence available to support such claims is inconclusive and documented for some types while not observed in others. Thus, the dominant "Western" stance regarding FGM may stem from unsupported and exaggerated claims legitimized through numerous citations. Further, the methodological and ethical difficulties of researching FGM render it rather challenging to provide stronger evidence in support of these effects.

Most of the existing studies suffer from conceptual and methodological shortcomings, while the gaps in the evidence are difficult to fill due to certain ethical barriers (Ahmadu, 2007; Obermeyer & Reynolds, 1999; Obermeyer, 2003). Obermeyer (2003) outlines such shortcomings in the study of FGM effects, including how experimental design cannot be used to measure the impact of socially prescribed customs, how sampling bias occurs wherein those experiencing complications are more likely to seek health care, as well as the complexity of conducting longitudinal

design in areas with limited health care facilities (p.445). Further, ethical questions arise in response to observing the possible harmful effects of FGM over time without intervening (p.445). Ahmadu (2007) echoes these ethical concerns by questioning how claims of sexual dysfunction came about; there are apparent ethical barriers to measuring the sexual response of women who have undergone FGM (p. 300). Thus, research to better support or refute the claims made by UNFPA, UNICEF, and WHO are stunted by the practical and ethical limitations of studying FGM and its effects. Scholars have also questioned the dominant anti-FGM stance by unpacking the valuable social function of the practice.

Numerous scholars have outlined FGM's integral role in the construction of particular social identities, with many claiming that FGM is less harmful than the social ostracism individuals may face if they do not undergo such procedures within particular contexts (Ahmadu, 2015; Newland, 2006; O'Neil, 2018; Shweder, 2000). In the context of Newland's fieldwork in rural West Java, FGM is conceptualized as a particularly important birth ritual; it symbolically constructs morality and physically creates a Muslim identity. O'Neil's fieldwork in Fouta Toura proved similar to Newland's findings; FGM ensures a woman's purity before Allah, her cultivation of bodily control, and her sexual fidelity to her husband. The practice is also framed as integral to the construction of gendered identities, wherein some adolescents in Kenya purportedly look forward to entering womanhood through FGM (Shweder, 2000). Despite such arguments, the dominant anti-FGM stance remains fixed. Similar ambiguities and contradictions exist in the claims made about FGCS procedures.

FGCS includes all procedures which alter the appearance and function of genitalia for aesthetic and sexual reasons (Goodman, 2009). This includes "clitoral hood reduction" for removing excess folds of skin from around the clitoris, "labiaplasty" for reducing the length of the labia minora and size of the labia majora, "G-spot amplification" via collagen injections, and "vaginoplasty" to tighten the vaginal canal (American Society of Plastic Surgeons, 2019, p. 1). There exists ambiguity regarding the efficacy and outcomes of FGCS. It diverges from FGM in that it is ultimately rendered permissible despite this ambiguity.

Indeed, the American College of Obstetricians and Gynecologists' Committee on Gynecologic practice issued a statement in 2007 claiming that FGCS are not "medically indicated and [their] safety and effectiveness have not been documented" (p. 1). Thus, clinicians are advised to uncover why their patients may wish to undergo such operations, evaluate whether there is a legitimate physical need for surgical intervention, and to discuss the lack of research and the potential complications of FGCS (i.e. infection, altered sensation, dyspareunia, adhesions, and scarring; p. 1). Cartwright and Cardozo (2008, p. 286), as well as Goodman

(2009, p. 154), have outlined a lack of long-term, peer-reviewed data specifically regarding the safety, cosmetic, functional, and psychosexual outcomes (pp. 286 & 154). Research has attempted to fill these gaps in the FGCS literature; however, such research is arguably limited, and there seems to be a discrepancy in the findings and the conclusions of such research.

For instance, Goodman et al. (2010) attempted to fill such gaps via outcome questionnaires sent to FGCS patients and surgeons. The results indicate a considerable discrepancy between surgeon and patient perceptions of successful procedures, wherein surgeons typically reported more success than did patients (p. 1574). Furthermore, a statistically significant percentage of patients felt they had postoperative complications, including infection and excessive bleeding (p. 1571). Despite such findings, Goodman et al. (2010) concluded that FGCS might provide certain women with increased comfort regarding their genitals and enhanced sexual pleasure (p. 1576). The discrepancy between Goodman et al.'s conclusions and the evidence is similar to the engagement with FGCS within "Western" media advertisements, wherein the procedures are effective for reducing the negative psychological effects of having "abnormal" genitals and for improving sexual satisfaction, despite a lack of evidence to support such claims (Braun, 2005).

Official engagement with FGCS arguably overlooks potential harms while exaggerating potential benefits, which is further evidenced in the legality of the practice. Indeed, FGCS is legal in many countries, including the UK, the USA, Canada, Australia, and New Zealand (Shahvisi & Earp, 2018). Thus, there exists similar ambiguities and contradictions within the dominant "Western" stances of both FGM and FGCS; yet, FGCS remains legal in many of the countries that have contributed to the banning of FGM. Why does engagement with FGM and FGCS diverge so drastically within these contexts? Perhaps insight can be gained by unpacking how female genitalia, including in relation to utility, sexuality, and agency, are constructed and regulated within dominant "Western" discourse(s).

Foucault characterizes discourse(s) as the construction of particular sets of truths within specific historical and social contexts (1972, as cited by Smith & Atencio, 2017, p. 1171). These truths work in alignment with power structures to simultaneously produce and regulate the thoughts, speech and actions of individuals, as well as the meanings, practices, and institutions of society (1972, as cited in Smith & Atencio, 2017, p. 1171). Integral to this paper is the notion that discourse(s) produce and regulate the human body. Wright (2014) suggests that various public health "truths" that are existent in and perpetuated by the media, internet, medical and scientific fields, as well as government and corporate policies, do just that. Public health discourse(s), then, may work to produce and regulate

the normative aesthetics and function of female genitalia and thus, inform context-specific constructions of FGCS and FGM.

Braun's (2005) and Rodrigues' (2012) explorations of FGCS uncover public health discourse(s) which work to produce and enforce a normalized genital aesthetic within "Western" contexts. According to Braun, narrow constructions of "normal" genitalia, including those depicted in the media and porn, are juxtaposed with the "abnormal." Abnormal genitals are rendered a legitimate and pervasive phenomenon through the authoritative language of medicine. Terms such as "hypertrophic" are used to refer to "enlarged" labia (i.e., anything longer than a few centimetres), while 20th-century anatomy texts depict only "standard" vulvas (Moore & Clark 1995, as cited in Rodrigues, 2012, p. 781). Furthermore, physical discomfort and psychological problems resulting from the appearance of one's genitals are enlisted to legitimate the construction of "abnormal" genitalia (Braun, 2005; Rodrigues, 2012). The medicalization of "abnormal" genitals works in alignment with media advertisements, especially those recruiting gynecologists and surgeons proclaiming the benefits of surgical intervention, to legitimate FGCS as a viable "treatment" (Braun; Rodrigues). Braun ventures further in their analysis to uncover public health discourse(s) regarding a normalized genital function.

Indeed, along with physical and psychological problems, functional problems are also recruited to legitimate the construction of "abnormal" genitals and situate FGCS as a viable treatment (Braun, 2005). Within "Western" contexts, the primary function of female anatomy is in terms of sexual pleasure (Braun). Thus, abnormal genitals are a legitimated hindrance to the sexual satisfaction of those with vulvas and vaginas (Braun). Certain patient and surgeon accounts represented in New Zealand women's magazines claim that undergoing labiaplasty may alleviate the discomfort experienced when labia get in the way during penetrative sex (Braun, 2005, p. 410). Psychological problems, including anxiety, embarrassment and a lack of confidence, are also framed in terms of their negative effect on sexual pleasure (p. 411). Thus, FGCS is constructed as a viable option for improving the pleasure receiving capabilities of female anatomy by fixing the medically legitimated abnormal and the sexual dysfunction associated with it (p. 412). Within such discourse(s), then, pleasure is arguably medicalized and located in one's genitals.

Braun (2005) suggests that "Western" constructions of pleasure are largely confined to genital stimulation and one's ability to achieve a physiological orgasm from said stimulation (p.414). A media analysis conducted by Lavie-Ajayi and Joffe (2009) found orgasm to be the central indicator of sexual pleasure. This narrow conception of sexual function, much like "abnormal" genitalia, is

medicalized to render it more legitimate. Indeed, contemporary studies situate the clitoris as the primary source of orgasm and explain pleasure primarily in terms of bodily processes (Mah & Binik, 2001). "Western" public health discourse(s), then, arguably confine pleasure to one's ability to orgasm via the stimulation of their "normal" vulva and vagina. The influence of such public health discourse(s), however, is not limited to the construction of those procedures considered "Westernized" or operating as normative within "Western" contexts.

Similar genital discourse(s) are arguably existent in and reciprocally perpetuated by "Western" constructions of FGM. Ahmadu (2007) claims that assumptions about the sexuality of those who have undergone FGM are made based on "Western" scientific knowledge of women's bodies (p. 285). The following statement made by WHO supports this claim:

Removal of, or damage to highly sensitive genital tissue, especially the clitoris, may affect sexual sensitivity and lead to sexual problems, such as decreased sexual desire and pleasure, pain during sex, difficulty during penetration, decreased lubrication during intercourse, [and] reduced frequency or absence of orgasm. (2018, p. 1)

The anatomy where sexual pleasure is located within "Western" discourse(s) is either removed or damaged during FGM. Unlike FGCS, however, this genital modification is done without a medically legitimated reason (Johnsdotter & Mestre 2017). Thus, FGM is a threat to genital utility, particularly with regard to the "normative" sexual functioning of the female anatomy.

Such "Western" constructions of genital function and sexual pleasure operate even in scholarship attempting to critique this equating of FGM with sexual dysfunction. In Java, for example, FGM is claimed to enhance, rather than hinder, sexual enjoyment, including orgasm (Newland, 2006). Edgerton (1961-1962) once claimed that Kikuyu individuals "continue to be orgasmic" post-procedure (as cited in Shweder, 2000, p. 215). One may wonder, however, how scholars can gauge an individual's ability to orgasm and experience sexual pleasure. One may also wonder whether these scholars' conceptualizations of orgasm and sexual pleasure are adequate for representing another's context-specific experience.

Ahmadu (2007) levels a similar critique by outlining a continuing disregard for the contextual variance of such constructs within the majority of "Western" FGM discourse(s). Within Ahmadu's focus group research in the Gambia, the "excised" participants did not have a specific word for orgasm, nor was the clitoris or any other portion of the female genitalia identified as the location of pleasure. These participants did, however, describe experiencing the presence and absence of sexual pleasure in a similar manner to that of "unexcised" (i.e., those who have not undergone

FGM) women in "Western" countries. That is, some of the women described "falling down" and "[going] to that place over there" as the peak of sexual pleasure; some suggested that sexual pleasure occurs only when masturbating or with a sexually skilled partner; others suggested that they do not enjoy sexual intercourse, that it is painful, or that they do not have time to engage with their partners sexually (pp. 286-291). Thus, the similarities in accounts of sexual pleasure across contexts may lead to scholars like Edgerton (1961-1962), Newland (2006), and Shweder (2000) relying on context specific constructs, such as orgasm and clitoris, to conceptualize the sexual pleasure of the contextual "other," which is further evidenced through discourse(s) situating FGM as a threat to liberal sexualities.

Indeed, WHO's statement equating FGM with sexual dysfunction arguably illustrates and perpetuates the liberal sexuality discourse(s) that dominate in the "West" by framing sexual pleasure as inherently good and sexual dysfunction as inherently bad (Braun, 2005, p. 414). Within "Western" discourse(s), sexual pleasure is a legitimate pursuit for the liberated sexual subject (Braun 2005; Hawkes, 1996). FGCS acts as a medically legitimated means in this pursuit, while FGM is situated as a threat to both sexual pleasure and sexual liberation. Walley's (1997) analysis of North American and European discourse(s) largely situates FGM as an example of male sexual dominance and female sexual oppression. Thus, interpretations of FGM as sexually oppressive render it a threat to the "ideal" sexually liberated agent, while FGCS exists as a means to sexually liberated ends. This concept of the "free" and "liberal" sexualities of "Western" women grasps at a particular conceptualization of agency in which one is self-referential in their engagement with the body.

This conceptualization of agency can be referred to as "Neoliberal agency," which works to construct "superficially empowered individuals and perpetuates the illusion of autonomous decision making" (Wrenn, 2015, p. 1233). Neoliberal agency arguably influences discourse(s) of choice with regard to FGCS. Indeed, upon examining the representation of women's autonomy in FGCS discourse(s), Braun (2009) suggests that individuals are constructed as making an autonomous decision to purchase FGCS (p. 240). Representation of the practice in the media and the medical community are said to "create the very conditions they intend to correct" (Rodrigues, 2012, p. 786). That is, the construction of "abnormal" genitals results in problems perceived as arising from the genitals themselves. Regulation can then occur through legitimated surgical intervention, which, according to the Women's Wellness Institute of Dallas (2019), can cost upwards of ten thousand US dollars. Thus, such discourse(s) serve the interests of the neoliberal consumer society, which "depends upon our perceiving ourselves as defective," by stimulating economic participation (Bordo, 1997, p. 42). Thus, individuals are

superficially empowered to choose FGCS, as they may be unaware of and rendered powerless to influence the greater societal and economic structures responsible for constructing it in the first place (Wrenn, 2015).

While the dominant "Western" discourse(s) frame engagement with agency and choice as the default for "Western" women seeking FGCS, agency and choice are simultaneously framed as an impossibility for women in the context of FGM (Braun, 2009). This is further evidenced through the Harborview Medical Centre of Seattle's proposal for the legalization of a non-invasive "symbolic" procedure consisting of informed consent, anesthetic, and minimal scraping of the clitoral hood and labia minora (La Barbera, 2009, p. 486). Despite detailed health and safety regulations similar to those of FGCS, the proposal was ultimately rejected upon intense public backlash (LaBarbera, p. 486). Thus, discourse(s) of medically legitimized genital normalcy and self-regulation render choice available for "Western" individuals wishing to undergo medically legitimated "Western" procedures. Meanwhile, choice is unavailable for "other" individuals wishing to undergo "other" procedures, even when subjected to the same regulations as those legitimated and regularly undergone by certain "Western" women. Issues regarding the age of consent are often recruited to further illustrate how choice is an option foreclosed to individuals in the context of FGM.

Indeed, Black & Debelle (1995) state that FGM is most often performed on children ages 7-9; thus, UNICEF (2018) condemns the practice as child abuse. Even if children within certain contexts "look forward to the procedure" as an integral aspect of their gender and/or religious identities, are such children well informed on all such procedures may entail and are they in a position to contradict what their relatives and social context more broadly may wish to impose upon their bodies (Newland, 2006; Shweder, 2000, p. 222)? This question also extends to FGCS procedures performed on persons under the age of 18 in some "Western" contexts, but neoliberal conceptions of choice and the authoritative language of medicine are recruited to render it more permissible than FGM.

There is no official age of consent for FGCS surgeries in some "Western" contexts. In the USA, many aesthetic surgeries are available to individuals of all ages (American Academy of Pediatrics, 2015). There are stipulations, however, requiring that patients under the age of 18 demonstrate an understanding of the procedure risks and consequences, have proof of parental consent, and above all, they must be the sole initiator of the request (American Academy of Pediatrics). Such discourse(s) of consent arguably render choice available to these underage patients in the "Western" contexts of FGCS, yet such discourse(s) fail to account for pressures that may influence a child's decision to undergo these procedures.

One study found that parents of underage FGCS patients in Australia were often unaware of the normal variation of anatomy and thus, often expressed concerns about their children's anatomical differences (American College of Obstetricians and Gynecologists, 2017, p. 2). Though the underage patient must officially initiate such procedures, parental concerns over the aesthetics of their children's genitals cannot be ruled out as the motivating factor. On a broader scale, many feminists have been critical of this notion of choice in individual engagement with FGCS; Bordo (1997) and Morgan (1991) argue that pressure to conform to these norms is so great that choice can become impossible to exercise. This suggests that despite regulatory pressures existing within underage engagement with both FGSC and FGM, FGSC is made more permissible by "Western" authority due to these discourse(s) of choice.

The legitimating language of medicine is recruited alongside these discourse(s) of choice to construct FGCS as a viable option for underage individuals. In Australia, adolescent patients are said to express psychological distress towards the appearance of their labia, especially towards the visibility of the labia minora through tight clothing (American College of Obstetricians and Gynecologists, 2017, p. 2). This suggests that children are not exempt from the medically legitimated genital norm outlined earlier through the works of Braun (2005) and Rodrigues (2012). Indeed, terms such as "psychological distress" arguably legitimate FGSC as a viable "treatment" for such underage patients. Thus, neoliberal conceptions of choice and the authoritative language of medicine are recruited to render FGSC more permissible than FGM.

In conclusion, there is an apparent discrepancy between official engagement with FGM and FGCS, wherein the former is condemned and the latter is rendered a medically legitimated option for autonomous individuals. This discrepancy is accounted for by unpacking the dominant "Western" discourse(s) regarding each. Indeed, FGCS is constructed as a medically legitimated option for enhancing the utility of one's genitals and for liberating one's sexuality, while FGM is constructed as a threat to "Western" conceptions of genital utility, sexuality and agency. This discrepancy in "Western" discourse(s) of FGCS and FGM arguably illustrates the limits in "our" understandings of the contextual "other," as well as the tendency to take "our" own practices largely for granted.

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