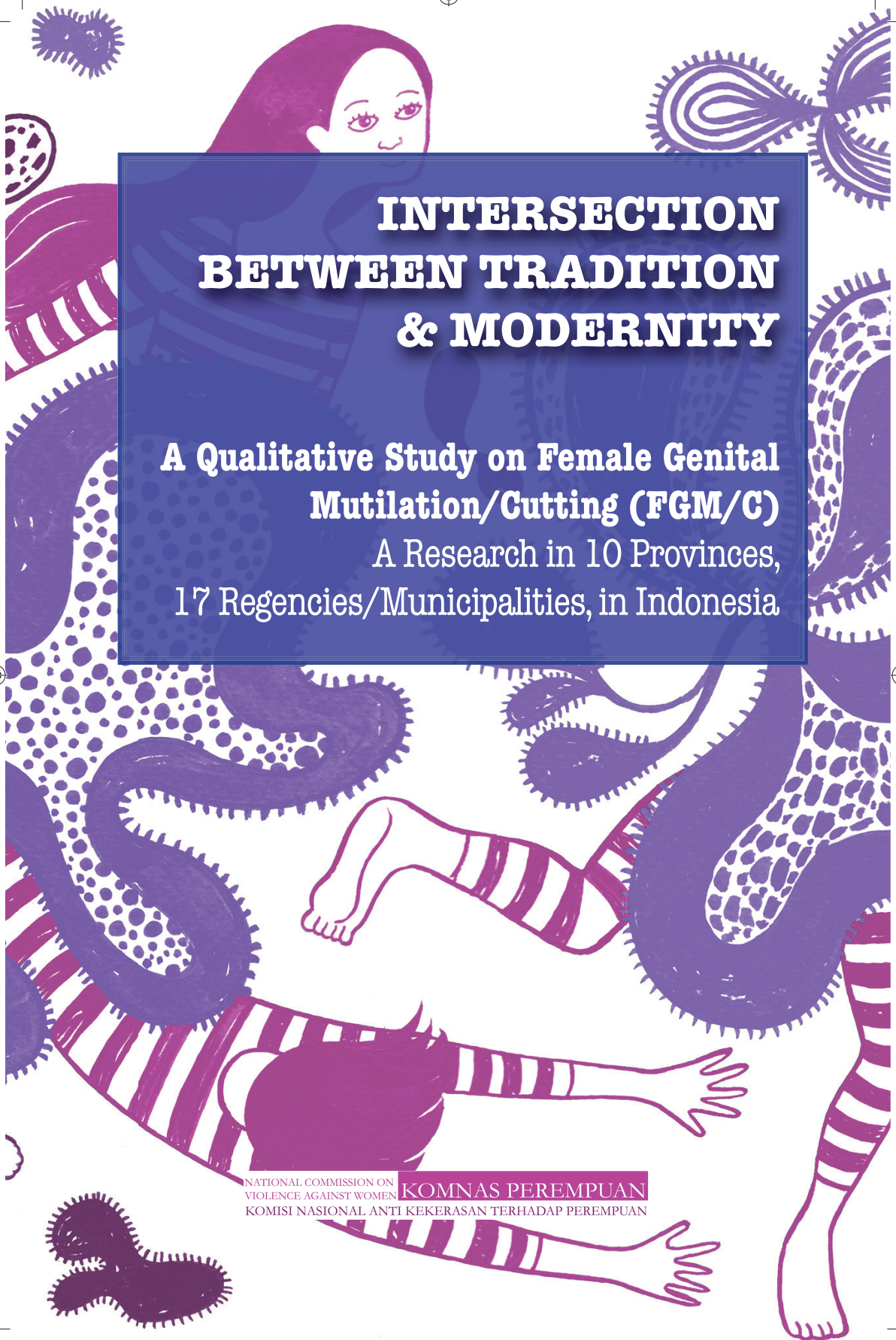

INTERSECTION BETWEEN TRADITION & MODERNITY

A Qualitative Study on Female Genital Mutilation/Cutting (FGM/C)

A Research in 10 Provinces, 17 Regencies/Municipalities, in Indonesia

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NATIONAL COMMISSION ON VIOLENCE AGAINST WOMEN KOMNAS PEREMPUAN
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Preface

The fight to end Female Genital Mutilation or Cutting (FGM/C) has begun a long time ago. Various studies and advocacy efforts on FGM have appeared in Indonesia and around the globe. In 2012, Komnas Perempuan conducted a research to identify different forms of culture-based violence in Indonesia, which then led us to FGM/C. The obstinacy of traditions, religious beliefs, and local beliefs have always been the obstacles in combatting FGM in many places. In Indonesia, the most vocal opposition to ending FGM originates from the Indonesian Ulema Council (MUI). The Ministry of Health comes under opposing pressures from MUI and the international community as a result. In response, the ministry issued an ambiguous regulation, which prohibits health workers from performing FGM/C while still giving authority for the Health and Syara'k Consideration Council *(Majelis Pertimbangan Kesehatan dan Syara'k—MPKS)* to develop a guideline for the practice.

This report is a fruit of collaboration between Centre for Policy and Population Studies (PSKK UGM) and United Nation Fund for Population Activities (UNFPA). PSKK UGM conducted the quantitative research in 10 provinces, 17 Regencies/Municipalities. The regions chosen are those with the highest prevalence rates of

FGM/C and/or that apply retribution fee for the practice. This study explores the history of FGM/C as well as its opposition in Indonesia and around the globe. We will also try to describe how the public and the government currently perceive FGM/C, their attitudes towards it, and how it is practiced and celebrated differently in 10 Provinces, 17 Regencies/Municipalities.

Putting together the victims' thoughts and experiences is not easy. But, by doing so, we expect to help fulfill their rights for protection, truth, and justice and avoid other women from falling victim into FGM/C. Ultimately, we hope that this qualitative research will help push for a more fundamental reform against FGM/C, a dangerous practice that has been a priority concern for many parties.

The National Commission on Violence against Women,
December 2017.

Budi Wahyuni
Vice Chair Person
The National Commission on Violence against Women
(Komnas Perempuan)

Acknowledgment

This research would not have been possible without the supports of many parties who have helped Komnas Perempuan's Qualitative Research Team during the research.

Komnas Perempuan's Qualitative Research Team would like to thank:

1. DFAT for their financial support, which were provided through UNFPA.
2. UNFPA for their financial aid and research recommendations, which were provided in every stage of the research, from instrument preparation to data collection and writing.
3. PSKK UGM for acting as the Quantitative Research Team who carried out the research from the preparation stage to data collection. We would like to also express gratitude for the extraordinary hard work and the cohesiveness of the team.
4. Komnas Perempuan's leaders and staff for their endless support during the research.
5. The Consultation Team—consisting of the Ministry of Women Empowerment and Child Protection, the Ministry of Health, the Ministry of Religion, the Ministry of Education and Culture, Statistics Indonesia, the National Commission for Child Protection, Non-Governmental Organizations, Religious Figures, and academicians – for providing various important assistances throughout this research.
6. Indonesian Midwives Associations in 17 Regencies/Municipalities for helping the Research Team conduct Focus Group Discussions for data collection.
7. Mothers, Religious Figures, Local Figures, Shamans, and Midwives in 17 Regencies/Municipalities for their willingness to be interviewed.

8. The Public Health Offices of 17 Regencies/Municipalities for their willingness to be interviewed about Female Genital Mutilation/Cutting (FGM/C) in their respective regions.
9. The Departments of Law of the Regional Offices in 17 Commission/Municipalities for their willingness to be interviewed about Female Genital Mutilation/Cutting (FGM/C) in their respective regions.
10. The Gatekeepers in 17 Regencies/Municipalities for connecting Komnas Perempuan's Qualitative Research Team with the informants.
11. We would like to convey our gratitude for the support of many other parties, whose names cannot be mentioned one by one, for helping us conduct this research.

Lastly, Komnas Perempuan's Qualitative Research Team would like to apologize for any wrongdoings that might occur during the research.

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1 Introduction

1.1. Background

The study of Female Genital Mutilation/Cutting is not new. FGM/C, as well as its related advocacies, has always been a topic of concern for researchers, civil societies, and governments around the world, including those in Indonesia. In fact, the practice can be traced back to as far as 6,000 years ago (Milos & Macris, 1992).

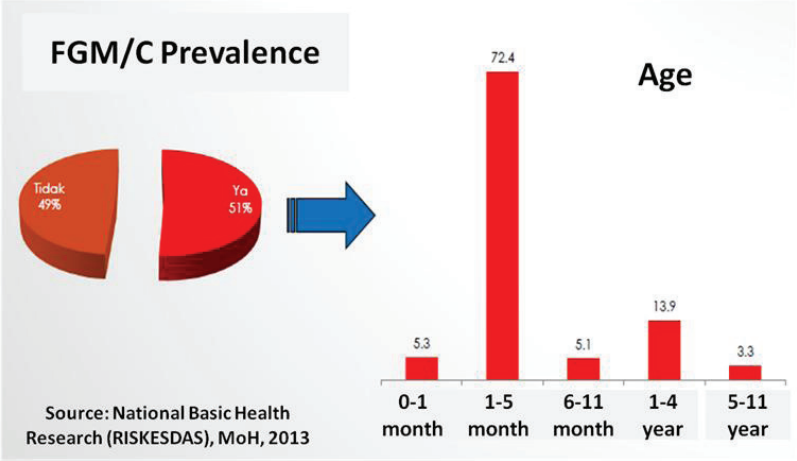
A group of Dutch researchers found that FGM/C was practiced in Aceh, Java, and Gorontalo by the Sundanese, the Bugis, and the Minangkabau in the 18th century (Putranti, 2008). The research, which was initially aimed at documenting Indonesian cultures, identified FGM/C as one of Indonesia's cultural traditions. Koentjaraningrat carried the study forward in 1984, which then led many other Indonesian anthropologists to ensue. In the early 2000's, research on FGM/C increased drastically (Center for Reproductive Rights, 2000), (Budiharsana, Amaliah, Utomo, & Erwinia, 2003), (Sumarni, 2005), (Uddin, 2010), (Kementerian Kesehatan, 2013); (Patel & Roy, 2013-2016). They covered a wide variety of aspects, including the different methods used to mutilate or cut genitalia, its health consequences, the cultural and religious values of the tradition, and women's rights. From 2010 to 2012, Komnas Perempuan conducted a research to document culture-

based violence in Indonesia, and classified FGM/C as one of them (Rostiawati, 2014).

WHO stated that FGM/C should be a topic of concern because the practice violates the right to health and may result in negative health consequences and trigger short-term and long-term trauma (WHO, 2008). The organization subsequently published *A Global Strategy to Stop Health Care Providers from Performing Female Genital Mutilation* in 2010. Furthermore, FGM/C also seeks to control women's sexuality, which is rooted in rigid gender constructs and patriarchy (Human Rights Council, 2015). Unsurprisingly, Sustainable Development Goals (SDGs) include the elimination of child marriage and FGM/C is stipulated in point 5.3 (Sustainable Development Solution Network, 2015). SGDs requires member states to report their works in eliminating all practices that endanger women, including FGM/C, to the United Nations Statistical Commission.

In 2013, the Ministry of Health published a survey report on violence against women, and found that 51% of girls aged 0–11 have undergone FGM/C. Below are the prevalence rates of FGM/C throughout Indonesia.

Chart 1 **Prevalence of FGM/C in Indonesia**



According to the National Basic Health Research (RISKESDAS) and many other studies, FGM/C that is carried out in Indonesia qualifies as type 1 and 4 based on WHO's classification of FGM/C. Budiharsana, et.al (2003), Uddin, et.al (2010), and Habsjah (2013), found that

44% of hospitals or health clinics provide service for FGM/C type 1 while the rest (56%) provide service for FGM/C type 4. The study also discovered that three provinces in Indonesia have a local law regulating the collection of retribution fee for the practice of FGM/C.

Indonesians are divided on FGM/C. In 2006, the Ministry of Health issued circular of Director General of Public Health Education number HK.00.07.1.3.1047a, which prohibits health workers from medicalizing FGM/C. Enraged by the act, the Indonesian Ulema Council (MUI) issued a religious decree *(fatwa)* in 2008, stating that FGM/C is *"makrumah"* (honorable) and that prohibiting FGM/C is against Islam. The decree puts MUI at odds with Muhammadiyah – another big Islamic organization—who condemns FGM/C (Komnas Perempuan, 2014).

The disagreement eventually pushed the Ministry of Health to issue Regulation on Female Genital Mutilation/Cutting Number 1636 on 15 November 2010. Instead of condemning FGM/C, the regulation endorses the practice in the name of the girls' own safety and details a procedure to guide health workers in carrying out the mutilation/cutting (Komnas Perempuan, 2014).

1.2. Research Problem and Research Questions

Our research problem concerns FGM/C as a violence against women. Because (1) The Indonesian Basic Health Research (RISKESDAS) has found that FGM/C does take place in Indonesia; (2) there are discriminative local laws that mandate the financing of FGM/C, including for the stitching expense; (3) many research and advocacy efforts have been conducted against FGM/C worldwide, including in Indonesia; and (4) many cases of violence against women have been found during the process of female circumcision.

The research problem is subdivided into four main research questions:

(1) What is the history of FGM/C in Indonesia, as well as in other parts of the world?
    a) What frameworks or policies that have appeared to support and oppose the practice?
    b) What were/are the roles of various social movements and the (Islamic) states in regards to FGM/C?

(2) How do the Indonesian public and the state understand the Human Rights Framework and public policies related to FGM/C?

(3) What are the attitudes of the Indonesian public and the local governments towards FGM/C?

(4) How is FGM/C practiced in 10 provinces, 17 regencies/municipalities, throughout history?

1.3. Research Purposes

1. Trace the history of FGM/C in Indonesia, as well as in other parts of the world.
   a) Describe how certain frameworks or policies help preserve or eliminate FGM/C.
   b) Describe how social movements, including feminist movements, and the government help either preserve or end FGM/C.
2. Describe the understanding of Indonesian society and the government about human rights and public policies related to FGM/C.
3. Describe the attitudes of the Indonesian public and the government towards FGM/C, specifically in 10 provinces, 17 regencies/municipalities, by utilizing the perspectives of feminism, anthropology, and psychology.
4. Describe the variety of FGM/C that is practiced in 10 provinces, 17 regencies/municipalities, throughout time.

1.4. Research Outputs

1. Literature review

   We review various sources that discuss relevant international human rights framework; feminist, anthropological, and psychological theories; policy dynamics; or domestic as well as international feminist movements against FGM/C.

2. Our research provides additional data and information on FGM/C, especially on various attitudes towards and understandings about FGM/C and related regional regulations in Indonesia.

3. Qualitative Research Report on FGM/C in 10 Provinces, 17 Regencies/Municipalities, in Indonesia, along with several points of conclusion and recommendation.

1.5. Research Significances

This research may help formulate a set of recommendations about FGM/C for the central and the regional governments. This research also demands the Government to fulfill the rights of women, specifically their reproductive and sexual rights, by prohibiting FGM/C, which is generally violent towards women.

This research will also provide a set of data, which will be useful for (1) Komnas Perempuan's future works, including in attaining SDGs and for (2) future advocacies in ending gender-based violence carried out by Komnas Perempuan or other social movements. Ultimately, we expect that this research will help eliminate FGM/C to protect the sexual and reproductive rights and the overall health of Indonesian girls and women.

1.6. Research Timeline

The research was conducted from November 2016 to October 2017 with the following sequence:

1. Reviewing the literature on FGM/C (November 2016–March 2017)
2. Formulating research instruments and Research Manual (March–April 2017)
3. Testing research instruments in Solo and Kudus (April 2017)
4. Conducting field studies (April–May 2017)
5. Data processing (June–August, 2017)
6. Writing the report (August–September 2017)
7. Validating the research outputs (September 2017)
8. Finalizing the research outputs (September–November 2017)

Field studies were conducted in 10 provinces, 17 regencies/municipalities:

1. Bangka Belitung (South Bangka and Manggar Regencies)
2. Riau (Meranti and Dumai Regencies)
3. Jambi (Jambi Municipality)

4. West Java (Bogor Regency and Bogor Municipality)
5. Banten (Lebak dan Pandeglang Regencies)
6. West Nusa Tenggara (West Lombok Regency)
7. East Kalimantan (Samarinda Municipality)
8. South Kalimantan (Banjar dan Barito Kuala Regencies)
9. Gorontalo (Bone Bolango dan North Gorontalo Regencies)
10. West Sulawesi (Polewali Mandar and Majene Regencies)

Reasons for choosing the regions:

- We chose 7 districts/municipalities with the highest prevalence rates of FGM/C based on the Indonesian Basic Health Research (RISKESDAS) (2013): (1) Bangka Belitung, South Bangka Selatan and Manggar Regencies; (2) Riau, Meranti and Dumai Regencies; (3) West Java, Bogor District and Bogor Municipality; (4) Banten, Lebak dan Pandeglang Regencies; (5) South Kalimantan, Banjar dan Barito Kuala Regencies; (6) Gorontalo, Bone Bolango dan North Gorontalo Regencies; (7) and West Sulawesi, Polewali Mandar and Majene Regencies.
- We also targeted other regions that collect tax reparation fee for FGM/C: (1) Jambi, Jambi Municipality; (2) West Nusa Tenggara, Lombok Barat District; and (3) East Kalimantan, Samarinda Municipality.
- This study was also conducted in areas that was previously determined through a quantitative sampling technique to allow triangulation of the qualitative data with the quantitative data.
- We tried to include both urban and rural areas for improved representativeness

1.7. Research Methodology

This research utilized a multidisciplinary qualitative approach, combining several feminist research methods with an approach typical of a policy study. The feminist research methods include in-depth interview, Focus Group Discussion (FGD), and oral history.

Qualitative research method is a data collection method appropriate for understanding social problems holistically. Personal experiences, opinions, and feelings of the informants are at the heart of a qualitative research. A qualitative approach allows the researcher to take the informants' shoes, understand a phenomenon thor-

oughly, and connect various concepts at once. This approach was used because experiences documented by this research were unpleasant, and thus required an approach that could document the discomforts to eventually develop a rich account that truly reflects the phenomenon studied (valid).

In-depth interviews equipped with open-ended questions will enrich the output of a research. Because they enable the researcher to dive into the thoughts, opinions, and emotions of the interviewees, and to eventually walk in their shoes. The output of a series of in-depth interviews usually takes form in a detailed account of the phenomenon studied.

Focus Group Discussion (FGD) is best suited for acquiring information on how a particular group of people think about a certain topic. We conducted FGDs among midwives from the Indonesian Midwives Associations (IBI) of the predetermined regencies/municipalities. FGDs allowed us to document interactions/discussions that would have not taken place in the setting of individual interviews. In addition, FGD also enabled us to ask questions that evoked the participants to think critically. Most importantly, this technique is important to locate women in their social settings, in particular those living in certain cultural contexts in Indonesia, which do not yet count a woman as a fully human being whose rights—both as a person and a citizen—need to be fulfilled.

Oral history enabled us to pose open-ended questions to provide a detailed account of how a particular woman has been living her life. Her personal experiences and background may be vital in understanding how she perceives the world and why she adopts a certain stance. With this technique, we can enrich accounts on FGM/C in Indonesia from the perspectives of women. We also hope to make example of these women, who have been showing great courage in opposing FGM/C. The ways in which they negotiate social norms may serve as examples of best practices that we need to adopt in addressing this problem further.

Research methods employed in this research are expected to help complete the discussion on FGM/C, attend to the rights of Indonesian girls and women, and put an end to the practice by producing a rich account of the phenomenon.

1.7.1 Unit of Analysis

We conducted interviews with four different groups of informants: (1) mothers whose daughters have undergone FGM/C and those whose daughters have never undergone it; (2) midwives who practice FGM/C and those who do not; (3) shamans who practice FGM/C and those who do not; (4) religious, local, and community figures; (5) educators responsible for carrying out socializations on FGM/C; (6) Public Health Offices in various regencies/municipalities; and (7) the Departments of Law of the Regional Government Office in various regencies/municipalities.

Location-wise, we picked (1) areas with local laws that allow the collection of reparation fee for FGM/C, (2) urban and rural areas—especially for investigating how shamans and midwives might differ in attitude—(3) regencies/municipalities with the highest prevalence of FGM/C according to Indonesian Basic Health Research (RISKESDAS) 2013.

1.7.2 Data Analysis

In the beginning, the research team conducted a literature review by looking at studies, advocacy reports, UN reports, and relevant laws and regulations. We compiled the findings in a matrix, which sums up the varying definitions of FGM/C, its prevalence, and relevant laws and regulations. We then subsequently examined (1) the history of FGM/C; (2) various normative frameworks of relevant international conventions, the MDGs, the SDGs, and public policies on FGM/C worldwide, including in Indonesia; (3) the variety of FGM/C in terms of the technique used, the medical and religious views on FGM/C, local traditions, and the human right aspects; and (4) social-political movements to end FGM/C—carried out by academics, civil societies, or governments—worldwide as well as in Indonesia.

At the second stage, we extracted and operationalized the compiled information into a set of research instruments and a research manual for field studies that would later take place in 10 provinces, 17 regencies/municipalities. The research instruments were firstly tested in two cities, Solo and Kudus. The results guided us in further refining our instruments and the qualitative research manual before performing the actual study.

At the third stage, after conducting the field study, the research team transcribed all the interviews and FGDs, and synthesized them into

a matrix based on the previously-formulated interview and FGD guidelines. Data analyses were later performed in several stages:

1) Analysis 1: Categorize the informants and FGDs based on the previously-formulated interview and FGD guidelines.
2) Analysis 2: Categorize the informants and FGDs based on their respective regency/municipality as previously determined by the interview and FGD guidelines.
3) Analysis 3: Compare all groups of informants across provinces using the pre-determined categories and indicators.
4) Analysis 4: Compile and classify the data based on the indicators formulated in the research problem: (1) knowledge, (2) attitude and perception, (3) types of FGM/C, (4) the society's and the government's understanding of laws and regulations on FGM/C.

At the fourth stage, after categorizing them based on pre-determined indicators, we thoroughly integrated and analyzed the research findings using feminist, anthropological, and psychological theories and the international human rights framework. We expected to trace the dynamics of FGM/C in Indonesia, from which we could develop several points of recommendation for policymakers, the authorities, and other stakeholders.

1.7.3 Data Collection Techniques

Our data consists of primary and secondary data. The primary data were gathered through (1) observations; (2) in-depth interviews; (3) FGDs; and (4) oral history—conducted to further examine pieces of information that we thought unique.

Direct observations were carried out by visiting the target regions. In-depth interviews gathered information on individuals' understanding about and attitude towards FGM/C. We posed various questions, including about the appropriate age for undergoing FGM/C, the ritual, the costs of the ritual, and the effects of FGM/C, if any. Focus Group Discussions were held for midwives. We aimed to inquire how much midwives know about the relevant laws, their experiences with FGM/C at work, and their personal stance on it. From the interviews and the FDGs, we shortlisted several women whom we found unusually rebellious against FGM/C for the oral history interviews.

1.8. Research Obstacles

We faced difficulties in accessing the relevant literature. Some of the past studies were kept confidential due to the sensitive nature of the topic, so much so that they are still unpublished until today. Even the publication of this research had to firstly secure an approval from the central government, which were successfully acquired after several sessions of negotiation with the authorities.

Our informants in Bogor Regency and Bogor Municipality had to commute daily to Jakarta for work, and were therefore very hard to meet. Not to mention, the poor traffic in Bogor also compelled the research team to reschedule interviews for several times.

1.9. Structure of the Research Report

This research report is structured in the following order:

Chapter I covers the introduction, research purposes, research outputs, research significances, research methodology and literature review. This chapter also specifies our research approach, unity of analysis, data collection method, research obstacles, and the order in which we write this report.

Chapter II traces the history and dynamics of FGM/C in the world, Asia, and Indonesia. We discuss why and how FGM/C travels to many parts of the world, including to Indonesia. We also review various kinds of female circumcision that take place throughout the world, its motives, and efforts to eliminate them.

Chapter III discusses the legal framework to support the elimination of FGM/C. We utilize the Human Rights framework and relevant international conventions as our legal grounds for this research. We also take advantage of the feminist, anthropological, psychological, medical, and religious perspectives to back up our arguments against FGM/C in Indonesia.

Chapter IV reviews national and/or regional policies and regulations related to FGM/C. We aim to expose problematic Indonesian laws that help spur FGM/C in Indonesia, including the tax reparation laws.

Chapter V aims to paint the basic pictures of the areas we studied. We looked at their demographic profiles and their social, cultural,

political, and economic landscapes. This chapter primarily aims to compare how each region views FGM/C.

Chapter VI characterizes (1) the public's and the government's understandings of FGM/C; (2) the public's and the government's attitudes towards FGM/C; and (3) how FGM/C is carried out and celebrated differently throughout Indonesia.

Chapter VII will finally conclude this qualitative research and offer several points of recommendation for future research and various other stakeholders.

Chapter

2 Tracing the History of FGM/C

The History of FGM/C Worldwide and in Indonesia

This chapter will trace the history of Female Genital Mutilation/Cutting worldwide, especially in Indonesia. The discussion will include efforts to end the practice, and various obstacles they faced. We will also single out the best advocacy practices to allow the government and other parties to take note of the examples. The history and the political dynamics of FGM/C will be explicated in the following chapter.

2.1. FGM/C in the Global Context

FGM/C is a global phenomenon that affects the lives of many women. The high prevalence of FGM/C in Africa may mislead one into believing that it is an exclusively African problem. But, FGM/C also occurs in the Middle East and Asia. UNICEF estimated that as many as 200 million girls in 30 countries have undergone FGM/C (UNICEF 2016). The report names Egypt, Ethiopia, and Indonesia as countries with the highest prevalence of FGM/C. Although the number has been declining for the past 30 years, the progress is sluggish, especially because the practice is culturally and/or religiously endorsed. In short, many girls are still in danger now.

According to UNICEF, FGM/C takes place in 28 African countries with the prevalence rate of 80%–85% (NCPE, 2013). Many women —mostly from Somalia, Eritrea, and Guinea – seek asylum in Europe to escape the practice (UNHCR, 2014). Since the 1990's, FGM/C has also been found in the Netherlands because migrants, who come from FGM/C-practicing countries, carry the tradition with them, ironically. Some of the immigrants are even willing to return to their countries of origin just to perform FGM/C since it has been made illegal in Europe.

FGM/C is usually carried out on girls aged 4–12. But, in several places, FGM/C is performed on newly-born babies or before a woman marries (WHO, 2008). Shamans take charge of the procedure in some countries, whereas doctors are responsible in some others. And this procedure is usually kept secret by the families. WHO classifies FGM/C into four types (World Health Organization , 2017):

- **Type 1:** Often referred to as **clitoridectomy**, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2:** Often referred to as **excision**, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
- **Type 3:** Often referred to as **infibulation**, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- **Type 4**: This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

FGM/C may lead to complication, directly or indirectly and in the short-run or long-run (NCPE, 2013) The direct complication include bleeding, excessive pain, local infection, difficulty in urinating, shock, and damages to the surrounding organs. The long-term complication include cyst, infertility, other complications during labor, difficulty in engaging in sex, mental health issues, keloid, swelling, pain, and difficulty in urinating. Sexual health may also be impaired because FGM/C may cause pain during penetration, psychosexual problems, dysmenorrhea, low sex drive, difficulty in enjoying sex, and difficulty in reaching orgasm.

Studies conducted in Gambia, Kenya, and Mali also show that women who have undergone FGM/C type 1 or 2 are 4 times more likely to experience complication during labor (ibid.). Type 3 is the most damaging to genitalia. De-infibulation or surgical reopening of the vaginal introitus will be required before delivery. Women who have undergone type 3 FGM/C are at 70% risk of experiencing bleeding after labor.

Despite its complications, FGM/C continues to be performed due to its cultural and/or religious significances. In some countries, FGM/C is performed to prepare women before adulthood or marriage because the practice signals virginity (ibid). Many societies believe FGM/C can contain sexual drive, allowing girls to be kept virgin until marriage. FGM/C reduces women's sex drive and increases the sexual satisfaction of the men. Furthermore, some believe that the mutilation of the clitoris can cut away 'masculinity' from the body and beautifies female genitalia. FGM/C is a form of violence and discrimination against women, and, suggests the dominant presence of patriarchy in the society.

2.2. Efforts to End FGM/C Worldwide

FGM/C draws opposition from many parties, including various civil societies and religious groups. English Protestant missionary had condemned the tradition since 1950's. But, they faced resistance from Kikunyu Tribe in Kenya. The cultural significance of FGM/C used to discourage WHO from interfering (Elise etc., 2008; McChesney, 2015). But mounting pressure from governments eventually pushed WHO to view the matter as a serious health issue.

Research on and campaigns against FGM/C had begun to appear since. In 1979, Frans Hosken published a research estimating the prevalence rates of FGM/C in several countries and presented her paper in the Women's International Network (McChesney, 2015; UNICEF, 2013). Her research successfully drew international attention to FGM/C. In response, international organizations began to frame FGM/C as a violation of human rights. In 1993, this view was then formalized in the World Conference on Human Rights in Vienna. Subsequently, the Fourth World Conference on Women in Beijing also approved the status of FGM/C as a threatening tradition that needed to be eliminated. Following the agreement, in 1997, WHO, UNICEF, UNFPA, and UNDP signed a memorandum of under-

standing on FGM/C, which stated that the procedure is not merely a health problem, but also a violation of children's rights (UNICEF, 2013).

Many parties then began to partake in advocacies and campaigns on FGM/C. For example, in 2014, Organisation of Islamic Cooperation (OIC)—with a total member of 57 countries—publicly condemned FGM/C during an international conference (OIC, 2014). They clarified their position by agreeing that FGM/C is dangerous and expecting governments to act preventatively.

International and national efforts to end FGM/C continue to appear until today, including in Europe. The Government of Netherland has banned FGM/C of any kind since 1993. Asylum seekers who are escaping FGM/C in their home countries head to Belgium, the Netherland, or Sweden because they have outlawed the practice (Balzan, 2013). Malta has also criminalized FGM/C performed by their citizens inside or outside the country since 2013. Not to mention, various organizations of non-European governments have also formulated many transnational programs to campaign to eliminate FGM/C at policy level and the practices in the society.. They also involve countries in Africa and the Middle Eastern to jointly conduct workshops, educational programs, and mass media campaigns, especially in remote areas with limited access to information and technology (Spadacini & Nichols, 1998).

Despite such efforts, the prevalence of FGM/C remains high in many countries. A research once noted that the REPLACE program, which is usually implemented in Africa, tends to work ineffectively and invite rejection from the target communities (Brown, Beecham, & Barrett, 2013). The communities may view the concept of human rights as western, and therefore fails to align with their values. In a surprising twist, some even believed that their ability to practice FGM/C as a part of local tradition should be considered a human right worthy of protection.

A legal approach to ending FGM/C, which emphasizes on the criminal nature of the act due to the bodily harms inflicted, is equally impotent (.ibid). Most of the laws are enforced only to the registered residents of a jurisdiction, but are irrelevant for undocumented migrants. Furthermore, the health approach can easily turn into a disaster when the community translates the campaign as promoting the use of professional health workers instead of village shamans—a phenomenon known as medicalization. Such communi-

ties believe that involving professionals will necessarily address the health concerns related to FGM/C, especially through the use of sterile tools and the overall improved standard of hygiene. Unfortunately, medicalization still falls short at tackling the root of the problem.

REPLACE program is now experimenting with a behavioral approach, which is believed to possess the strengths that other approaches lack. The behavioral approach mainly deals with knowledge, perception, and beliefs of the local communities. It acknowledges the individual complexity of why someone might think FGM/C is necessary. Utilizing a bottom-up approach, the process puts forward dialogues with the local communities to try to understand their knowledge about FGM/C and what they think is required to end it. By changing the attitudes of small communities, REPLACE expects to eventually influence the larger communities.

The new approach has been adopted by other organizations working in Africa, such as IAC (Inter-African Committee on Traditional Practices Affecting the Health of Women and Children) and Tostan. Both organizations advocate against all sorts of traditional practices that endanger girls and women and promote their rights and well-being.

Tostan works by establishing community-based assistance at the grass-root level. Their first strategy is educating the community about human rights, especially women's rights. One of their most successful works is in Senegal (Berg & Denison, 2012; McChesney, 2015). The participants of the project felt satisfied with the project. Tostan programs prove that an intervention program will only be effective if it considers local context and the people's needs and aspirations and has secured widespread social support and involvement of men and women (Spadacini & Nichols, 1998; Berg & Denison, 2012).

Another strategy to approach FGM/C is the alternative rite of passage (ARP) (Leye, Bauwens, & Bjalkander, 2005). ARP was first introduced by Maendeleo ya Wanawake (MYWO) and PATH, a women's rights organization in Kenya. This strategy was especially created for communities where FGM/C holds a significant cultural value. The strategy basically allows the community to retain cultural ceremonies without performing the genital cutting or mutilation. In Guinea, intervention program takes form in inter-group and

inter-generation dialogues. Efforts to eliminate FGM/C involves creative campaign techniques, such as theatrical shows, puppet *(wayang)*, soap opera, and poster displays.

2.3. FGM/C in Asia and Indonesia

Although Asia also suffers from FGM/C, studies on the tradition is centralized in Africa and the Middle East (Kassa-Mali in Clarence-Smith, 2008). Many studies (Feillard & Marcoes, 1998; Budiharsana etc., 2003; Putranti, 2008) consistently stress the correlation between FGM/C and Islam in Southeast Asia. For example, James Peacok (in Clarence-Smith, 2008 p.160) once documented that clitoridectomy practiced in Singapore is usually performed on girls aged 6–10. The procedure usually takes place before shahada ritual and before the girl starts learning to read the Koran (Feillard & Marcoes, 1998). In some cases, FGM/C is carried out right before the onset of puberty, and celebrated together with her brother's circumcision ceremony. FGM/C tends to also be performed on women marrying a Muslim man, a phenomenon documented in Southern Philippines and North Sulawesi, Indonesia (Budiharsana etc., 2003; Clarence-Smith, 2008).

FGM/C has been practiced in Indonesia since Islam first entered the country (Rostiawati, 2014). In 1840, Dayak Tribe used to practice FGM/C as a part of ritual to 'purify' and Islamize women who were 'robbed' or 'bought' (Feillard & Marcoes, 1998; Clarence-Smith, 2008). The practice is called 'sunat perempuan' or 'khitan perempuan'. Aside from religious reasons, FGM/C is also performed for aesthetic and sexual reasons. Indonesian society believes that FGM/C can reduce libido and maintain women's faithfulness to their husbands (Feillard & Marcoes, 1998). FGM/C is also believed to be able to beautify the shape of vulva, especially after giving birth. The procedure is usually carried out 40 days after delivery along with the baby's hair cutting (akikah) and/or ear piercing ceremonies. In the early 20th century, mothers usually perform FGM/C before their daughters turn 2 years old, especially in the outermost islands and West Java.

Due to cultural and religious reasons, FGM/C is still widely practiced, although secretly. In 1950, social anthropologists identified where and what kind of FGM/C was practiced in Indonesia. FGM/C is usually practiced as a part of a long, big ritual, which usually

crescendos with a feast. Midwives or village shamans cut, scratch, scrape, prick, incise, massage, stretch clitoris or labia minora, or both. Sometimes a small part of the genitalia, not as big as a grain of rice, is cut and then buried in some ceremonies. They use bamboo knife, penknife, kitchen knife, 'pisau jari', straight razor, or scissor. FGM/C does not always cause bleeding. But when it does, some communities perceive it as an indication of a successful procedure. In conclusion, FGM/C is understood, valued, and practiced differently depending on the local tradition (see table 2.1).

2013 RISKESDAS shows that 37.3% of 114.993 girls aged 0-11 surveyed have had undergone FGM/C when they were less than one year old. More than half of them (54.1%) was circumcised at the age of 5–11. Most of them (55.8%) took place in urban settings, not rural areas. Unfortunately, RISKESDAS only studied the prevalence of FGM/C in Indonesia, but not how it was done. This research will try to address how FGM/C is performed as well as how Indonesians perceive it.

Table 1 **FGM/C Throughout Indonesia**

Region	Meaning	Process
Aceh (Clarence-Smith, 2008)		• Circa 1960, girls used to be circumcised before they turned 12. But, FGM/C is now performed on infants. • Cut a little bit for formality. • Some rituals are involved, such as making yellow sticky rice and *peusijeuk*.
Bengkulu	• Valued as a hereditary ritual for infants	• Touch the clitoris with a needle • Serawai Tribe performs FGM/C on girls above 8 years old.
Sambas, West Kalimantan (Nurdiana, 2010)	• Control women's libido so that they will not turn promiscuous	• FGM/C used to be performed by mutilating clitoris entirely. But in light of Ministry of Health's new regulation on FGM/C, the ritual is now performed out of mere formality • In Kalimantan's rural areas, total (removal of) clitoridectomy still takes place.

Sunda (Clarence-Smith, 2008)	• Prevent deviant behaviors. • Uncircumcised women are not Muslims yet. They fail to provide sexual satisfaction for their husbands, and are considered 'bad' in general. They will be subjected to local grapevine. The practice is therefore socially and culturally mandatory.	• Performed on the same day with gusaran, a teeth filing tradition. • The practice is called rosulan in Cirebon. • FGM/C is carried out discreetly on newborns in Sukabumi.
Yogyakarta (Feillard & Marcoes, 1998; Putranti, 2008)	• Known as tetesan, the practice is performed to welcome menstruation. • Symbolizes an act of cleaning genitalia. • A celebration upon entering adulthood and true womanhood, where women are ready to procreate.	• FGM/C is usually performed on girls aged 9–10, and followed by a communal feast or syukuran. • The girl will be put in a 'kerobong' that will cover her entire body. 'Juru tetes' will then perform the cleaning while she is sitting in the 'kerobong'. • Recently, it is performed only by members of the monarchy/ sultanate. The ordinary citizens usually perform circumcision on infants.
Jawa abangan (Claence-Smith, 2008)	• To get rid of bad luck (Putranti 2008) • Viewed as a celebration where gamelan will be played, like in male circumcision celebration	• Symbolically performed by cutting a thumb of turmeric that is placed near to the clitoris. The turmeric is then buried or thrown away to the sea.
Sasak Tribe, Sumbawa	• A prerequisite to be a 'true' Muslim. • Many believe that uncircumcised girls will turn out naughty and flirtatious.	• Girls are circumcised when they are still very young, usually simultaneously with akekah, a hair-cutting tradition. • The clitoris is incised a little bit using a razor blade by a village shaman or an esteemed female figure who knows how to carry out the procedure.

Pelauw, Central Maluku	• Known as Oiwael, FGM/C is performed by a particular kind of families. • An uncircumcised girl is considered not yet a Muslim.	• Performed by placing gata-gata (a chopstick used to eat papeda) on top of vagina. • FGM/C is usually not followed by a big celebration, and is therefore relatively cheaper. But FGM/C still marks a difference between rich versus poor families.
Sulawesi	• Performed to validate a girl's status as a 'Muslim'. • Performed to get rid of 'bad luck'. • Uncircumsied women will be subjected to local grapevine and are considered not yet a Muslim. • FGM/C is believed to be able to release feminine aura from female bodies. • Flirtatious girls are often mocked as uncircumcised.	• In Mongodow, North Sulawesi, FGM/C is performed on infants below 3 years old, and must cause bleeding to be considered successful. • Toro, Bajo, Muna, and Tolaki Tribes of Southeast Sulawesi perform FGM/C on girls aged 2–3 years old [CITATION Ros14 \l 1033]. They incise girls' clitorises with knife *(sembilu)* or a razor blade. • In Mandar Tribe, South Sulawesi, FGM/C is performed on girls below 1 year old. Recently, they merely scrape parts of the vagina that they think is dirty as opposed to mutilating the clitoris. • In Bugis, Makassar, and Luwu Tribes of South Sulawesi, FGM/C is performed only symbolically, although excision of the clitoris can still be found sometimes. • In Toraja, South Sulawesi, FGM/C used to be carried out with a hook. Circumcised women usually wore a hand or foot bracelet. However, with the presence of Christianity, women are no longer circumcised. Men still undergo circumcision, but now it is performed by doctors or other health workers.

2.4. Movements against FGM/C in Indonesia

Civil rights movements against FGM/C are sporadic, and has not been able to interfere with the practice at the grassroot level. However, many studies on the tradition has been done. One of the most comprehensive research conducted early on was the one by Population Council in 2003, which solely identified how FGM/C was practiced in Indonesia. In 2013, the Indonesian basic health research (RISKESDAS) made an estimation of the prevalence rates of FGM/C throughout Indonesia. Many academics and NGOs' have also been involved through writing policy assessments and advocacy reports (Uddin, 2010; Habjah, 2013; Kalyanamitra, 2014).

Mounting pressure from civil societies pushed the Ministry of Health to issue Circular of Director General of Public Health Number HK.00.07.1.3.1047a in 2006, which prohibited the medicalization of female genital mutilation or cutting due to unproven medical benefits. This move was praised by female activists, especially those fighting for sexual and reproductive rights. In response, Indonesian Ulema Council (MUI) issued a religious decree *(fatwa)* Number 9A Year 2008, which endorses FGM/C by stating that the practice is makrumah (honorable) and that prohibiting FGM/C is against Islam (Komnas Perempuan, 2014). The Ministry of Health reacted by issuing the Regulation of the Ministry of Health Number 1636/ MENKES/PER/XI/2010. The regulation insisted that FGM/C is conducted for the girls' own safety and security. It neither discourages nor discredits the practice. If anything, the regulation provides a manual to 'properly' carry out the procedure.

The regulation quickly drew criticisms. Amnesty International considered the move a regress and a violation of human right. Seemingly dubious, CEDAW also questioned the attitude of Indonesian Government on FGM/C. In response, the Ministry of Health issued Regulation of the Ministry of Health Number 6 Year 2014 about the Revocation of Regulation Number 1636 on Female Genital Mutilation/Cutting. The newest regulation finally acknowledges FGM/C as a cultural tradition that lacks of medical benefit.

Chapter

3 Weaving Theoretical Knowledge, Human Rights Framework & Practical Dialectics of FGM/C

In the previous chapter, we have discussed and assessed the long-standing history of Female Genital Mutilation (FGM/C), which unfortunately, still exists today. This archaic practice does not only happen in Africa, but also in Asia and Indonesia. As it stands, studies have been unsuccessful in finding any viable justification that can reasonably explain the continuation of the FGM/C practice aside from cultural beliefs and traditional norms which have been passed down through generations. Nevertheless, efforts on abolishing FGM/C practices continue, not only in Africa, the Continent with the highest FGM/C figures, but also in developed countries such as Britain and other European countries. Similarly, organizations in Indonesia have long persisted in its advocacy efforts for the abolition of FGM/C practice.

In order to challenge the FGM/C practice and formulate a possible solution, this chapter also assesses elements which are used as a pretext to carry out FGM/C practices, such as religion and tradition. Additionally, this chapter provides an in-depth examination of the concept of FGM/C practice and its contravention of International Human Rights Standards, affording special attention to the rights of women and girls, in an attempt to assess any plausible factors that result in the propagation and persistence of FGM/C practices

in many communities. The International Human Rights Framework discussed in this chapter is based on several international conventions and documents which provide concepts and articles pertaining to the protection of Women and Girls from harmful practices.

The focal point of our argument expresses any FGM/C practice as an abhorrent and direct violation of human rights. The premise of our argument and concepts will be structured as follows:

1. The assessment of FGM/C-related community knowledge and how the said knowledge is transferred. Our assessment looks into methodologies and processes which have been traditionally used as a way to preserve FGM/C practices in an attempt to discuss any potential opportunity for its elimination.
2. The cultural justification for FGM/C, and how this results in the persistence of the FGM/C Practice in many communities in Indonesia.
3. The consensus and conceptual approach adopted by feminists with regards to public perceptions of FGM/C practices.

3.1. FGM/C Practices and Its Incompatibility with the International Human Rights Framework

Our primary argument stems from the basis that there exist various cases of acts of violence against women, including violence that threatens a woman's rights with regards to their sexual and reproductive organs.

This argument asserts that women have not been granted the autonomy, power, and worst still, are traditionally excluded in decision-making processes related to their own reproductive rights. The list of negative implications resulting from FGM/C are by no means exhaustive only to grievous bodily harm and potential destruction of women's reproductive organs, but also to the deprivation of a woman's reproductive, and economic rights.

One relevant example of the deprivation of women's reproductive rights is the practice of female circumcision (Sumarni, 2005 p.1-2), officially recognized internationally as "Female Genital Mutilation (FGM)". The FGM/C practice has, on an international and national levels, violated several human rights provisions, enacted to provide protection to women and girls.

The rights violated by the practice of FGM/C are (Center for Reproductive Rights, 2000):

1. The right to be free from all forms of gender discrimination,
2. Right to life and physical integrity,
3. The right to health, and
4. Rights of the child.

Additionally, the National rights violated by the FGM/C are, as provided by Chapter XA of the 1945 Constitution of The Republic of Indonesia:

1. Article 28H- The right to live in physical and spiritual prosperity;
2. Article 28I: The right to live free from torture, and discrimination.

Alarmingly, despite the severe consequences and social ramifications of FGM/C, its practices have persisted and plagued several regions around the world-not just in Indonesia. This now begs the question; how can International policies regulate the practice of FGM/C more effectively? Our discussion henceforth will further analyze the practice of FGM/C against the violation of rights in several categories within the International Conventions on Human Rights.

3.1.1. Universal Declaration of Human Rights (DUHAM)

The Universal Declaration of Human Rights states that all persons are born free and have equal dignity and rights (Article 1) and each person has the right to life, liberty and salvation as an individual (Article 2). From the first two chapters of the Universal Declaration of Human Rights (DUHAM) it can be concluded that every human being is born free and is automatically afforded freedom of will and life.

It is therefore imperative to re-examine the relevant fundamental rights violated, such as the right to choose, and to consent to P2PG Practices. The question now is whether or not it gives women full autonomy, and the freedom (.ibid p.15) to decide whether or not they wish to undergo female circumcision procedures; or whether or not women have culturally been conditioned to acquiesce to "socially expected" P2PG Practices. The latter suggests that there is "presumed consent" to P2PG procedures which results in two significant implications. Firstly, the violation of provisions set forth in DUHAM, regarding the independence and rights of individuals; and secondly, it sets forth a hazardous social standard that contravenes several human rights' principles owned since birth. It results

in the exacerbation of an abusive patriarchal system that indirectly silences and oppresses any Woman who tries to defy the accepted social convention.

FGM/C procedures conducted in some areas entails a series of painful processes and may even have an impact on mortality (WHO, 2008). WHO categorizes various FGM/C procedures into four stages, where each stage describes the type of action performed on the female genitalia (Patel & Roy, 2013-2016). FGM/C procedures should be considered a cruel act as one of its methods require the severing of female genital parts that can be fatal and could potentially result in death (WHO, 2008). This is a blatant and direct contravention of Article 5 of the Universal Declaration of Human Rights, which prohibits torture and cruel treatment to any persons.

3.1.2. Convention on the Elimination of All Forms of Discrimination against Women/CEDAW

FGM/C is an act that can be categorized as a form of discrimination against women (Center for Reproductive Rights, 2000 p.13). The definition of discrimination as stipulated in Article 1 of CEDAW suggests that it is a form of discrimination which oppresses and limits certain rights which should be afforded to women. CEDAW considers FGM/C procedures harmful as the process has traditionally been used to directly and indirectly reduce or eliminate the recognition of rights which women should be able to invoke, as a matter relates to their bodies.

FGM/C practice in Indonesia is part of violations of the state's commitment to CEDAW and a form of discrimination against women. Nonetheless, there is no strong commitment from the government to protect women from such practice. The gross negligence or blatant disregard of State commitment is contrary to article 2 of CEDAW, which stipulates that every country that has participated in the ratification of CEDAW is required to implement policies that eliminate discrimination against women. Furthermore, Article 2, subsection (d) of CEDAW convention, stipulates that states are prohibited from engaging in acts or allowing practices that is conducive to the discrimination of women. As suggested by the CEDAW committee, a potential solution to the issue is the invalidation of any FGM/C practice. In theory, the regulation and prohibition of FGM/C practices should be the responsibility of the Ministry of Health in Indonesia. However, the implementation and viability of

this solution is subject to the complex bureaucracy prevalent in Indonesian politics. It can then be assumed that any attempts to provide a solution will not stand against any political rigmarole that is advocated by conservative religious parties. The lack of deterrence measures in place that discourages FGM/C practices only serves to contribute to the continuation of the issues at hand. Pressure from certain parties using customs and religious arguments in favor of FGM/C practice is the reason why such practice still exists in some regions in Indonesia.

Article 5, subsection (a) of the CEDAW convention, stipulates that the state has the authority to implement changes in order to influence the elimination of prejudicial and discriminatory gender-biased customs and practices. Studies have suggested that FGM/C is traditionally based on a patriarchal approach which seeks to control female sexuality, and "immoral" desires. There is a belief that women need to be circumcised in order to remove any body part that can result in biological erogenous stimulation. FGM/C is essentially a control mechanism used to suppress any sexual or potential promiscuous desire that is frowned upon culturally (Suparmi et al, 2015).

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3.1.3. Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)

Based on the Article 1 Paragraph 1 of the UN Convention against Torture (UNCAT), FGM/C can be easily qualified as a form of torture, which is defined as any act that inflicts severe pain or suffering. Although the article solely covers the act of information gathering, we believe the definition of torture used by the convention also fits the cruel practice of FGM/C. The following article also specifically mandates the state to eradicate all acts of torture that take

place within their territory. The Government of Indonesia and its apparatus are therefore under an obligation to end any forms of FGM/C across the country.

3.1.4. International Covenant on Civil and Political Rights (ICCPR)

Article 2 Paragraph 3 of the ICCPR states that each State Party must be committed to providing effective remedy for anyone whose civil and political rights or freedoms are violated. In the context of FGM/C, the recovery of the victims must also be addressed by the government, considering that the procedure can be painful and traumatic (Uddin, 2010). FGM/C may also lead to death, resulting in the violation of the right to life as guaranteed in the Article 5 of ICCPR, which further necessitates government intervention on the cultural/religious practice.

3.1.5. Convention on the Rights of the Child (CRC)

The Convention on the Rights of a Child sets out its limitations in Article 1, stipulating that a child is a human being below 18 years of age. Article 2, 3, and 4 stipulate that States party to the Convention are obliged to ensure that protective measures are implemented in order to ensure the protection of the child and his/her rights. Furthermore, article 19 of the Convention stipulates that States party to the Convention is to implement all form of measures to protect the child from "physical and mental violence, abuse, and neglect..." Article 24 stipulates that a child has a right to health and rehabilitation facilities.

However, article 3, paragraph 2; and article 5 recognize that there has to be a balance between the best interest of the child, and the parental autonomy with regards to the upbringing of their child. Article 5 in particular, recognizes that parenting styles may vary according to local customs and cultural influences.

The controversy between the Convention on the Rights of the Child and FGM/C stems from the duty of the state to protect children, and the rights of a parent with regards to upbringing standards. However, this balance is often disproportional as FGM/C practices have traditionally failed to meet adequate hygiene standards required of normal medical procedures. This often leads to potentially serious infections that could result in the additional suffering of the victim. Additionally, studies have also shown that there is no evidence available to prove the benefits of female genital mutilation practices.

Against the backdrop of the above argument, we now move our argument into the topic of "consent". Studies have shown that since children are traditionally subjected to FGM/C practices at a young age (Patel & Roy, 2013-2016 p.10), their consent is often neglected (Suparmi et al, 2015).

Therefore, in-light of the research above, we argue that since it is the duty of the state to ensure that:

1. The child is not subjected to torture, and to violence of all forms;
2. The decision taken by the parents of the child has to be in the best interest of the child.

It would be in the best interest of a child to protect them from physical harm, torture, and any potential psychological trauma. Therefore, in the interest of providing effective protection for children, FGM/C practices should be abolished.

3.1.6. International Covenant on Economic, Social, and Cultural Rights

The accessibility of medical facilities, as well as access to information regarding health and medical well-being is always the primary subject of concern in every convention. This is particularly true with regards to the International Covenant on Economic, Social and Cultural Rights (2000).

In this international convention, it is stipulated that every country which ratifies the International Covenant on Economic, Social and Cultural Rights must recognize and implement the right attain the highest standard of physical and mental health facilities (Article 12, paragraph 1).

FGM/C practices are significantly detrimental on the physical and mental well-being of victims. Consequently, as there is no medical proof that FGM/C benefits the victim in any shape or form, and as it results in unnecessary mutilation of a significant and natural body part, a woman's right to "enjoy the highest attainable standard of physical and mental health" has been violated despite any measure of success or the lack of any complications during any FGM/C procedure. Placing a person at a health risk in the absence of approved medical support should be seen as a violation of the right to health of that person (.ibid p.16).

3.1.7. African Charter on Human and People's Rights

The African Charter on Human Rights and Population is an agreement that freedom, equality, justice and honor are essential goals for the legitimate aspirations of African nations. Broadly speaking, the Charter is a declaration to abolish all forms of colonization from Africa by coordinating and intensifying efforts to achieve a better life for African nations. Additionally, it merges the Charter of the United Nations and the Universal Declaration of Human Rights (EL-SAM, 2014).

In the context of FGM/C practices, the African Charter generally emphasizes the right to freedom (Article 2) for everyone including enjoying the best attainable physical and spiritual health conditions (Article 16). The practice of FGM/C is a practice that threatens the freedom of women and young women who are ignorant to any rights that they are eligible for due to cultural traditions and social demands (Center for Reproductive Rights, 2000).

3.1.8. Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa

The movement against FGM/C practices began in the 1960s and 1970s. The movement was a stand against the abhorrent violation of women's rights and was supported by The African Charter on Human Rights and Article 5 of the African Protocol on Women's Rights,1 which explicitly recognizes women's right to be free from any form of FGM/C practice (.ibid p.9-10).

3.1.9. International Conference on Population and Development (ICPD)

The International Conference on Population and Development (ICPD), held in 1994, was a historic milestone that sparked international cooperation. The meeting was held in Cairo and was considered fundamental in the movement towards social development.

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1 African Charter on Human and People's Rights on the Rights of Women in Africa (African Protocol on Women's Rights). **Art.5. Article 5 Elimination of Harmful Practices** "States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women and which are contrary to recognised interna-

The meeting was the beginning of global deliberations concerning the progress and the strategic development of human rights within a predetermined social timeframe. The primary emphasis of the conference focused on the following aspects; dignity of individual, human rights, and social values. The conference also affirmed that man power and individual rights are indispensable resources which are crucial to sustainable development (BKKBN Jambi, 2013). As such, the ICPD Program of Action has highlighted several steps to be implemented to ensure that the rights of Women are recognized, and upheld.

ICPD's 8 Program of Action ICPD2 states that everyone has the right to attain the attainable standard of physical and mental health. Apart from subjecting the child to torture and physical harm, FGM/C practices are culturally influenced procedures which presume a child's consent. This consent is arguably more akin to acquiescence as standing against the practice often results in either forced consent through physical means, social exclusion, or both. This is in direct contravention of the 11 Principles of Program of Action of ICPD,[3] which obligates States and families party to the con-

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tional standards. States Parties shall take all necessary legislative and other measures to eliminate such practices, including:

a) *creation of public awareness in all sectors of society regarding harmful practices through information, formal and informal education and outreach programmes;*
b) *prohibition, through legislative measures backed by sanctions, of all forms of female genital mutilation, scarification, medicalisation and para-medicalisation of female genital mutilation and all other practices in order to eradicate them;*
c) *provision of necessary support to victims of harmful practices through basic services such as health services, legal and judicial support, emotional and psychological counselling as well as vocational training to make them self-supporting; protection of women who are at risk of being subjected to harmful practices or all other forms of violence, abuse and intolerance."*

2 Programme Action of ICPD. Principle 8. *"Everyone has the right to the enjoyment of the highest attainable standard of physical and mental health. States should take all appropriate measures to ensure, on a basis of equality of men and women, universal access to health-care services, including those related to reproductive health care, which includes family planning and sexual health. Reproductive health-care programmes should provide the widest range of services without any form of coercion. All couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children and to have the information, education and means to do so."*

3 Programme Action of ICPD. Principle 11. *"All States and families should give the highest possible priority to children. The child has the right to standards of living adequate*

ference to give the highest priority to children in all aspects of life. Therefore, in-light of the argument above, and in alignment with Action 4 in ICPD's Program of Action focuses on gender equality, justice and the empowerment of women, specifically the Girl Child Action, governments of all member states must take action to prevent the practice of FGM/C.[4]

3.1.10. Istanbul Convention

The establishment of the Istanbul Convention was based on several objectives, namely;

a) To protect women against all forms of violence and to establish a legal framework in order to prevent, prosecute and deter violence against women;

b) To contribute to the elimination of all forms of discrimination against women and to empower women by promoting substantive equality between genders;

c) To design comprehensive frameworks, policies and measures for the protection and assistance of all victims of violence, including domestic violence;

d) To promote international cooperation advocating a collective goal of eliminating violence against women, including domestic violence;

e) To provide support and assistance to law enforcement organizations and agencies to work together effectively in order to adopt an integrated approach to eliminate violence against women, including domestic violence.

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for its well-being and the right to the highest attainable standards of health, and the right to education. The child has the right to be cared for, guided and supported by parents, families and society and to be protected by appropriate legislative, administrative, social and educational measures from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sale, trafficking, sexual abuse, and trafficking in its organs."

4 _____. Action IV. Gender Equality, Equity, and Empowerment of Women—The Girl Child Action. Actions point 4.22. *"Governments are urged to prohibit female genital mutilation wherever it exists and to give vigorous support to efforts among non-governmental and community organizations and religious institutions to eliminate such practices."*

3.1.11. Sustainable Development Goals (SDGs)

Sustainable Development Goals (SDGs) were the result of the RIO + 20 Conference where 17 goals, all of which considered the 4P's: People, Planet, Peace, and Partnership, were developed in order to provide progressive development solutions that would be effective on a multi-dimensional level (Social, Economic, and Environmental). The general focuses of SDGs are to combat poverty, world hunger, to uphold human rights, and to empower women and girls in an effort to achieve gender equality. The primary provision advocating equality is target number 5 of the SGDs, which seeks to "Achieve Gender Equality and Empower All Women and Girls". Indicator 5.3 in particular, seeks to eliminate all forms of harmful practices such as child marriages and FGM/C practices.

3.2. FGM/C in Practice: Formation of Mindset, Transfer of Knowledge and Debate between Preservation and Elimination of FGM/C

This section attempts to discuss knowledge formation and transmission process with regard to FGM/C issues, among communities in the research areas in 17 regencies/municipalities, following Borofsky (1992 p.80-92). The purpose of this section is to deconstruct the concept of FGM/C in order to articulate a plausible solution that could potentially eliminate FGM/C practices.

The premise of Borofsky's study is based on elements and factors that influence a pro-FGM/C mindset. The study attempts to understand the psychological factors present in the creation, preservation, and generational transfer of the concept of FGM/C from one family member to the next. Borofsky asserts three methods which have traditionally been the most effective methods significantly contribute to the development of a pro-FGM/C mindset. These methods are:

1) Observation and imitation;
2) Direct (in person) or indirect inquiries;
3) Repetition.

This study is compliments a principle developed by Gatewood (1985), who asserts that practical observation is a more effective learning mechanism as compared to learning through "word of mouth", or any knowledge imparted through verbal teaching meth-

ods. Researchers surveyed parents, relatives, government officials, religious leaders, lawyers, and even medical experts to conclude that knowledge of the concept of FGM/C is passed down either through word of mouth, or a persisting social norm. This normalization is derived from cultural repetition that is socially expected to perpetuate indefinitely. This concept has formed a "scheme" that has dire implications on the positive development of society.

The scheme is a combination of the various elements of individual knowledge and feelings used in the processing of information (Strauss & Quinn, 1997; Winarto & Choesin, 2001). Past experiences, cognitive familiarity, and social constructs contribute to the comprehension of a concepts and information. Knowledge is subjective and it is interpreted differently from one individual to another.

The acceptance and normalization of the FGM/C practice is heavily attributed to the perspective and attitudes of the community that the individual was exposed in the early years of his/her life. The durability of the concept of FGM/C and the social normalization of FGM/C practice relies on influences in the individual's community.

Strauss and Quinn (1997) theorizes that the perpetuity of FGM/C practices handed down through generations as this scheme invokes a sense of nostalgia within the individual that relates to their contribution to continuation of cultural traditions. Further, Strauss and Quinn (1997: p.52) suggests that the consensus and attitude attributed to the scheme changes through the generations. However, studies have suggested that communities often attempt to re-invigorate the pro-FGM/C mindset by portraying it as a stepping stone towards the glorification of a social status. Additionally, it is also portrayed to be a necessary procedure to remove impurities in order to allow girls to transcend into a quintessential Muslim Woman worthy of respect and reverence.

This attitude almost guarantees the continuation of FGM/C practices in many communities around Indonesia and has heavily hindered efforts to abolish FGM/C practices on regional/community, and national levels. As Keller and Keller (1996) suggests, there is a direct co-relation between the influence of social expectations on a mindset, and its effect on the actions of an individual. Since FGM/C practices are deeply embedded in customs and traditions, many individuals choose to ignore the risks involved in order to follow the rules of their communities.

On the other hand, evidence that can prove the lack of benefits resulting from FGM/C procedures could bode well for a shift in attitude and could also diminish social confidence in its necessity. An example of this is the progress and modernization of labor procedures. Traditionally, women relied on village shamans to aid them through labor. However, modernization and access to medical facilities have caused a shift in approach. The correlation between village shamans and a high maternal mortality rate was proven right as the mortality rate decreased with the use of proper medical experts.

As such, evidence that demonstrates a strong correlation between FGM/C procedures and a high mortality rate could be an effective deterrence measure. Once evidence is available, it can be used as the basis for the collaboration between communities and regulators. The combined efforts of the community and national regulators could lead to the implementation of a national program which works towards the reduction of high mortality rates.

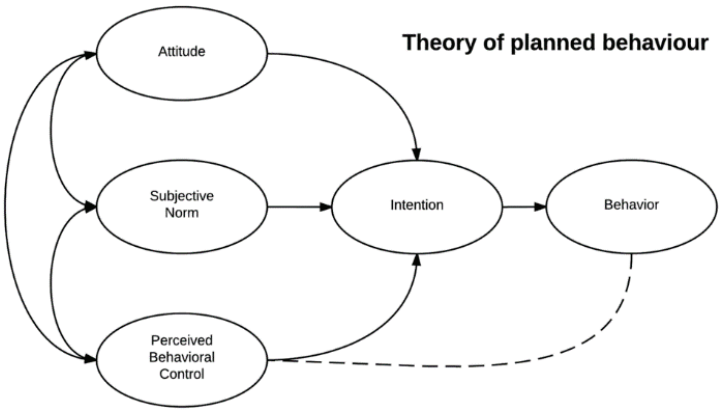
Female Genital Mutilation is often done without the supervision of proper medical experts, and as such, often results in messy medical complications. Trauma can play a pivotal role as a deterrence measure. Midwives, mothers, or individuals could feel less inclined to continue the practice after witnessing the gory nature of FGM/C procedures. The combination of trauma and the realization that FGM/C does not provide any benefit to the victim could prove to be an effective measure against FGM/C practices.

Therefore, the challenge is to provide communities with evidence that demonstrates the disadvantages of FGM/C practices on women and girls. In-light of the concept of pro-FGM/C mindset and "schemes" discussed above, it is imperative to demonstrate that FGM/C practices provide no benefit to an individual in any form or measure. This could potentially invoke an internal sense of realization that renders FGM/C practices unnecessary. Additionally, it could also encourage communities to recognize that FGM/C practices are dangerous to girls and women.

Another approach that attempts to determine factors that are crucial to the preservation and generational survival of FGM/C practice is the study of social psychology through the Theory of Planned Behavior (Ajzen 1991). This approach is regarded as a breakthrough in the efforts to eliminate FGM/C. This theory assesses the concept of FGM/C and its compatibility with human rights, feminism, and le-

gal frameworks (Brown, Beecham, & Barrett, 2013). Furthermore, it can specifically be used to identify the factors that drive a person (especially mothers) to practice FGM/C. This theory explains that a behavior is influenced due to various factors that encourage the desire to perform such behavior. In the following chart, it is clear that:

***Chart* 2 Theory of Planned Behavior (Ajzen 2002)**



The chart explains that behavior occurs as a result of the urge to put an intention into practice. An intention can be formed as a result of the interaction between the three elements of belief. These elements are, individual attitude; an individual's perception of social pressure (subjective norm); and an individual's perception of their ability and capacity to perform the said behavior (perceived behavioral control) (Ajzen, 2002).

Attitude or perception towards a specific behavior is based on individual judgment and personal preference (.ibid). If individual is not found of performing certain behaviors, the person is less likely to repeat the behavior, vice versa. The second element is based on an individual's subjective assessment of relevant social pressures and the consequences of deviating from the social norm.

An individual's intentions are also significantly attributed to their capacity to perform an act—where the definition of capacity includes adequate resources, manpower, physical ability, mental fortitude, and the appropriate skills to perform the act. Addition-

ally, an individual's confidence in being able to perform an act also significantly influences the outcome of an intention. The emphasis here is on the individual's subjective perception on his/her ability to complete a task. This theory is called the Perceived Behavioral Control (Ajzen 1991 p.183).

There is a notion that suggests that the practice of FGM/C is viewed as a welcomed tradition that is based on religious influences. As such, there are social consequences that results from the deviation of the subjective social norm. Individuals are reluctant and pressured to perform certain acts for fear of social exclusion, and/or be considered to have committed act against the religion. This notion is often exploited by individuals seeking to perpetuate and preserve the FGM/C tradition. Brown, Beecham, and Barett (2013) argue the consequences and risks of going against the social convention forces many individuals to perpetuate the tradition.

The consensus of the majority may affect an individual's perception and decisions. Arguably, an individual would feel more inclined to perform tasks that would garner social recognition and acceptance. Furthermore, the difficulty of opposing the views of the majority would often force an individual to succumb to social expectations. Essentially, it would be less of a hassle to comply with social norms than to go against it. This is especially true in a religious community that offers factors conducive to the perpetuity of FGM/C practices. Studies have shown that FGM/C has been deeply embedded in the traditions and culture of most communities in Indonesia. FGM/C has traditionally been deeply rooted into the mindset of community leaders, parents, and other influential individuals in a community, so much so that it has transcended beyond a mere social norm, into a moral norm that society expects an individual to maintain.

The behavioral change approach is one of several breakthroughs that has the potential to eliminate FGM/C practices (Brown, Beecham, & Barrett, 2013). This theory is a two-step approach, which first identifies the source of the problem, before moving on to the second stage, where focus is to deconstruct the issue to find a viable solution.

FGM/C practices have a cultural role in most communities around Indonesia. As such, the perpetuation of the pro-FGM/C mindset is heavily reliant on the efficacy of social stigma. The application of the Behavioral Change Approach would first require the identifi-

cation of factors contributing to oppression; I.e., social stigma and cultural norms. The second phase would be eliminating the social stigma by either normalizing the choice of being against FGM/C; or by spreading awareness of its detrimental effects on women and children. The participation of community leaders, religious figures, or other individuals of influence would increase the chance of success of the Behavioral Change Approach.

3.3. Sexuality of Women in Religion and Cultural Exegesis: FGM/C Practices from a Feminist Perspective

According to research findings, most FGM/C practices in rural Indonesian communities are perpetuated by rigid Islamic teachings based on morality. It is considered immoral and unattractive for a woman to be susceptible to "impure thoughts", or for a woman to have had sexual desires. Consequentially, this suggests that strict Islamic teachings have arbitrarily established a correlation between sexual desires and the clitoris. The implication of this correlation has resulted in religious and community expectations that mandate the removal of the clitoris, a specific body part which biologically contributes to sexual stimulation. This form of suppression is evidence of a patriarchal society which uses FGM/C as a tool to oppress and manipulate women.

Radical feminist movements believe that FGM/C practices are one of the many negative implications of the traditional gender system in societies all over the world. Essentially, a patriarchal system is instrumental in the oppression of women who are considered to be the inferior sex between the genders (Tong, 2010 p.69). According to Alison Jaggar and Paula Rothenberg, this can be interpreted as follows:

1) Women have historically been the first oppressed group;
2) The oppression of women will always exist in almost every society;
3) Oppression of women is the most difficult form of oppression to abolish and cannot be removed even through changes in Social Class;
4) The oppression of women is worse for victims;
5) The oppression of women can be used as a conceptual model to understand other forms of oppression.

According to Gayle Rubin, a libertarian radical feminist, the gender and sex system is a social construct used to transform biological sexuality into a product of human activity. Radical-libertarian feminists reject the assumption that there is or should be a definite relationship between one's sex (male or female) or one's gender (masculine or feminine). Radical-libertarian feminists assert that gender is a concept that is separate from biological sex which has led to rigid gender roles that dictates that women should be socially passive as opposed to men, who are expected to remain socially active (.ibid p.72).

Kate Millet, the author of Sexual Politics, discusses sex and gender roles in a political perspective. Millet asserts that the relationship between men and women is a paradigm of power. The literature suggests that since male dominance in both private and public sphere, results in patriarchy, it must be abolished if women were to gain freedom. Additionally, in order to eliminate patriarchy and discourage prejudice, society must work collectively to abolish socially constructed gender roles, status, and sexual temperament. Millet's patriarchal ideology exaggerates the biological differences between men and women, and came to the conclusion that it has resulted in a social construct which relegates most men to masculine and dominant roles, while women are more likely subjected to subordinate or feminine roles in the community.

The prevalence of the ideology has led to the establishment of accepted social norms despite its patriarchal and discriminatory nature. Millet asserts that society has social institutions such as families, churches, and colleges to affirm the subordination of women to men, contributing to the development of a range of insecurities, a detrimental sense of inferiority in particular (.ibid p.73). According to Patel and Roy (2013-2016), Islamic academics and parents advocate for FGM/C in the firm belief that it leads to religious enlightenment. Additionally, it serves as a control mechanism used to discourage activities such as "pornography" that are culturally frowned upon. Essentially, this is based on the premise that it suppresses the sexual curiosities of their child by removing the body part which is generally considered to be a significant booster of the sexual libido.

The argument thus far suggests that FGM/C is a significant process to religious internalization which has in effect, created a social ultimatum which subjects women who reject the practice to sin; and women who accepts the practice, to spiritual and religious reward.

Alarmingly, this implication succeeds despite the lack of evidence to support its validity. Unfortunately, this mindset is also often accompanied by rigid parenting regimes which contribute to the perpetuation of patriarchy..

The hereditary tradition of conducting FGM/C in Indonesia has indirectly preserved the patriarchal system, and by extension, the oppression of the female body. The gender stereotype attached to females (loving, submissive, sympathetic, concurring, cheerful, kind, and friendly) legitimizes long-standing sex and gender systems in a patriarchal society. The expectations which result from gender stereotypes have encouraged Muslim parents to continue the tradition of FGM/C in the family. However, research has pointed out that there is an interesting deviation from traditional decision-making structure in the family. It is usually the mother, not the father (who has traditionally been considered the person in charge of decision-making in most communities around Indonesia) who predominantly decides on the decision to conduct FGM/C. On the other hand, Abdurrahman Wahid (1999) states that religious affiliation (Islam) differ among ethnics.

Abdurrahman Wahid (1999) asserts that there are at least four typical models of religious and ethnic relations amongst the different archipelagos:

1) **Aceh Pattern**: As a majority Muslim Community, the region is regulated by Islamic based community law, more formally known as Marhum law. The law appoints a religious figure-head, formally known as an *Ulema* who is usually reserved for the king or queen *(Sultan)* of Aceh. The Sultan is responsible for incorporating regulations based on religious morality. *Marhum* Laws mandate that the word of the Sultan equates to the law. Consequentially, *Marhum* law is infamous for its anti-democratic and religiously oppressive nature.

2) **Minangkabau Pattern**: Minangkabau has no central government. However, the kingdom of Pagarruyung, a small kingdom, is regulated through several law-making institutions such as the house of Gadang and the Hansip post. There is a saying in the Minang Society, "adat basandi syara ', syara' basandi kitabullah", which is based on sharia customs and Sariah holy scriptures, which translates to "Custom is based on religious rule and religious rule is based on the holy book". Individuals originating

from Minang who migrate to other regions often perpetuate this mindset and the practice of female circumcision.

3) **Goa/Malacca/Malaysia Pattern**: In Malacca, Islam weaves through different states though what is known as the "absorption process". This concept dictates that Islam is incorporated into the system either as a new element, or is dynamically modified through established old elements. The old elements are in the form of other religions such as Hinduism, which generally accepts other religions into the community. One famous example is the kingdom of Buton, which has accepted Christian clans, such as the Theo Safe'i. Buton has embraced Christianity as an additional layer of the pre-Hindu, Hindu and Islamic layers. In Malaysia, Sultans are required to "behave religiously" on Fridays, but are allowed to behave "freely" on any other days. This is effectively an attempt to find common ground between religion and local traditions. As such, religion is only considered on face value every other day. Consequentially, if there is tension between religion and the State, the issue is easily resolved as citizens share homogeneous views. In Riau, a melting pot of cultures, most women are considered to have independent views with regards to FGM/C practices. The same rings true in West Sulawesi where midwifes often portray independent views which are often against FGM/C practices.

4) **Java Pattern**: Islam has never been fully incorporated and accepted by regulators. Instead, only several abstracts of Islamic law, including its ceremonial rituals are often practiced throughout Java. The distinction between Islam in Java on one hand and Malaysia, Goa and Malacca on the other hand stems from the access to the Islamic Religious Administration, an institution that regulates through Islamic Laws, even though populations in the latter countries are culminations of other traditions / laws. In Java, citizens have autonomy with regards to the choice and practice of their religion. As a result of this, FGM/C practices are either disparaged, or not well known throughout Java. According to a testimony from a study in Lebak, Banjarnegara Central Java, FGM/C is not a common practice as the tradition is foreign to the community.

There are two prevailing social proverbs such as *tepo sliro* (adaptation, adjustment and respect of the prevailing culture), the term *rasa-pirasa* (a sense of indecision if it does not follow the prevail-

ing customs/traditions) which have generally influenced societies in Indonesia. Practices in socio-cultural life, often prioritize Tepo Sliro, a social norm, to the rule of law. This has had significant implications on the perpetuation of the FGM/C mindset as these social norms have discouraged social stigma. The said stigma comes in various forms and has been the topic of controversy in modern times. Mothers are expected to perpetuate FGM/C tradition for fear of social stigma and exclusion; the lack of education regarding the topic in educational institutions; and the influence of Religious leaders who have adopted FGM/C traditions despite originating from regions where the practice is not common.

- The FGM/C cultural paradigm ranges from a metaphysical paradigm: religious, customary, cultural, to its method / applicability or structural engineering that is institutionalized or practiced by local and cultural entities.
- At the theoretical/ideological and applicative level, the FGM/C tradition has spawned many controversies amongst the public.
- The issue is metaphysical - the view that FGM/C or known for female circumcision to glorify / makrumah has been considered "truth" for those who subscribe to religious teachings. Whereas "the glory of man" is 'fitrah'. Fitrah is fixed, as is the origin of man. This nature is attached to every individual, including the right to life (not tortured, not hurt), and reproductive rights (sexual pleasure).
- Government and societies are at the core of the spectrum of development or changes in civilization that humanize others are influenced by historical developments occurring in local and national contexts.

Women in Indonesia are still susceptible to cultural violence resulting from conservative religious ideologies (Budianta, 2006). In the context of female circumcision, there is a policy/regulation on circumcision, and a health service regulation that regulates retribution for victims of female circumcision. Melani added that the State and conservative Islamic parties are still struggling to implement measures that could censor the bodies of women. Social norms stipulate that FGM/C procedures are a necessary stepping stone towards becoming a legitimate Muslim Woman. As such, women are encouraged to perpetuate and continue the practice with their daughters. Conclusively, the lives of Indonesian women often sub-

jugated. Religion and cultural norms often dictate their degree of religious commitment, and morality.

3.4. Circumcision as a Religious Norm

Religion, specifically social obligation that stems from an archaic perspective of morality, stands to be one of the primary justification for the perpetuation of FGM/C practice. In order to comprehensively assess its strengths and weaknesses, our discussion henceforth will further consider the actual weight it plays on communities around Indonesia. Religious regulation plays a significant role in the community. Since Indonesia's Muslim community makes up 82% of the entire population, Islamic regulations which are patriarchal and detrimental to women are often adhered. Below we discuss the psychological understanding of an average individual.

3.4.1. Understanding Male Circumcision and Female Genital Mutilation/Cutting (FGM/C)

In Indonesian, circumcision is called *'khitan',* which originated from the Arabic language, where *'al-khitan'* means circumcision and *'khatana'* means to cut. In this context, a part of the genitalia is the one that is being cut. Islam requires men to remove the foreskin *('hasyafah')*. And there seems to be an almost universal agreement in the Islamic world on this matter. However, unlike male circumcision, the practice of female circumcision varies, ranging from a slight modification of the genitalia to the most extreme. A slight modification of the genitalia may include the kind of procedure where a small part of the labia minora is removed. The most severe case takes form in the total removal of labia minora and/or the clitoris and the stitching together the edges of the vulva (infibulation). Such extreme case is commonly found along the Nile, Sudan, and other parts of Africa.

Islam does not compel women to be circumcised. There is no verse in the Koran that says so. However, there seems to be no explicit prohibition against it as well (Clarence-Smith 2008). But, there is still room to argue that circumcision may have medical benefits for men. The foreskin may inhibit proper cleaning of the penis, and thus allowing bacteria to thrive, which can trigger cervical cancer to grow in the body of the woman he has sex with. Male circumcision may also give sexual benefits by exposing the glans penis, which is

extremely sensitive. Arguably, this procedure can therefore bring more pleasure for the man, help prevent premature ejaculation, and eventually satisfy his sex partner.

But female circumcision is completely different; it has no proven medical benefit, and may even be dangerous. Female circumcision may result in infection, difficulty in reaching orgasm, and trauma. Sexual pleasure is a right for both men and women. Chapter 2 (Surah Al Baqarah) of the Koran verse 187 states that "they [wives] are a garment for you, and you [husbands] are a garment for them." It means that men and women are meant to complete and fulfill each other's needs. Chapter 30 (Surah Ar Rum) of the Koran verse 21 also adds that God has "placed between you affection and mercy." By taking both verses into account, female circumcision can therefore be interpreted as a violation of the right to sexual pleasure, which has been naturally given to women by God.

3.4.2. FGM/C According to Islamic Jurisprudence (*Fiqh*)

According to Islamic literature, and contrary to popular belief, the Prophet did not introduce the practice of female circumcision. However, it was said that the Prophet did learn of the practice through his observation of a tribe. From that point onwards, the practice took flight after the Prophet instructed a village shaman named Ummi Rafiah, who was well-known for circumcision, to continue the practice. However, the shaman was instructed to remove as little of the clitoris as possible.

Hadith Abu Dawood from Umi Athiyah asserts that a woman who is circumcised is a woman of the Medina. The Holy Prophet was believed to have saidd

> *"Do not overdo it, because it (the clitoris) serves a specific purpose (to please wives) and is most favored by husbands. Other interpretations support this suggested that the Prophet merely instructed to severe the tips of the clitoris, carefully warning his followers not to overdo it as it is required for sexual pleasure ".*

There is evidence to argue that FGM/C practices, although they should be abolished, should only involve the minimal removal of the clitoris. This assessment is in alignment with Husein Muhammad, who highlights the Prophet's criticism of the practice of female circumcision that is commonly done by Arabians and traditions in various other places of the world at that point in time (Muhammad,

Ijtihad Kyai Husein: *Efforts to Build Gender Justic*e, 2011). Even during the pharaohs, the practice of female circumcision was done by cutting a number of genital tissues and eliminating all the labia minora. The message that was said to have been conveyed by the Prophet Muhammad to Ummi Rafiah was actually within the process of cultural transformation that was seeking a gradual reduction of that tradition or culture. Husein Muhammad reiterated that the Prophet wanted the abolition of the practice of female circumcision (.ibid). However, the Prophet realized that abolishing this tradition was a slow process, and that he had to discourage the practice methodically as FGM/C was deeply embedded in the tradition of society at that moment in time. Forcing the issue would have resulted in resistance, rebellion, and the dissatisfaction of society, which is a contraction of the Prophet's main mission of bringing peace and acceptance.

Another scripture which explains the law of female circumcision is a scripture narrated by Imam Ahmad bin Hambal, as follows: From Abu Hurairah r.a., the Prophet said:

> *"Circumcision is an obligation for men and honor for women" (HR Ahmad and Al Bihaqi). This scripture explicitly affirms that circumcision for men is obligatory, while for women it is "honor".*

Shaykh Yusuf al Qardhawi interpreted the word "honor/*makrumah*" as something that is considered good for women according to tradition. There are no religious texts that oblige or advocate that women partake in the practice of circumcision. However, this has always been subject to change. A tradition regarded honorable at a certain time or place is not always honorable in other circumstances. It is clear that different territories, like the Arabian Gulf states and all of the northern states of Africa, differ in practice with regards to women and religion.

Qardhawi asserts firmly that FGM/C is a mere tradition, but it is not based on religion. It is highly contextual and conditional to circumstances. According to Qardhawi, if the FGM/C practice result in physical and psychological detriment and it takes away the rights of women, it is *haram* (sinful). This is emphasized by the juristic rules agreed upon by the cleric who states that "should not hurt yourself and others".

Meanwhile, according to Hamim Ilyas, female circumcision is originally a tradition of society, but because religion accommodates/

compliments the tradition, it is generally considered a religious command (Ilyas, 2005). Within religious communities, there is adagium *al-'adatu muhkamatun* (custom made law) and custom is highly regarded to be sacred. Religious heads often rule by adopting what is considered to be the word of God that has been interpreted from Holy Scriptures. This often includes the perpetuation of archaic and detrimental practices such as FGM/C. This effectively reinforces the stereotype that stipulates that a woman is naturally promiscuous. Therefore, in order to control women, they are often socially, and religiously obligated to be circumcised.

The practice of FGM/C is believed to have been spread throughout the world as more societies adopted Islamic teachings. However, upon further study, there is room to argue that no verse in the Qur'an explicitly obligates its followers to practice circumcision.

The most common reference is verse 123 of the An-Nahl, which commands the Prophet Muhammad to follow the teachings of Abraham, who was said to be an example of a righteous Muslim *(hanif)*. While the prophetic scriptures associated with female circumcision are based on traditions and the nature of the circumstances at the time of its inception. The Hanafi and Maliki schools hold that female circumcision is impossible under Sunnah (religious encouragement), and is not recommended.

The Shafii school of thought holds that female circumcision is mandatory, while consensus in The Hambali school are conflicted. Some who follow the school feel that practice is mandatory, while others do not consider it obligatory (Ibn Qudama). Interestingly, various school of thoughts discussed above justify their advocacy of FGM/C practices by referencing Prophetic Scriptures which, if carefully inspected, do not obligate the said practice. Essentially, the conservation, and perpetuation of the practice relies significantly on the subjective interpretation of religious institutions which differ according to the community and region. Despite the interpretation used to justify the advocacy of FGM/C law, Sayyid Sabiq asserts that: "All traditions related to the commandment of female circumcision are *dha`if* (weak), and none is authentic" (Sabiq, 2013). Not all schools of Shafi'i also agree on the obligation of circumcision for women (Muhammad, 2001). Female circumcision is a case of *ijtihadiyah* (religious interpretation), and its obligatory status established by the religious leaders of various schools should be subject to reviews and changes. On that note, there are various interpreta-

tions of the concept of *"makrumah"*. The Qardhawi view *makrumah* as something that is a traditionally positive obligatory concept; while the Health Assembly and *Syara'* Assembly of the Ministry of Health of the Republic of Indonesia (MPKS MOH RI) consider makrumah as a "religious directive that has been decreed by the religious hierarchy" and is either religiously recommended, or is mandatory practice. However, the viabilities of these contrasting opinions are undermined by the teachings of Husein Muhammad, who was believed to consider *"makrumah"* as a mere honor. This suggests that any religious teaching in favor of FGM/C is neither compulsory nor recommended (Muhammad, 2011, p.112).

At its conception, the laws regulating FGM/C were aimed to complement the implementation of Islamic sharia laws, which were primarily enact teachings that would benefit its followers universally. Several characteristics fall under the umbrella of the "benefit" mentioned above; and it can be achieved and maintained through the consideration of five basic elements. These elements are religion, soul, descent, wealth and intellect (Subhan, 2007). Since medical literature has not been able to produce any evidence of the benefits of FGM/C, and worse still, is widely considered significantly detrimental, FGM/C should be abolished from existing cultural traditions.

Over the years, scores of studies have been done to assess and raise awareness of the dangers of FGM/C. Special attention was given to several regions and tribes in Africa and Egypt, where the practice is generally believed to be more inhumane as compared to other parts of the world. This has led to a global controversial debate on the viability, and legality of the tradition. On June 24, 2007, Egyptian Mufti Sheikh Ali Gom'ah issued a *fatwa* (religious decree) which forbids female circumcision after an organization of Egyptian Doctors affirmed that the death of the girl named Budur Ahmad Syakir, as a result of circumcision in the South Elmania Province of Cairo (Muhammad, 2011).

3.5. FGM/C Practice: The Needs of a Woman, Power Relations, and Decision-Making

The trauma suffered as a result of FGM/C can only truly be comprehended by its female victims. The perpetuation and preservation of the practice is influenced by several factors. Firstly, to continue generational traditions. Secondly, it is done to adhere to religious customs which are heavily practiced in each community. The decision which obligates a girl to undergo FGM/C procedures often fall onto the parents. However, this responsibility could also fall onto the grandparents of the victim. This insinuates that there is a collective communal effort influences the perpetuation FGM/C practices. This influence is often propagated by other social institutions (religious institutions, government, etc.) which heavily contributes to FGM/C's status as a social norm. This hints at a cyclical pattern which involves transfer of power. Social influence would often empower parents to perpetuate the practice generationally. Children often fall victim to an abuse of power as they are not afforded the legal right to make decisions on their own. This effectively makes children vulnerable to the consequences of decisions that was not made in the best interest of the child.

Michael Foucault criticized the concept of "power", which is generally conceptualized as the capacity of the ruling party to impose their will against the wishes of those who have no power at all. Additionally, it is the ability to force others to do things that the other party does not want to do (Foucault, 1978). This suggests that power is often utilized as a control mechanism to control weaker parties. According to Foucault, power must be seen as something done, and an element which contributes to long term strategy rather than control. Essentially, power must be seen as a verb instead of a noun, as a catalyst to achieve a positive goal, rather than a tool of oppression.

There are several important points to consider with regards to the concept of power according to Foucault (Mills, 2003 p.50), namely:

- Power must be conceptualized as a chain or web, where the system of relationships is spread throughout society, not just a relationship between the oppressed and the oppressor;
- Secondly, the individual must be seen not only as the sole recipient of power itself but as the 'catalyst' in which power develops and should be distributed.

The approach developed by Foucault forces us to conceptualize the definition of power and the role of the individual within the structure of power relations. This applies whether the individual is the subject of the oppression or whether the individual plays an active role in their relationship with fellow individuals or institutions. Foucault considers the concept of power as a strategy that contributes towards a collective goal. As such, power must be seen as catalyst for progression rather than something that has to be obtained.

The concept of power, and power relations are highly relevant to FGM/C practices. As a prelude to a conclusion, power relationships are often neatly hidden relationships within the social fabric of society and are difficult to detect (.ibid p.51). One such example of a power relation with regards to FGM/C practice occurs whenever a parent, who is heavily influenced by religion and social norm, decides to have their daughters circumcised. This is arguably a display of power which results in the oppression of freedom of choice, and mutilation of the female body. The blatant disregard of the consent of the child is a significant indicator of the power play that runs rampant throughout communities around Indonesia.

3.6. FGM/C in the Context of Femicide

WHO defines the concept of femicide in broad and narrow senses. Broadly speaking, femicide is the planned killing of females incentivized by a hatred of the female gender in a narrow sense, femicide also covers the killing of infant girls due to their sex (WHO, 2012).[5] It is difficult to conclusively include FGM/C practices within the narrow definition above. However, there is evidence to support an argument which suggests that FGM/C practices have resulted in the death of children.[6] Historically, female babies have been exposed to medical malpractices performed by village shamans who conducted FGM/C procedures despite the lack of proper medical training or equipment. A crucial medical procedure requires the medical expert to confirm the baby's blood type, as it could determine the potential consequences and complications that could arise due to FGM/C procedures. As a result, female babies often lose a significant amount of blood, which would sometimes prove to be fatal.

5 Femicide is generally understood to involve intentional murder of women because they are women, but broader definitions include any killings of women or girls.

6 See Chapter 6.

Conclusively, Komnas Perempuan believes that femicide is a serious problem, and firmly asserts that an in-depth study of the correlation between FGM/C practices is imperative. This study deviates from an analysis of religion and traditions which influence FGM/C, but instead focuses on the medical detriment as a natural consequence of the practice. This includes whether or not FGM/C should be included within the narrow concept of Femicide; the risk of death with regards to the mutilation of the biological parts involved; and relevant medical conditions such as blood-clots.

3.7. Understanding FGM/C from a Medical Perspective

To accurately determine the typology of FGM/C in Indonesia, it is important to develop a firm understanding of the anatomy of the female genital. As an organ, the clitoral parts begin from the glans clitoris to the clitoris cruz (which is shaped like a pavilion, a cape). The external part that is often exposed physically, theoretically, is usually the clitoral glans and the clitoral hood.

The clitoral glans is situated at the top of the organ. This section is covered by a clitoral hood (prepuce) when the clitoris is not sexually stimulated, but is exposed when the individual is sexually aroused. The clitoral hood and the clitoral glands are often the parts that are relevant to FGM/C procedures.

Picture 1 **Anatomy of the Vulva and Clitoris by OpenStax College**

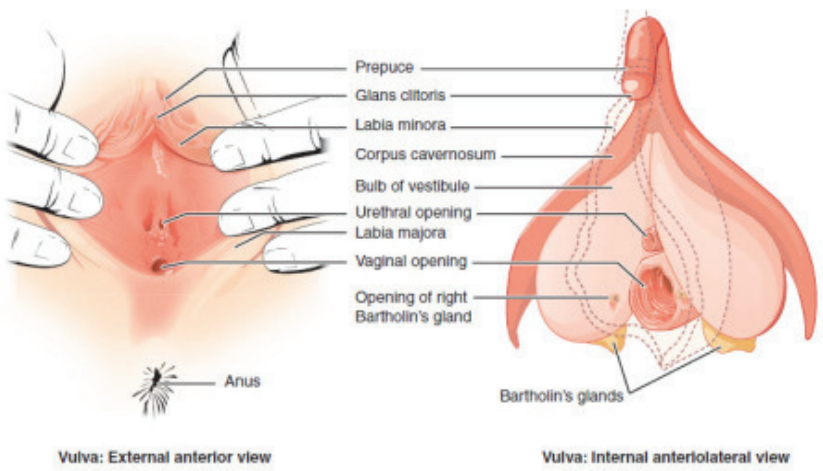


Table 2 **Classification of FGM/C Procedures by WHO**

Type I — *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 mutilation, the following subdivisions are proposed:*

- ***Type Ia,*** *removal of the clitoral hood or prepuce only;*
- ***Type Ib,*** *removal of the clitoris with the prepuce.*

Type II — *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:*

- ***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 — *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:*

- ***Type IIIa****, removal and apposition of the labia minora;*
- ***Type IIIb,*** *removal and apposition of the labia majora.*

Type IV — *All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization*

Chapter

4 FGM/C from a Human Rights' Perspective and Public Policy

The previous chapter dealt with conceptual frameworks from diverse perspectives, including the International Human Rights Framework; the Feminist Framework; and the Sociological Framework. Moving forward, this chapter will comprehensively assess FGM/C from within a Human Rights and Policy Framework. Additionally, the chapter discusses and illustrates regulations that govern FGM/C practices at the national and regional levels. This includes existing approaches that have been considered; and an assessment of the authorization and policies in Indonesia. Furthermore, the discussion below also attempts to analyze the various barriers and constraints affecting the said regulations.

4.1. Regulations and Policies at a National and Regional Level

FGM/C practices are regulated on national and regional levels. At the national level, PG2P practices are regulated through the legislative policies enacted by the Ministry of Health. Meanwhile, at the regional level, regulations primarily focus on access to health services and retribution. They include the compensation amount

that a victim can claim for the damages suffered as a result of the procedures.

In the beginning, Komnas Perempuan research team was only able to successfully identify three regions with a regulation that explicitly states the provision of retributions and medical treatment for FGM/C practices. They are Jambi Municipality, East Kalimantan of Samarinda Municipality, and West Nusa Tenggara Province of West Lombok. However, at this stage of the study, the research team also conducted a thorough a check and review of the regulation of regency / municipality related health services in 17 regencies / cities. These studies are further discussed in depth below.

4.1.1. The Dynamics of Regulations and Policies at National Level

As briefly introduced above, at the National Level, the Ministry of Health Indonesia are responsible for the implementation of Regulations and Policies with regards to FGM/C. Regulations and policies debating the abolishment of FGM/C practices have experienced multiple revisions over the years.

The topic was subjected to a heated debate in 2006, and the discussion was focused on determining whether or not Indonesia was to abolish or preserve the practice as an integral part of culture and tradition at both at government and civil society level. Initially, it was held that Indonesia was to completely prohibit any FGM/C practice. However, the regulation was later amended to not expressly allow the practice but still allow a semblance of its former practice by trained medical personnel at health facilities under limited circumstance. The law took another change as this rule was then later revoked under the consensus that female circumcision cannot be seen as a medical act. Interestingly, law-makers also held that the topic was still negotiable through the Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k - MPKS).*

Generally, the events contributing to the dynamic changes with regards to FGM/C practices are, inter alia,

1. Ministry of Health issued Circular Letter of Director General of Public Health Number HK.00.07.1.3.1047a in 2006 regarding Prohibition of Medicalization of Female Circumcision by a Health Officer.

2. As a response to the Circular Letter, the Indonesian Ulema Council (MUI) issued a religious decree *(fatwa)* of the Indonesian Ulema Council (MUI) Number 9A year 2008 concerning Law of Prohibition of Circumcision against Women. The document argued that circumcision for women is *makrumah* (honorable) and prohibition of circumcision for women is considered contrary to Islam. As one of the Islamic institutions, the MUI's decree was not in line with the opinions issued by other similar institution in Indonesia, namely Muhammadiyah, who do not advocate female circumcision (Komnas Perempuan, 2014)
3. This disagreement was followed up by the Ministry of Health who responded by issuing the Regulation on Female Circumcision, Number 1636/MENKES/PER/XI/2010 dated November 15, 2010. This regulation only acts as a mechanism that guarantees that the medical personnel performing female circumcision procedures have been trained, and are taught to provide the highest standard of care as possible. This regulation in no way affirms the prohibition of female genital mutilation, but instead serves as a guideline for medical personnel who are responsible for conducting P2GP practices (ibid).
4. As a result of pressure from Non-Governmental Organizations such and the UN, and countless controversial debates on the abolishment of FGM/C, the Ministry of Health issued the Regulation of the Minister of Health No. 6 of 2014, which revoked the Regulation on Female Circumcision, Number 1636/MENKES/PER/XI/2010. This regulation mandates tthe Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k—MPKS).* to issue guidelines for the implementation of P2GP, which ensures the safety and health of women who are circumcised and do not engage in female genital mutilation.

According to a field study, regulation number 6 year 2014, issued by the Ministry of Health, enacted by the influence of civil movements especially the Women's Movement, is ambiguous and impractical. Although it prohibits FGM/C practices in general, it affords communities a legal loophole, which allows them to practice FGM/C as long as it is performed on the basis of religion and tradition, in accordance with the guidelines provided by the Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k - MPKS)*. Additionally, although the Ministry of Health has an authority to discourage the practice from a medical perspective,

and as such, has declared the prohibition of FGM/C procedures in medical facilities, the Ministry of Health has stipulated that it is beyond its discretion and duties to regulate FGM/C from a religious and cultural perspective.

Based on a SDGs' Forum meeting held in 2016 and the FGM/C Practice Assessment Validation Meeting convened in October 2017, it was agreed that since FGM/C practices are often conducted on the basis of religion and tradition, and since it is considered a dangerous practice and violence against women, its regulation should fall under the discretion of the Ministry of Women's Empowerment and Children's Protection.

Based on the findings of a qualitative field research spanning 10 provinces and 17 regencies/municipalities, Ministry of Health's Reguation number 6 year 2014 has not been implemented effectively. This is true on neither a Regency Health Office level nor other related Regional Government Organizations (OPD).

Another interesting finding is that many midwives, who still adhere to the ordinances of circumcision, are not discouraged by the regulation enacted by the Ministry of Health in 2010. This has been used as a catalyst which accommodates to the community demand for FGM/C practices. This suggests that health workers pay little attention to the regulations mandated by law, but are only mildly concerned with medical technicalities involved. Furthermore, several Public Health Offices also stated that various regency governments saw the importance of consistency and assertiveness of the Central Government, the Ministry of Health, to FGM/C practice regulations. Although, they have grounds to follow the rules effectively and educate the public, it is difficult to influence other parties who are still adamant on perpetuating religious and cultural traditions.

There is room to argue that the regulations enacted by the Ministry of Health have the potential to change people's behavior or the demand for FGM/C. To that end, the Government needs to influence the views of community and religious leaders in order to implement regulations that are more acceptable to the community (ibid).

4.1.2. Regional Regulations and Monetary Reparations

The team conducted studies concerning Health Services under regional regulations. As briefly mentioned in Chapter 1, three provinces in three cities that issued local Health Service Levies, one of which is for circumcision. Circumcision usually refers to male circumcision but is also an applicable term of reference to female circumcision. The review team assessed all regency/municipal regulations in 10 provinces 17 regencies/municipalities. As a prelude to our findings, our discussion describes the process of establishment of local regulations related to health services beforehand as follows:

1. Procedures for the formation of local legal instruments carried out in accordance with the mandate of Law No. 12 of 2011. The initiative or proposed regulation can be passed through two channels. The first being government proposals, and the second being legislative initiatives. According to procedures, academic manuscripts are required for new regional regulations, whereas only explanations and descriptions are required for revisions.

   Consultation and hearing processes are usually done at the beginning stages of the process. After the synchronization of legal discussions, the draft regulations are brought to parliament to be scrutinized and entered into official discussions. The principle of the proposed regulation has to follow the procedural rules mentioned above, and has to consider the urgency and interests of the community.

   The suggested regulation is then debated between the legislature and the executives. When a consensus has been reached, a special committee will be tasked to determine any additional discussion if applicable. Additionally, this stage also allows for public consultation.

2. The levy is determined on inputs from leading sectors. For example, health service charges. The amount of the levy represents and is determined based on the particular needs associated with the service, such as administrative fees, equipment costs, equipment age, etc. Additionally, inflation also determines, albeit a small fraction, the agreed amount of levy.

3. Tax retributions will be obtained through local taxable income. These levies only come from health facilities managed by local governments and are reinvestment for the respective regional developments. Bogor Municipality for example, regulates the

use of taxable income in a mayor regulation *(perwali)*. Studies of other regions were not conclusive due to insufficient information available. However, the local agency of regional income (Dispenda or any other government agency related to regional income), is the most well-known organization responsible for the collection and redistribution of tax levies..

4. In accordance with the mandate of the law, this Regulation of the regional public service is usually reviewed at least once every three years in order to harmonize the legislation in accordance to the higher regulations.

Based on data collected from 10 provinces, and 17 regencies/municipalities, only five local regulations in five regencies relate to circumcision and FGM/C practices. Interestingly, Gorontalo, the province believed to have highest number of FGM/C procedures, is not regulated by any form of health service levies. This is because FGM/C practices in those communities are performed by local shamans who opt to use traditional methods based on mystical and religious beliefs. Consequentially, many members of the community are not eligible under any government or regional schemes related to health.

Parts of data collection were document review, field work and interviews with law agencies of the local government in the respected areas of study, the data collected are as follow.

Table 3 **Local Regulation that Governs the Monetary Retribution for Female Circumcision**

Regencies/ municipalities	Regional regulations regarding FGM/C practices (based on document reviews)	(Local) situation when in-depth interviews were conducted
Bangka Selatan (South Bangka)	South Bangka Regulation number 16 year 2011 on Health Service Retribution, in which retribution for circumcision amounts to Rp 50,000 per service.It is unclear whether or not female circumcision is included in the regulation..	It is not clear whether or not the regulation still applies.

Jambi	Bylaw number 2 year 2012 on Public Service Levies explicitly mandates monetary retribution amounts to Rp 35,000 per service, charged at health facilities managed by the local government.	Regulation number 8 year 2015 on Public Service Levies in which female circumcision becomes one of the objects of retribution. The amount of the retribution is Rp 70,000 per service, charged at health facilities managed by the local government and those that have been covered by national health insurance (BPJS). Several medical facilities do not provide services for female circumcision (compare FGD results).
Bogor	Bylaw number 4 year 2012 regarding the Retribution of Health Services. The object of retribution is circumcision which is considered as a small surgery, amounts to monetary retribution of Rp 75,000.	Regulation number 8 Year 2014 about Public Health Service Levies, where the object of retribution is circumcision which is considered as part of a small surgery. Retribution amounts to Rp 150,000. According to the respected law agency, this retribution applies for male circumcision only, although it can also be interpreted that the retribution applies to female circumcision as well. On the other hand, the health agency confirms that the retribution applies to male circumcision only, not female's

Lombok	Regent's regulation number 16 year 2016 (this regulation is not listed in JDIH website, as such, findings were inconclusive).	Socialization and implementation of this regulation is done through the Health Service Fund of the Health Agency. Since this regulation is inaccessible, the study attempts to use regent's regulation number 6 year 2002 instead, to compare and to differentiate between female and male circumcision's compensation. Female circumcision is charged Rp 5,000, while the male's is Rp 15,000. Based on interviews with midwives and other health workers, the charges are now higher.
Samarinda	Bylaw number 13 year 2011 on Public Service Levies.	Bylaw number 2 year 2012 regarding retribution through Public Service Levies in which female circumcision is not entitled to retribution. The reason (of the exclusion of female circumcision from retribution) is unclear. It could be that this is the result of evaluation from related agencies.

The data gathered above suggests a uniform regulation, in alignment with the procedural rules established; retribution for circumcision has to be established in order to compensate for the damages suffered by all victims. The next step forward would be to clarify the varieties of the term "circumcision" in order to ensure that female circumcision is included in the definition of the bylaws.

Our research has suggested that main obstacle that hinders further progress is that regulations of Ministry of Health (Permenkes) is yet to be passed through national legislation. This would effectively obligate regions to acknowledge the inefficacy of the regulatory system in place and could potentially boost efforts towards the goals that the current legislation sets to achieve.

Research findings suggested that most regions were ignorant or unsure of the nuances included in the regulations set by the Ministry of Health. The misalignment of goals and aims between the Ministry of Health and some regions has effectively undermined the aim of fair retribution for female victims of circumcision.

One of the more prominent examples of the ignorance uncovered from research findings is Jambi Municipality. The Local Health office (Dinas Kesehatan), a leading institution in this regard claimed to be unaware of updated information regarding Regulation of Ministry of Health (Permenkes) number 6 year 2014. Consequentially, the medical facility was still operating under the mandate of an outdated regulation, the Regulation on Female Circumcision, Number 1636/MENKES/PER/XI/ 2010.

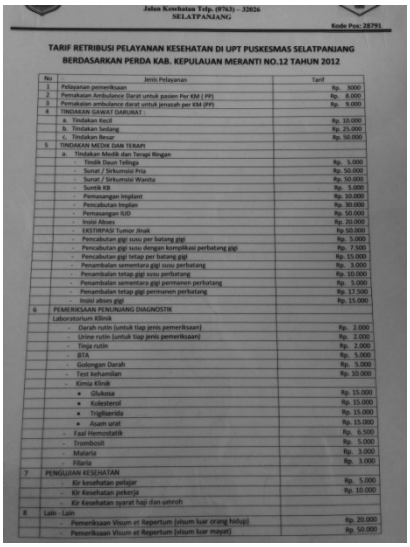
Research shows that most regions have opted to remove regional regulations governing FGM/C practice as it has been incorporated into the Public Service Regulations and Compensation Programs.

In regional cities, both the Female and Male Circumcision procedures are generally placed as part of small surgery clusters provided by Public Health Service Institutions.

The concern and disproportionality of an inefficient retribution system have been acknowledged by several regional heads. The Government of Bogor municipality has asserted the inefficacy of the current system and regulations in practice. This is exacerbated by the inadequate number of local regulations available to address the issue. However, our study suggests that this can be resolved by the effective implementation of Public Service Levies as a mean to compensate the respected victims. The dilemma that stems from this solution is that female circumcision is not included in the regulation's definition of "Circumcision".

Consequentially, it has effectively closed off an avenue for fair compensation for female victims. This is potentially explained by the fact that female circumcision procedures are more commonly performed by self-employed midwives, whereas the procedures are rarely performed in Public Health Service Institutions. As such, the numbers of instances are too small, and it is difficult to gather accurate statistics that could contribute to a viable solution.

Picture 2 **Local Regulation on Retribution at Meranti Islands that lists 'Female Circumcision' (2012)**



Jalan Kesehatan Telp. (0763) – 32026
SELATPANJANG
Kode Pos: 28791

TARIF RETRIBUSI PELAYANAN KESEHATAN DI UPT PUSKESMAS SELATPANJANG
BERDASARKAN PERDA KAB. KEPULAUAN MERANTI NO.12 TAHUN 2012

No	Jenis Pelayanan	Tarif
1	Pelayanan pemeriksaan	Rp. 3000
2	Pemakaian Ambulance Darat untuk pasien Per KM (PP)	Rp. 8.000
3	Pemakaian ambulance darat untuk jenazah per KM (PP)	Rp. 9.000
4	TINDAKAN GAWAT DARURAT :	
	a. Tindakan Kecil	Rp. 10.000
	b. Tindakan Sedang	Rp. 25.000
	c. Tindakan Besar	Rp. 50.000
5	TINDAKAN MEDIK DAN TERAPI	
	a. Tindakan Medik dan Terapi Ringan	
	- Tindik Daun Telinga	Rp. 5.000
	- Sunat / Sirkumsisi Pria	Rp. 50.000
	- Sunat / Sirkumsisi Wanita	Rp. 50.000
	- Suntik KB	Rp. 5.000
	- Pemasangan Implant	Rp. 10.000
	- Pencabutan Implan	Rp. 30.000
	- Pemasangan IUD	Rp. 50.000
	- Insisi Abses	Rp. 20.000
	- EKSTIRPASI Tumor Jinak	Rp.50.000
	- Pencabutan gigi susu per batang gigi	Rp. 5.000
	- Pencabutan gigi susu dengan komplikasi perbatang gigi	Rp. 7.500
	- Pencabutan gigi tetap per batang gigi	Rp. 15.000
	- Penambalan sementara gigi susu perbatang	Rp. 3.000
	- Penambalan tetap gigi susu perbatang	Rp. 10.000
	- Penambalan sementara gigi permanen perbatang	Rp. 5.000
	- Penambalan tetap gigi permanen perbatang	Rp. 17.500
	- Insisi abses gigi	Rp. 15.000
6	PEMERIKSAAN PENUNJANG DIAGNOSTIK	
	Laboratorium Klinik	
	- Darah rutin (untuk tiap jenis pemeriksaan)	Rp. 2.000
	- Urine rutin (untuk tiap jenis pemeriksaan)	Rp. 2.000
	- Tinja rutin	Rp. 2.000
	- BTA	Rp. 5.000
	- Golongan Darah	Rp. 5.000
	- Tesi kehamilan	Rp. 10.000
	- Kimia Klinik	
	▪ Glukosa	Rp. 15.000
	▪ Kolesterol	Rp. 15.000
	▪ Trigliserida	Rp. 15.000
	▪ Asam urat	Rp. 15.000
	- Faal Hemostatik	Rp. 6.500
	- Trombosit	Rp. 5.000
	- Malaria	Rp. 3.000
	- Filaria	Rp. 3.000
7	PENGUJIAN KESEHATAN	
	- Kir kesehatan pelajar	Rp. 5.000
	- Kir Kesehatan pekerja	Rp. 10.000
	- Kir Kesehatan syarat haji dan umroh	
8	Lain - Lain	
	- Pemeriksaan Visum et Repertum (visum luar orang hidup)	Rp. 20.000
	- Pemeriksaan Visum et Repertum (visum luar mayat)	Rp. 50.000

4.2. Regulations and Policies of the Ministry of Health, Bylaws on Retributions and Other Regulations: Knowledge and Understanding of Communities and Local Governments

This section will describe and assess the level of knowledge displayed by communities and members of the local government regarding FGM/C regulations. Furthermore, our discussion also looks into the behaviors and approach that locals have taken in order to objectively measure their understanding of the laws and policies that have been issued by the State. This is against the backdrop of a comparative assessment between customary or religious law regarding FGM/C practices that is understood by the community.

In full, this description of knowledge and understanding is discussed as follows.

4.2.1. Ministry of Health's Regulation Banning FGM/C: Community Knowledge and Understanding of the Regulation in 17 Regencies/Municipalities

Most of mothers, community shamans, educators, religious leaders, and community leaders in 10 provinces 17 regencies/minicipalities admitted that they were unaware and ignorant to the local policies regulating FGM/C Practices. This stems from the adamant belief that FGM/C practices are an integral part of tradition and religion, and as such, there should be no interference from the government.

> *"I heard that there are some policies regulating female circumcision through word of mouth by a village midwife, but I do not know the details exactly" (Interview with RS, a Village Local, April 14, 2017, Banj*ar).

One of the village shamans in the region of Banjar, South Kalimantan, admitted to having heard about the FGM/C related regulations from the village midwife, even though he was not well informed of the regulations/policies involved.

Meanwhile, most female informants from ten provinces admitted they are unaware of any public health service programs available, and believe that there is no official regulation from the central government regarding female circumcision.

Generally, all informants stated that the practice of female circumcision is a community provision that is perpetuated as a hereditary custom. Upon further assessment, our studies concluded that the locals were inherently unaware of the origins of the local custom. However, some interviewees argued that instead of government regulations prohibiting the practice of female circumcision, it would be better to regulate the circumcision process in order to avoid unwanted complications, rather than an absolute prohibition. They firmly believe that the practice of female circumcision will still be perpetuated by the community despite any regulation prohibiting the act.

Our research finds that a collective consensus has to be reached in order to develop a potential solution to the issue. This includes establishing cooperation between, inter alia, religious leaders, health care workers, and members of the community. The inclusivity needs to be coupled with an effort by the Government to increase social awareness, and the clarification of the dangers that FGM/C practices pose.

Our study has shown that generally, Regional Government officials, and public sector workers are either aware of or have read through the Regulations concerning FGM/C practices,

> *"I have read the Ministry of Health's Regulations enacted in 2010 and 2014. The 2010 Regulation allows circumcision procedures as long as it is performed by a medical expert. However, the conditions of the procedures are strict. The 2014 Regulation supersedes the 2010 Regulations. However, I am of the opinion that a lesser degree of circumcision short of mutilation or cutting, is still allowed. As an attempt to further study the regulations stipulated by the Ministry of Health, we spoke to midwives who are well versed in the practice and who have a better understanding of the community. Generally, when performing the practice, midwives tend to avoid mutilation. However, it is unclear whether the same approach is taken by village shamans" (Interview with DW, an ex midwife who currently works for Mothers' and Children's Health (KIA) and Nutrition Division, Banjar Health Office [Dinkes], April 17, 2017, Banjar*).

The Banjar Health Office staff, who also have prior experiences working as midwives, have stated that midwives usually inform each other about the FGM/C regulations. However, a majority of the community only believes that the prohibition of FGM/C in any Regulations, only prohibits the excessive mutilation of the female genitalia.

Nevertheless, our study concludes that the degree of understanding of National Policies enacted by Community Health Centers (Puskesmas) varies in 10 provinces and 17 regencies/municipalities. Although most housewives in other regencies have admitted to some semblance of knowledge of national regulations with regards to female circumcision, most midwives in the Manggar, Polewali Mandar, and Gorontalo Regencies are absolutely unaware of any national-level policies that prohibit the practice of female circumcision.

> *"... I am aware of the regulations related to female circumcision, it is good because female circumcision is painful and the removal of the clitoris affects the sex life. This is unfair and brings disadvantages for women who deserve to live a good life. I have only realized that prohibition is difficult because there is a belief that the regulation should only be limited to mutilation...."* (Interview with FF, a midwife, 15 April 2017, Banjar).

"... Knowledge of government regulations [on female circumcision] has not been spread throughout the community. Most locals are unaware of any regulations, they are only aware of intentions to prohibit and discourage the practice..." (Interview with ON, a midwife, 17 April 2017, Banjar).

"... If I am not mistaken, there was a regulation in 2006 that discouraged female circumcision or completely prohibits the practice..." (Interview with NM, a midwife, 7 May 2017, Majene).

The information gathered above concludes that the degree of knowledge and comprehension of FGM/C regulations vary. The knowledge ranges from full awareness of regulations, to a mild understanding obtained from either word of mouth, or a leaflet summarizing the intentions of the government. A midwife in Banjar regency said that regulation is hindered by its contravention of traditional and religious beliefs. This issue is more controversial in some regions. A midwife from Meranti Regency suggests that she considers the Public Health Sector Regulation a western and 'kafir' (sacrilegious) intervention, as it uses terminology established by the World Health Organization. She said:

"... Public Health Service Regulations prohibiting the medicalization of female circumcision is the intervention of Westerners and is sacrilegious as they have categorized female circumcision using the terminology established by the World Health Organization.." (a midwife, May 2017, one of the participants of Focus Group Discussion, Meranti Regency, Riau Province).

Institutionally, the Indonesian Midwives Association in three provinces, namely, South Kalimantan, Banten and West Nusa Tenggara acknowledged receiving updates regarding updated Ministry of Health's regulation that prohibit the practice of female circumcision. However, most of them have also asserted that they did not receive a formal document regarding its dissemination and the obligations decreed by the Ministry of Health. When questioned, and queried about the extent of her awareness, a midwife's response was that she obtained the knowledge from mere heresy. One midwife claimed that "Most listen to it, and accept that the FGM/C is no longer allowed. They just have to attend to their vaginal hygiene more carefully" (M, a midwife, Lebak, April 2017). Our interviews have also concluded that most midwives are unsure or unaware of

the details of Public Health Service Regulations regarding female circumcision.[7]

The methods of dissemination of information regarding Public Health Service Regulations include:

1. Word of mouth;
2. Social congregation
3. Improvisation and development of knowledge gained from senior midwives or fellow midwives;
4. Practicing vulva hygiene as an alternative and response to prohibition;
5. Spreading awareness while managing community demand of female circumcision.

These methods above are prime examples of knowledge transmission methods discussed in Chapter 3 (Borofsky, 1992: 80-92);- i.e. that the crucial factor instrumental to the effective impact is learning through practice. Briefly, the elements present include,

1) Observation and imitation,
2) Passive listening, active inquiries directly or indirectly, and
3) Repetition.

Furthermore, these methods also follow Gatewood's assertion that the dissemination of information regarding FGM/C were most impactful if it is directly practiced rather than just through word of mouth. (1985: 199-2016).

4.2.2. Local Regulation on Health Service Levy: Knowledge and Understanding of Society and Government in 17 Regions/Municipalities

Our studies have concluded that there no regulatory measures found in policies at the provincial and district/city level. Most local authorities utilize and refer to National Level Policies such as the Public Health Service Regulation Number 6 of 2014. Any District/ Municipal Regulation found to be relevant to P2GP only stipulate Health Service Levies for a limited number of medical circumcision procedures. Furthermore, the discouraging level of ignorance prevalent in communities regarding the subject matter, regulations in particular, only serves to contribute to the perpetuation of P2GP practices.

7 Femicide is generally understood to involve intentional murder of women because they are women, but broader definitions include any killings of women or girls

This highlights an urgent necessity for increased efforts of information dissemination. Results from our field research have asserted that only a minority of locals were aware of some semblance of the regulation, whether the regulation was at a National or Local level. Additionally, information on Public Health Levies regarding FGM/C are only known to several midwives in the West Lombok Regency. This suggests that there is no primary Public Health Service Regulator accountablee for overseeing collective efforts of similar institutions in different regions of Indonesia. In regions that implement the Ministry of Health's regulation or Health Service Levies, the penalties often only apply in cases where physical injury is involved, or through arbitrary discretion. Interestingly, the deterrence measures of levies are further undermined by health coverage included in packages offered by institutions such as the national health insurance scheme (BJPS).

The following are assessments of the dissemination of information on policies and regulations related to FGM/C practices in 17 regencies/municipalities.

HEALTH SERVICE SECTOR AND DIFFICULTIES FACED BY LEVIES WITH REGARDS TO P2GP

In West Lombok Regency, some midwives claim that they are able to avoid Public Heath Levies as their services are not considered FGM/C procedures.

According to a midwife who admitted to knowing that FGM/C practice provides no medical benefit to the victim, their services were integral to society as it discourages members of the community from resorting to village shamans for FGM/C services. Although their services are locally considered to be a FGM/C practice, they are often legally penalized as their procedures are considered to be an "act". This "act" includes cleaning the genitals in any way that would result in physical injury. This suggests that in order to be eligible for levies and penalties, the FGM/C procedure has to involve physical injury as a result of cutting, or piercing of a part of the body.

However, studies have suggested that the law still implements Health Service Levies on all FGM/C practices in other areas in Lombok that consider FGM/C an obligatory religious practice. The efficacy of Health Service Levies are further undermined by procedural flaws in practice. FGM/C services performed by independent midwives are often not be reported to the Health Service Regulators or Health Offices. The impractical burden of identifying potential perpetrators is beyond the means afforded to any local regulator.

Banten Province: Rangkasbitung and Pandeglang Regencies

Banten and Lebak regencies have not imposed or implemented any regulations or levies with regards to FGM/C practices.

Riau Province: Dumai and Meranti Regencies

Dumai bylaw number 20 year 2011 on Health Service Levies. In theory, this regulation stipulates that the old tariff charging individuals who practice "female circumcision" amounts to Rp 5,000 while the new rate amounts to Rp 10,000. However, our sources have confirmed with various relevant agencies who claim that although this regulation has not been formally revoked, it has been made obsolete and it has not been utilized by Community Health Centers (puskesmas), which follow the intention of the Ministry of Health. This regulation is no longer valid and has been superseded by rules enacted in 2017 that no longer stipulate charges for those performing female circumcision procedures.

Similarly, the midwives working for Community Health Centers (puskesma) in Meranti regency no longer perform female circumcision procedures. This regency is governed by regional regulation number 12 year 2012 which mostly mandates a Health Service Levy. Its policy holds that the penalty midwives could face for performing circumcision is valued indiscriminate of the sex of the patient at Rp 50,000. Our researchers on the field have confirmed that this regulation is still affixed to the announcement board of Community Health Centers (puskesmas) in the area. However, the female circumcision procedures are still performed by independent midwives who do not work for any institution. According to our sources, independent midwives justify their services as the best alternative to village shamans who lack medical expertise.

South Kalimantan Province: Barito Kuala and Banjar Regencies

The regions of Barito Kuala and Banjar have not enacted any regulations or levy schemes regarding P2GP practices.

Jambi Province: Jambi Municipality

Our sources gather that at this current point in time, female circumcision procedures are generally performed by midwives, whereas previously it was solely performed by local village shamans. The female circumcision levy is set forth in regional regulation number 8 year 2015 on Public Service Levies which stipulates that services regarding female circumcision in government facilities could face a

penalty of Rp 35,000. In practice, many government health facilities no longer provide services to meet the demand for female circumcision. However, mothers tend to circumcise their daughters through independent midwives when they do postpartum health check. The Jambi Municipality Health Office still adheres to the 2010 Ministry of Health's regulation

Central Java Province: Bogor Regency and Bogor Municipality

The dissemination of information regarding the 2014 Ministry of Health's Regulation has been successful amongst midwives in the area. While many midwives have taken the decision to discontinue the practice, others still choose to perpetuate FGM/C procedures to meet public demand. Additionally, it is generally believed to be the best alternative to village shamans as they possess the appropriate skills to perform the procedures safely.

Bogor Municipality Midwives Association (IBI) is one of those sthat have chosen not prohibiting the practice of female circumcision. Although the Health Office does not advocate the practice of female circumcision, it has decided to develop relationships with midwives working for Community Health Centers (puskesmas) in order to maintain a strong relationship with the community. The lack of support evidence available has impeded any efforts to abolish FGM/C practices. This is exacerbated by the lack of regulations regarding FGM/C in Bogor. However, the Health Office has begun to build a network of stakeholders in an attempt to look into family health issues, especially with regards to children. The primary obstacle would be to change the mindset of the general community which could prove to be an arduous uphill battle as FGM/C is deeply imbedded into Bogor's religious and traditional custom.

East Kalimantan Province: Samarinda Municipality

Public Health Levies regulating FGM/C practices in the City of Samarinda is found under Local Regulation number 13 year 2011 and number 2 year 2016. The 2011 regulation was superseded by the 2016 regulation. This has had the effect of removing any Health Service Levy stipulated by the old regulation. Unfortunately, our research has concluded that the approach in this city continues to be progressively regressive. Although the detriments resulting from FGM/C are known, the social structure and beliefs remains conservative.

West Nusa Tenggara Province: Central Lombok Regency

Based on our desk review, Law No. 16 (2002) regarding Health Service Levies stipulates that penalties for performing female circumcision procedures could amount to Rp 5,000, while male circumcision procedures could amount to Rp 15,000. However, our research team on the field has concluded that this regulation is no longer applicable in practice. Instead, the 2002 regulation has been superseded by Regent's regulation number 18 year 2016 on Health Service Levy. Although the penalty afforded by this regulation has increased to Rp 50,000, it provides a vague definition of circumcision. Our research suggests that it is generally believed to only be applicable to male circumcision procedures.

4.3. FGM/C with Regards to Human Rights Policy: State Responsibilityy in the Fullfilment of Women's Reproductive and Sexual Rights

Article 1 of the Universal Declaration of Human Rights stipulates that all people are born free and equal in dignity and rights. Furthermore, article 5 of the same declaration states that no one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment.

In the context of violence against women, the Declaration on the Elimination of All Forms of Violence Against Women states that violence against women is any action based on sex which results in or may result in misery, or physical, sexual or psychological harm (Article 1). Additionally, an FGM/C procedure, no matter the degree of resulting harm, explicitly contravene the rights to freedom of thought and opinion, the freedom to live independently, and effectively removes any freedom of choice from children.[8]

Based on our studies, we argue that FGM/C should be legally considered as an act of violence. As such, we argue that it should formally be categorized under the definition of "violence against women".

8 Article 13 Convention of the rights of the child: 1) The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.

Though FGM/C procedures differ in degree and brutality in different parts of the world, we firmly believe that it is a blatant disregard of human rights. Furthermore, FGM/C practices contravene the rights stipulated not only by the National [human rights] Instruments, but also International instruments such as the Universal Declaration on the Elimination of All Forms of Violence against Women; the Universal Declaration of Human Rights; and various CEDAW recommendations whether directly or indirectly

The Government regulates this issue through the Ministry of Health. The Governing body has issued regulation number 6 year 2014, which revokes Regulation of the Minister of Health number 1636/Menkes/PER/XII/2010 regarding Female Circumcision. The justification for the revocation is that the enactment of Ministry of Health's Regulation number 6 year 2014 supersedes regulation number 1636/Menkes/Per/XII/2010, which will effectively be declared null and void. Article 2, of Ministry of Health's Regulation number 6 year 2014 mandates that the Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k —MPKS)* to issue guidelines for female circumcision procedures in order to ensure the safety and health of women. Additionally, the regulation has explicitly distinguished female circumcision from female genital mutilation.

Ministry of Health's Regulation number 6 year 2014 is considered as a consolidation and an instrument that mediates the pros and cons of FGM/C that has occurred since the enactment of initial regulations. Controversy has sparked heated debates since the conception of Ministry of Health's Regulation number 1636 year 2010 which has attempted to assess the medical practicality and benefits (or lack of) of FGM/C practices. Nevertheless, the success and impact of the regulation can only accurately be measured through an assessment of its implementation and whether it has succeeded in abolishing FGM/C in practice. Based on our field findings, most of the informants in various categories (mothers, shamans, religious leaders, educators, and customary leaders) were not aware of Ministry of Health's Regulation number 6 year 2014. Our research on midwives from 10 provinces also suggests that the degree of knowledge of Ministry of Health's Regulation number 6 year 2014 ranges from full comprehension to total ignorance. This raises concerns about the effective dissemination of Ministry of Health's Regulation number 6 year 2014, three years since its enactment.

As FGM/C practices are still rampant in various regions and communities in Indonesia, we argue that the implementation of Ministry of Health's regulation number 6 year 2014, has not achieved its desired effect and impact. The ongoing presence of FGM/C practices in Indonesia to date indicates that the Government of Indonesia has not taken all possible measures to effectively abolish the practice. This is concerning as Indonesia is party to several International Human Rights conventions and declarations. An FGM/C procedure directly and indirectly deprives a woman's right to enjoy the highest attainable standard of physical and mental health as regulated in a non-exhaustive list of instruments. These Articles are,

1) Article 12 paragraph 1 of the International Convention on Economic, Social and Cultural Rights;
2) Principle 8 of the ICPD Program of Action;
3) Article 16 of the African Charter on Human and People's Rights

Additionally, FGM/C procedures performed without any clear medical evidence that proves that it is beneficial, violates a woman's health rights (Center for Reproductive Rights, 2000).

FGM/C is practiced by families and communities who believe that it will be beneficial for a woman's life. As such, the decision to circumcise is more widely viewed as a personal decision. Since FGM/C is deeply rooted in the traditions and culture of the communities, any external intervention in the name of human rights will be regarded as a cultural colonization (Irianto, 2006). However, it does not mean that FGM/C cannot be stopped; the government can act decisively to stop FGM/C practice by placing an emphasis on its detriment to a woman's health, and body.

The continuing existence of FGM/C in Indonesia has become a concerning issue. We argue that despite the enactment of measures such as the regulations issued by the Ministry of Health, i.e. Ministry of Health's regulation number 6 year 2014, its impact has been insignificant. Additionally, its ambiguity has brought up the question of whether the Government wants to stop FGM/C or continue to allow it to take place so long as it is in accordance with the prevailing religious norms.

An example of this is presented by the uncertainty from article 1 of Ministry of Health's regulation number 6 year 2014 which states that although Ministry of Health's regulation number 1636 year 2010 has been revoked, article 2 of the same regulation stipulates that the Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k—MPKS)* is given the discretion to

establish guidelines for the implementation of female circumcision.

The ambiguity that the government portrays has the effect of weakening Public Health Service Regulations as a deterrence measure. The negative implications of legal uncertainty and conflicting provisions in Ministry of Health's regulation number 6 year 2014 could result in the social disregard of its legitimacy in practice. In fact, our research has suggested that members of local community still persist in FGM/C efforts and believe in its benefits despite being fully aware of the provisions stipulated in article 2 of the above regulation. Although the Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k—MPKS)* have been given the responsibility of formulating guidelines concerning the implementation of female circumcision, our research has concluded that there has been no evidence of any significant efforts from both parties.

The State's lack of assertiveness towards FGM/C could have a detrimental effect on its efforts to abolish it. Allowing FGM/C practices to persist is in direct contravention of Indonesia's pledge to protect and provide equal rights to its citizens. As Indonesia is party to a group of countries which collectively seek to promote Sustainable Development Goals (SDGs), its lack of urgency and assertiveness contributes to the contravention of indicators such as target number 5 which seeks to "Achieve Gender Equality and Empower All Women and Girls". Indonesia should therefore be expected to invest more efforts into abolishing the harmful practice of FGM/C.

4.4. Dangerous Practices and Violation of Human Rights: FGM/C within the Framework of Social, Economic, and Cultural Rights

FGM/C practice in Indonesia will always be synonymous with religious and moral teachings. There is a belief that FGM/C procedures will elevate their sense of morality and the future of Muslim girls. Consequentially, there is a social expectation that girls who are uncircumcised will have a "bad fate" and will have a high sexual libido. Deeply embedded in most Muslim communities, FGM/C practices have a significant influence on Islamic teachings which has consequentially resulted in the advocacy of infant circumcision of both boys and girls. Our research has suggested that families often hold celebrations to honor the occasion. This is still done by some people in Sulawesi despite ambiguity and the lack of a clear foundation of Islamic teachings (BBC Indonesia, 2016).

Based on research done in 10 provinces, the Qualitative Research Team of Komnas Perempuan concludes that there is a strong correlation between celebration and FGM/C practice in some areas. The Basic Health Research Data (Riskesdas) is a statistical indicator published by the Ministry of Health in 2013 which shows that 51.2% of girls have been circumcised nationally. The highest percentage from Gorontalo stands at 83.7% (Balitbang Kemenkes, 2014). Research has suggested that the locals of Gorontalo believe it is their cultural duty to perpetuate FGM/C through generations. Essentially, the people of Gorontalo adhere to an archaic saying- "Adat bersendikan Syara dan Syara' bersendikan Kitabullah", which loosely translates to "Custom is based on religious rule and religious rule is based on the holy book". This highlights Gorontalo's headstrong respect for their traditions. In Gorontalo, female circumcision is locally known by several terms of reference, the two most prominent are Molu Bingo (Pinching), and "Lemon Bathing". Participation in Lemon Bathing ritual is seen as an honorable tradition and is considered an integral aspect of their culture.

Lemon bathing ritual in Gorontalo is a tradition that has been passed down through generations of families who embrace Islam. There is a belief that every girl who is born into Islam is obliged to perform lemon bath process before they reach two years of age. This is a process that must be done just before the girl is about to be circumcised. Interestingly, the existing tradition stipulates that the severed body part would be placed into a lemon jar. The lemon jar would then be stored by the family or by the *hulango*[9] who performed the circumcision. Lemon bathing ritual requires the family to fulfill several requirements and before the girl can be circumcised.

Results from a field study performed by Komnas Perempuan Qualitative Research Team in Gorontalo suggest that lemon bathing ritual is a mandatory procession for Muslim families who have daughters. However, the process can be costly. Poorer families in the communities can often rely on social compassion, or the community support to participate in the circumcision process. As such, families who are unable to afford the full cost of the Lemon Bathing process often group together and agree to hold a large event collectively. In the spirit of community, families who intend to hold big

9 *"Hulango"* is a local term for village shamans in Gorontalo. Only *"hulango"* who can perform the circumcisionn.

wedding celebrations would often offer to allow other families to use the occasion to hold a lemon bathing celebration jointly, bearing the brunt of the costs.

Collective celebration is an integral part of FGM/C in Gorontalo. Circumcision is almost always followed by prayers and a feast, so much so that they are thought to be compulsory. Our research also reveals that families will intentionally save up in anticipation of the lengthy, festive tradition. Their relatives are usually willing to help with the finances in case the family is poor. Because this tradition is deemed as religiously compulsory, no one ever articulates the burden of having to arrange such an extravagant celebration, not that we know of.

This tradition puts a tremendous pressure on Muslim families with daughters. They will most likely end up spending a great amount of money for the tradition. Societal judgements may also be thrown at parents whose daughters are not yet circumcised due to poverty. People may ask in a judgmental tone, "why is your daughter not be circumcised yet?". As a result, parents succumb to the pressure and spend a lot of money for a tradition that is not only pointless but also potentially harmful. Social jealousy due to FGM/C celebrations which are conducted based on parents' varied economic ability is unavoidable. Unintentionally, FGM/C practice sustains due to tradition and culture which force parents to allocate a certain amount of money to perform the (unnecessary) practice to their daughter.

The International Covenant on Economic, Social, and Cultural Rights clearly condemns any act of discrimination on the basis of race, skin color, sex, language, political views, nationality, social and economic status, birth status, and many others (Article 2 Paragraph 2). And Article 2 Paragraph 3 specifically guarantees men and women equal economic, social, and cultural rights. Unknowingly, FGM/C discriminates against the poor, especially the mothers and daughters, by compelling them to hold a festive celebration. But, most importantly, it is the girls who are the primary victims of discrimination here. Although not as harsh, their parents will be subjected to social sanctions for failing to pass down the intergenerational tradition. For this reason, the State must step in to bring an end to the discriminatory practice. It is noteworthy that the State has done virtually nothing so far to do so. It is unsurprising that FGM/C remains thriving in many parts of Indonesia, disadvantaging many girls and parents in the process.

Chapter

5 Societies/Communities and Regional Context

5.1. Demographic Overview

We found that Female Genital Mutilation/Cutting (FGM/C) was practiced in every area studied. Unfortunately, the data on the types of FGM/C performed was not completely obtained. The 2013 Basic Health Research (RISKEDAS) shows that the prevalence of FGM/C is high in Indonesia, where 51.25% of girls have had FGM/C performed on them. RISKESDAS used the term 'female circumcision', not FGM/C.

RISKESDAS also found that 72.4% of the girls had the procedure performed when they were as little as 1–5 months old. Gorontalo turned out as the province with the highest prevalence of FGM/C (83.7%) and East Nusa Tenggara as the lowest (2,7%). The survey relied on questionnaires filled out by female household members.

This study was conducted in 10 provinces, 17 Regencies/Municipalities) shows that FGM/C still takes places throughout Indonesia. It is mainly performed on girls below 3 years old by female health personnel or female shamans under the order of mothers or grandmothers. Mothers who have undergone FGM/C in the past tend to re-perform the tradition on their daughters. Our interviews with

many women revealed that FGM/C is perceived as a harmless intergenerational tradition. There were only a small number of women who articulated the negative side effects of the procedure as recorded in official documents or during interviews.

Chart 3 **Percentage of Girls Aged 0-11 Years Old Who Have Undergone FGM/C (RISKEDAS, 2013)**

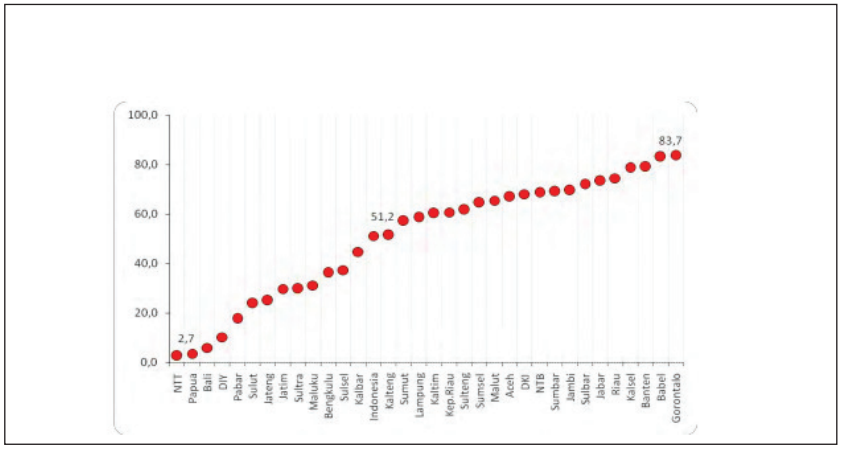


Chart 4 **Percentage of Girls Aged 0-11 Years Based on When They Underwent FGM/C (RISKEDAS, 2013)**

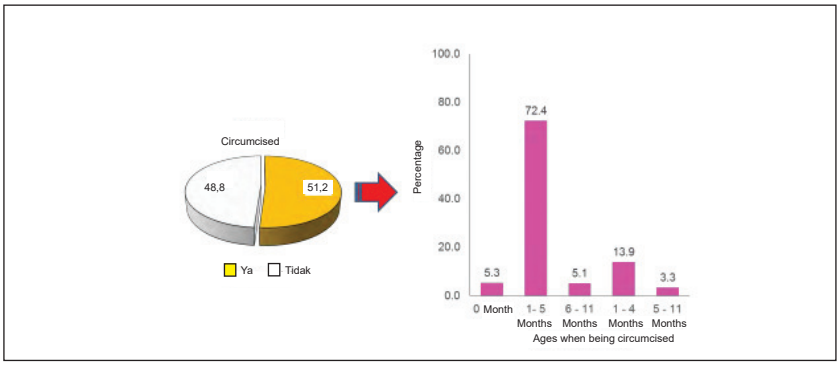
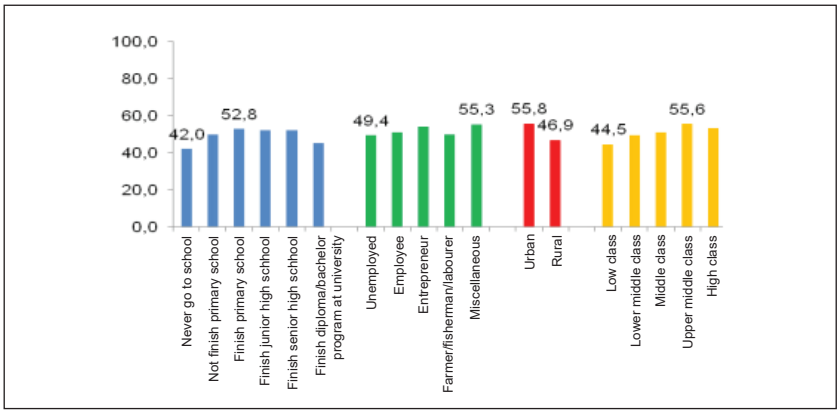


***Chart 5* Percentage of Girls Aged 0-11 Years Old Who Have Undergone FGM/C Based on Other Characteristics (RISKEDAS, 2013)**



According to RISKESDAS, the percentage of girls aged 0–11 years old who have undergone FGM/C in urban areas (55,8%) is higher than the prevalence rate of FGM/C in rural areas (46.9%). Based on the data, we picked several regions with the highest prevalence rate of FGM/C and those with local laws regulating the practice:

***Table 4* Chosen Regencies/Municipalities (SMSP, PSKK UGM, 2017)**

No	Province	Regencies/ Municipalities	Consideration	
		1 Province 2 areas	FGM/C prevalence rate (Riskesdas, 2013)	Posess laws regulating FGMC/C
1	Gorontalo	Bone Bolango North Gorontalo	93,1 86,9	
2	Bangka Belitung	East Belitung South Bangka	93,1 90,6	
3	Banten	Pandeglang Lebak	90,7 87,6	
4	Riau	Kota Dumai Kep. Meranti	85,8 83,5	
5	South Kalimantan	Barito Kuala Banjar	85,7 84,6	

6	West Java	Bogor Bogor Municipality	93,5 92,8	
7	West Sulawesi	Majene Polewali Mandar	92,5 90,7	
8	East Kalimantan	Samarinda	80,5	Yes
9	Jambi	Jambi	74,6	Yes
10	West Nusa Tenggara	West Lombok	58,1	Yes

5.2. Regional Description

Below are the general overviews of each region studied. The details were obtained from BPS' documents titled "Regencies/Municipalities in Numbers" *("Kabupaten/Kota dalam Angka")*, which can be found online in BPS' website.

5.2.1. Gorontalo Province

Gorontalo consists of 5 regencies and 1 municipality: Boalemo, Gorontalo, Pohuwato, Bone Bolango, North Gorontalo Regencies and Gorontalo Municipality. This study covered two regencies, Bone Bolango and North Gorontalo Regencies.

Demography

Bone Bolango spans 1,984.58 km2, encompassing 18 districts. 80,444 men and 79,222 women reside in this regency. Most of them (99.88%) are Muslims. As many as 27,800 people live below the poverty line. Bone Bolango is a watershed area *(Daerah Aliran Sungai/DAS)*. Several rivers pass through this regency (BPS Bone Bolango, 2017).

North Gorontalo spans 1,777.03 km2, encompassing 11 districts. A record from 2013 shows that the regency is home to 103,324 people, consisting of 54,902 men and 53,422 women. Most of them (>96%) are also Muslims (BPS Gorontalo Utara, 2017).

Social and Cultural Profile

Bone Bolango Regency is made up of 18 districts: Tapa, North Bulango, South Bulango, East Bulango, Bulango Ulu, Kabila, Botupingge, Tilongkabila, Suwawa, South Suwawa, East Suwawa, Central

Suwawa, Pinogu, Bone Pantai, Kabila Bone, Bone Raya, Bone, and Bulawa (BPS Bone Bolango, 2017). The prevalence rate of FGM/C in Bone Bolango is as high as 93.1% (Kementerian Kesehatan, 2013).

North Gorontalo consists of 11 districts: Atingola, Gentuma Raya, Kwandang, Tomilito, Ponelo Islands, Anggrek, Monano, Sumalata, East Sumalata, Tolinggula, and Biau. As many as 96.2% of the people are Muslims. Some (3.70%) are Protestants, and the rest (0.05%) are Catholics (BPS Gorontalo Utara, 2017). Education is accessible until the upper secondary school. Available health facilities include hospitals, community health centers *(puskesmas)*, village maternity clinic *(polindes)*, village health station *(poskesdes)*, and integrated health center *(posyandu)*.

Fifty three midwives were documented working throughout North Gorontalo's health facilities in 2013 (.ibid). The prevalence rate of FGM/C in North Gorontalo is as high as 86.9% (Kementerian Kesehatan, 2013). Both (Bone Bolango and North Gorontalo) regencies have a high prevalence rate of FGM/C. Along with other regencies, they are a part of a community called Limo Lopuhala'a, which means 5 siblings, consisting of *Pohala'a Gorontalo, Pohala'a Limbolo, Pohala'a Bone, Pohala'a Bolango* and *Pohala'a Atingola*. An overwhelming majority of them are Muslims.

The people of Gorontalo consider FGM/C a cultural and religious tradition. They call the procedure *Mo Polihu Lo Limu or Molubin- go. Mo Polihu Lo Limu*, which literally means lemon bathing, is a tradition that involves bathing with water that contains lemon/ lime extract and other ingredients. *Molubingo* means pinching. Many people believe that lemon bathing/pinching is a necessary tradition to remove a forbidden *(haram)* item, white object from female genitals. All traditional tools and equipment, known as *hulande*, has to be prepared before FGM/C can be performed. At the beginning, the baby girl will be showered with ablution water. A shaman and the baby will then hide behind a white curtain where they will perform the circumcision. Afterwards, the baby will be 'cleansed' with lemon and scented water, and then dressed up in a traditional clothing. The ritual will usually end with plates-stepping ritual, prayers *(sholawat)*, and a feast..

This ritual is considered sacred and compulsory for Muslim girls in Gorontalo because it is perceived as a marker of Muslim-hood. This ritual is of a significant spiritual value that only shamans *(dukun/ paraji)*, not health professionals, are allowed to perform the pro-

cedure. Interestingly, how the procedure turns out will also serve as a prediction of the future behavior of the circumcised girl. For example, if there is blood during the procedure, the girl is predicted to be promiscuous. If there is 'light' comes out of the clitoris, the circumcised girl is expected to bring blessings and good fortunes in business. Initially considered *najis* or impure, the mutilated part will turn into a talisman after being dipped in a lemon water. The clitoris, which has been previously removed or 'pinched', is impure, unless if it is dipped in the lemon water, which will turn it into a talisman. Health workers in Bone Bolango and North Gorontalo are not allowed to perform this ritual because they perceive it as mere cultural tradition—even their daughters are circumcised.

Gorontalo promotes lemon bathing tradition as a tourist attraction. There, FGM/C is inseparable from religion, so much so that it is thought to be a marker of a girl's piousness. One of our informants in Gorontalo also mentioned a saying, which are commonly heard in Minangkabau, *"Adat Basandi Syara', Syara' Basandi Kitabulah",* meaning that "Custom is based on religious rule and religious rule is based on the holy book".

Almost all of our informants doubted that FGM/C will be legally banned and eliminated in the future because they believe that it has become a part of identity of the people of Gorontalo. Many take practicing FGM/C as an obligation of preserving local culture. They also did not seem to bother talking about bodily autonomy at all, as though the term is completely unrecognized there.

5.2.2. Bangka Belitung Province

Bangka Belitung Islands consists of two main islands, Bangka Island and Belitung Island, and smaller surrounding islands. The region is mainly composed of lowlands, valleys, and a few hills and mountains. Our study was focused on East Belitung and South Belitung Regencies..

Demography

Spanning as large as 15,461.03 km2, East Belitung Regency consists mostly of sea, and is composed of 4 districts. As many as 91,702 people reside there; 46,729 of them are men and 44,973 are women. Though, the numbers were obtained in 2006, and significant changes are therefore almost certain. Most of the residents are Muslims (BPS Belitung Timur, 2016).

Spanning 3,607.08 km2, South Bangka Regency encompasses 59 islands and 11 districts. A total of 197,670 people lives there, consisting of 102,654 men and 95,016 women. (BPS Bangka Sela- tan, 2017). East and West Bangka Regencies differ starkly in terms of development. Toboali, South Bangka Regency, may be classified as a rural area. In contrast, Manggar is an urbanized area in East Belitung, which are very popular among tourists. Unsurprisingly, Manggar is far more crowded than Toboali. Despite these differences, FGM/C takes place in both regencies.

Social and Cultural Profile

East Belitung consists of 4 districts: Dendang, Gantung, Manggar, and Kelapa Kampit. The regency is known for its seafood, tin, and tourism. Most of the people identify as Muslims. FGM/C is viewed as an intergenerational, religiously-motivated tradition there.

South Bangka Regency consists of eight districts: Payung, Pulau Besar, Simpang Rimba, Toboali, Tukak Sadai, Air Gegas, Lepar Pon- gok, and Pongkok Islands. This regency relies heavily on mining, agriculture, and fishing. As many as 96,45% of the residents are Muslims. And the rest are either Protestants, Catholics, Hindus, Buddhists, or Confucius. The prevalence rate of FGM/C in East Bangka is 93.1%, and 90.6% in South Bangka (Kementerian Kesehatan, 2013). Both regencies have a high prevalence rate of FGM/C.

The people of East Belitung view FGM/C as a necessity. It is usually performed on baby girls aged 1–2 days, a week, 40 days, or 44 days. In some regions, such as Bakolimau, female circumcision is considered mandatory. Uncircumcised women who are about to marry are culturally obliged to undergo circumcision before the marriage. FGM/C is practiced by both health professionals and non-professionals. Midwives usually use a tiny needle to nick the clitoral hood, and then clean the labia majora and labia minora with a piece of antiseptic gauze. And a shaman will complete the tradition by arranging some rituals, usually when the baby has turned 44 days old. During the ritual, the baby will firstly be bathed. The shaman will then pray *(sholat)*, shower the baby with coconut water, and circle around the baby while carrying a chick. To finally perform the circumcision, the shaman will use a knife that has been previously washed and is kept covered with cotton swab. While chanting some prayers, the shaman will mutilate a white part of the baby's genitalia. If bleeding occurs, an antiseptic swab will be applied. The circumcision will finally mark the Muslimhood of the girls. How-

ever, most female circumcisions are currently performed by health workers.

In South Bangka, the motivation to perform FGM/C—also known as *'sunat'* or *'selam'*—is varied. There is hygiene, cultural, and religious reasons. FGM/C is performed by health workers and shamans. But, some midwives start to question the health benefits of FGM/C. They take advantage over the fact that more people prefer to be served by actual health professionals than non-professionals. They merely clean the vulva with an antiseptic swab and warm water. They can also perform ear piercing for Rp 0–20,000. But, some midwives still provide services for FGM/C. Those who do think that the procedure is not dangerous and that religious leaders are more reliable than social campaigns as a source of information. They usually perform FGM/C by nicking the upper part of the clitoris with a needle. They charge approximately Rp 50,000 for their service.

When a shaman performs FGM/C, the procedure is called 'selam' which is usually carried out when the baby has turned 40 days old, along with *'ngayun'* tradition. The shaman usually uses a small scissor to slightly nick or cut the upper part of the clitoris. The wounding is expected to not be excessive so as to cause bleeding. Some shamans ask the parents to prepare food offerings, including sticky rice, white rice, brown sugar, and a living chicken, supposedly to help the girl remain calm during the whole procedure. Some other shamans believe that praying and chanting syahadat suffice, no offerings needed. Bleeding is expected, and will later be treated with an antiseptic swab. In short, FGM/C is considered a traditional and religious practice.

Islamic influence strongly contributes to the obstinacy of FGM/C. We narrowed our focus to Toboali, South Bangka and Manggar, East Belitung. We found that almost all Muslim girls there have undergone FGM/C when they were infants. Most of our informants admitted that circumcision is generally considered as religiously mandatory for Muslim girls. And some have even started to realize the spuriousness of the promised health benefits. Most people in Toboali and Manggar are native to Bangka Belitung Islands, and they hold strongly to local traditions, which have been practice for generations.

In this study, we also identified a trend where people shift from shamans to health workers especially in South Bangka. But some

health workers start to practice symbolic FGM/C, where no actual mutilation or cutting is involved. Sadly, we did not observe such trend in East Belitung. Aside from the permissive laws, the strong influence of religious figures makes it impossible to expect the complete abolishment of FGM/C in the near future.

5.2.3. Banten Province

The western most province in Java is home to ten million people, and is comprised of 8 regencies/municipalities. Serang Municipality is the capital of the province. Most of the people are Sundanese and Muslims. Islam does have a strong influence in this province, so much so that Banten is also known as 'the province with 1,000 Islamic boarding school students' *(santri)* due to a great number of the schools *(madrasah/pesantren)* the province has. Our research in Banten was narrowed to Pandeglang and Lebak Regencies.

Demography

Pandeglang Regency spans as large as 2,747 km2, covering 29.98% of the total size of Banten, and is comprised of 35 districts (BPS Pandeglang, 2017). The regency houses 1,200,512 people, consisting of 613,108 men and 587,108 women. Almost half of the population work in agriculture.

Lebak Regency used to be a part of Banten Sultanate. Spanning 3,044.72 km2, the regency consists of 28 districts (BPS Lebak, 2017). It is home to 1,269,812 people, consisting of 650,912 men and 618,900 women. The majority of the population are Muslims.

Social and Cultural Profile

Pandeglang consists of 35 districts. Most of the people work in agriculture. The government provides 36 Community Health Centers *(Puskesmas)* and 58 Supporting Community Health Centers *(Puskesmas Pembantu)*. Schools are available until upper secondary *(SMA/SMK)*. The regency also has more than 1000 Islamic boarding schools. Most of the people are Muslims. 113,140 people or 9.50% of the population live below poverty line (BPS RI, 2015).

The population of Pandeglang is more homogenous than the population of Lebak. We focused our study in Pandeglang on two districts: Menes and Pulosari. Both districts are adjacent to each other. In fact, they used to be a single district until Pulosari decided to secede. Menes District has a huge Islamic boarding school. It is unsurprising that the people there try hard to preserve their traditions.

With 28 districts, Lebak Regency divide their regions into four development areas: Northern Lebak for trade and industry; Southern Lebak for agriculture, mining, and tourism; Eastern Lebak for small-scale and large-scale agriculture, and Western Lebak for agriculture and protected forest (BPS Lebak, 2017).

The prevalence rate of FGM/C is 90.7% in Pandeglang and 87.6% in Lebak (Kementerian Kesehatan, 2013). The high rates of FGM/C in both areas justified our choice to single them out for our research. In Pandeglang and Rangkasbitung, FGM/C is also known as *capitan* or *nyapitan*. Midwives in Rangkasbitung usually pretend to perform circumcision, whereas they simply perform 'vulva hygiene'. One of the midwives in Rangkasbitung once treated a female patient who bled severely due to circumcision. A shaman incised her clitoris excessively, causing the girl to bleed uncontrollably and eventually die. Despite such deadly incidents, FGM/C continues to be practiced due to religious reasons.

Age deemed appropriate for circumcision keeps decreasing throughout time. Circumcision used to be practiced on little girls aged 3 years old and was performed outside the parents' house i.e. near a well, on a space covered with cloths in odd number such as 1, 3 or 7 pieces of cloth. Now, it is common for a girl as young as 2–3 months old to be circumcised, it can be performed inside a house as recommended by religious leaders. The circumcision ritual is usually held concurrently with a 40-day post-natal ritual. The cost to perform circumcision varies from Rp 15,000 to 150,000.

The tragic death of an infant after being circumcised 10 years ago fails to deter the people of Rangkasbitung from continuing the tradition. They respond by simply preferring midwives or nurses over shamans. The tradition persists partly because there is a stigma attached to uncircumcised girls. They are called haram, Chinese, or considered as the kind people whose prayers will never be accepted by God.

5.2.4. Riau Province

Riau Province is located in the central eastern coast of Sumatra along the Strait of Malacca, and used to act as a transit hub and an entry point for foreign traders in the colonial era. Now, cargo ships from around the world still make a transit there. It is located very closely to Malaysia and Singapore. In fact, it only takes 2-4

hours to reach any of those countries. Not to mention, the province has abundance of oil and gas, most of which have been acquired by international fossil fuel companies. High economic activity in Riau attracts migrants to the province, and thus bringing about a multicultural environment. We focused our study on Dumai Municipality and Meranti Islands Regency, which are vibrant regions in Riau.

Demography

Dumai Municipality spans 1,727.38 km2, encompassing highlands, lowlands, and 51 rivers. The municipality is comprised of 7 districts. It houses 291,908 people, consisting of 149,791 men and 142,117 women. And the population keeps increasing at the rate of 2,08% (BPS Dumai, 2017). Meranti Islands Regency spans 3,714.19 km2, encompassing 9 districts. The regency is most composed of rural areas. It houses 182,152 people, consisting of 93,488 men and 56,192 women. In 2015, the unemployment rate in Meranti reached 9.37% (BPS Kepulauan Meranti, 2017).

The prevalence rate of FGM is 87.6% in Dumai Municipality and 83.5% in Meranti Islands Regency (Kementerian Kesehatan, 2013). The high occurrence rate of FGM/C in both regions compelled us to limit the research in Riau on both regions.

Social and Cultural Profile

Dumai Municipality consists of 7 districts: Bukit Kapur, Medan Kampai, Sungai Sembilan, West Dumai, South Dumai, Dumai Municipality, and East Dumai. The poverty rate in the municipality hit 4.74% in 2016 (BPS RI, 2015). Health facilities are adequate. There are 3 hospitals in the municipality. Access to education is equally good. Agriculture provides the biggest labor market for the municipality (BPS Dumai, 2017). Dumai Municipality is a port city that shares sea border with Malaysia. Oil refineries and mining sites also surround the area. It is therefore unsurprising that people who live there are heterogeneous. The majority of people are Muslims and of Malay ethnic group. It is noteworthy that FGM/C is still widely practiced there.

Meranti Islands Regency is a newly formed regency, which was born out of a secession from Bengkalis Regency. Meranti Islands Regency is classified as one of the foremost, most underdeveloped, and outermost (3T). It is indeed a poor regency. Data collection was conducted in Selat Panjang at Tebing Tinggi district which is the

center of the regency. Most of the people are Muslims. Accesses to hospitals and higher education are now available (BPS Kepulauan Meranti, 2017). The population mostly consists of Malay or Chinese-Indonesian ethnic groups. Islam and Buddhism lead as the two most dominant religions there. Interestingly, there is a tribe called Akit living in Sesap Village. Akit Tribe is thought to be native to the region. They are Buddhists and do not practice FGM/C. They live alongside Javanese migrants, who still cling strongly to their traditions, including FGM/C. When they want to circumcise their daughters, the Javanese migrants will reach out to Javanese shamans who have mastered Javanese traditions. Complete abolishment of FGM/C in the near future is therefore unlikely.

The people of Riau generally view FGM/C as a tradition to reduce libido and to avoid sin for failing to fulfill God's order. However, unlike in many other areas, no big celebration ensues the procedure. Our oral history revealed that some women felt pain during urination until two weeks after circumcision. They also admitted to experiencing difficulty during sex because their clitorises were mutilated. Our informant was a midwife who made personal observation on her own circumcised genitalia and the genitals of her patients whom she helped during labor.

In Riau, mistakes in performing FGM/C have happened before. Instead of mutilating the tip of the clitoris, the midwives mutilated the labia minora. Such mistakes are very possible if the midwives are uninformed, misguided, or poorly trained.

The fate of FGM/C in Riau depends on the circulating information in the region. People consistently doubt whether avoiding FGM/C is sinful. Being uninformed themselves, health workers worsen the situation by failing to provide the public with clear, consistent information. They end up relying on unreliable sources, such as Mama Dedeh, a female preacher *(ulema)* who once endorsed FGM/C on television.

5.2.5. South Kalimantan Province

South Kalimantan is located in Borneo Island, and is well-known for its efforts to bring its river civilization to life. Our research was focused on Barito Kuala and Banjar Regencies.

Demography

Barito Kuala is a lowland that lies 0.2–3 km above sea level where

a large number of rivers flow through. The regency covers a total area of 2,996.96 km2 or 7.99% of the entire South Kalimantan, encompassing 17 districts. It is home to 302,304 people, consisting of 151,689 men and 150,606 women. Most of the people work in the agricultural sector (BPS Barito Kuala, 2017). Banjar Regency consists of 19 districts with a total area of 4,668.50 km2. As many as 554,445 people reside there, consisting of 281,714 men and 272,729 women. (BPS Banjar, 2016). The prevalence of FGM/C is 95.7% in Barito Kuala and 84.6% in Banjar (Kementerian Kesehatan, 2013). The high occurrence rate of FGM/C justifies the choice to single out both regencies in our research.

Social and Cultural Profile

Barito Kuala consists of 17 districts. Most of the people are employed in the agricultural sector. And the rest relies on manufacturing or services. For healthcare, the government provides Community Health Centers *(Puskesmas*) and Supporting Community Health Centers *(Puskesmas Pembantu)*. Education is available until the upper-secondary. Most of the people are Muslims. The rest are Hindus, Protestants, and Catholics. The poverty rate reaches 5.22% (BPS RI, 2015). The parliament is dominated by Golongan Karya Party (BPS Barito Kuala, 2017).

Banjar Regency is a part of what will be Banjar Bakula Metropolitan Region. But Banjar's culture differs slightly due to its strong Islamic influence, so much so that the capital city of the regency, Martapura, is also called the Mecca's Porch (BPS Banjar, 2016). An overwhelming majority of people there unsurprisingly are Muslims. The rest are Hindus, Protestants, Catholics, Buddhists, and others. FGM/C in South Kalimantan is more of a cultural tradition than a religious one.

5.2.6. West Java Province

West Java has the vision of becoming developed and prosperous for all. In this province, we focused our research on two regions, Bogor Municipality and Bogor Regency.

Demography

Bogor Municipality is located in West Java, specifically 29 km to the South of the Capital City of Jakarta and shares borders with Bogor Regency. Its motto is "Strong Believer" *('Tegar Beriman')*. It is also well-known as the City of Rain due to its high rainfall. Bogor Mu-

nicipality sits on an area as large as 118.50 km2 with a total population of 1,013,019 people, consisting of 514,797 men and 492,222 women (BPS Kota Bogor, 2017). Demographically, the municipality is home to various ethnic groups, including the Sundanese, Javanese, Bataknese, and Chinese-Indonesians. As many as 932,703 people are Muslims, 40,357 Protestants, 24,374 Catholics, 5,250 Buddhists, and 10,335 Hindus, and the rest are undocumented (Kementerian Agama Jabar, 2014). Most of the people speak Indonesian and/or Sundanesse.

Bogor Regency consists of 40 districts, spanning 2,663.51 km2. It is located strategically near to the Capital City of Indonesia, Jakarta. Bogor Regencies houses 5,715,009 people, consisting of 2,920,288 men and 2,794,721 women. The latest measurement estimated that the population grows at the rate of 4,68% (BPS Kota Bogor, 2017). The prevalence rates of FGM/C are 92.8% in Bogor Municipality and 93.6% in Bogor Regencies (Kementerian Kesehatan, 2013). We therefore narrowed our research to both regencies.

Social and Cultural Profile

Bogor Municipality consists of 6 districts and 68 sub-districts, including West Bogor, South Bogor, Central Bogor, East Bogor, North Bogor and Tanah Sareal (BPS Kota Bogor, 2017). The municipality provides 15 hospitals, 24 Community Health Centers *(Puskesmas*), and 29 Supporting Integrated Community Health Centers *(Puskesmas Pembantu)*. From 20,663 deliveries, 19,007 were delivered by health workers and the rest (1,656) were delivered by non-professional health workers (Dinas Kesehatan Kota Bogor, 2013). Economically, the regency relies on trading, restaurants, and accommodating services (BPS Kabupaten Bogor, 2017).

Female circumcisions are carried out by health workers and non-professionals, even though not everyone practices this tradition. For those who do, FGM/C is viewed as a ritual that is mandatory for Muslims. Unlike in many other regions, there is no celebration that ensues the procedure..

Shamans—usually called *'paraji'* or *'mak'*—usually use a coin, a thumb of turmeric, and a small knife to perform FGM/C. The procedure tends to be accompanied by prayers *(Basmallah and Al Fatihah)*. And it is usually performed on infants aged 40 days old, so that families can celebrate it together with other rituals, such as *marhabah* and *akikah*. Shamans are no longer easy to find in Bogor.

Most of them have turned so old that they cannot perform circumcision anymore. At the same time, the younger shamans no longer provide help for delivery or female circumcision. They simply handle other post-natal rituals and baby maintenance. Some of them live below the poverty line.

FGM/C is usually performed in non-government clinics owned by nurses because most Integrated Community Health Centers (Puskesmas) have refused to do the service. Medical evidences against FGM/C tend to be denied by those who support the practice due to religious reasons. Although most people would agree that female circumcision is not considered mandatory in Islam, they still think it is 'religiously recommended' as it can keep the body clean from *najis* (uncleanliness or impurity), which can render any acts of praying invalid. Nurses cannot therefore show an outright opposition to the tradition. Because people are so clever in identifying which nurses are willing to perform FGM/C and those who are not. If a request for circumcision is rejected by a nurse, the person can simply visit another nurse.

One of our findings revealed that a severe bleeding once occurred to an infant after being circumcised in Cibinong a few years ago. The girl was then immediately brought to a nurse. Having limited resources, the nurse referred the family to a hospital for a better care. Another nurse also reported a similar story when she performed circumcision on another infant. The incident made her realizes that FGM/C is actually harmful.

5.2.7. West Sulawesi Province

West Sulawesi Province is one of the newly-established provinces in Indonesia. It was founded in October 5, 2004 after seceding from South Sulawesi Province. In this region, we focused our research on two provinces, Polewali Mandar and Majene.

Demography

West Sulawesi covers an area as large as 16,796.19 km2 with Mamuju as its capital. Most of the people in the province is of Mandar ethnic group. The province houses 1,158,336 people, most of whom are Muslims (BPS RI, 2010). It is comprised of 6 regencies: Majene, Mamasa, Mamuju, Central Mamuju, North Mamuju, and Polewali Mandar. The most densely populated regency in West Sulawesi is Polewali Mandar. During the colonial era, Mamuju and Polewali Mandar used to en- compass 7 kingdoms called Pitu Baq-

bana Binanga (7 Kingdoms in the Estuary). The descendants of the royal families now become respectable figures, whose responsibilities constitute preserving local culture, including female circumcision. The prevalence rate of FGM/C is 92.5% in Majene regency and 90.7% in Polewali Mandar regency (Kementerian Kesehatan, 2013). The high occurrence of FGM/C in both regencies allowed us to focus on them.

Social and Cultural Profile

FGM/C has been practiced for generations in West Sulawesi. It is considered a true marker of Muslimhood, which is why only Muslims practice it. It is believed that the sooner a girl is circumcised, the more foremost the girl will be when queueing up—as a Muslim—in the afterlife. Shaman in West Sulawesi is called *Sando*. FGM/C is usually performed after hair-cutting *(akikah)* ritual and before swinging *(mengayun)* ritual. The people believe that FGM/C and the swinging ritual can control the girl's sexual life. The circumcision is usually performed behind a piece of female praying cloth so that only *Sando* can see what is happening. The *Sando* usually uses a knife and a swab.

The *Sando* will put the knife on top of the girl's genitalia. If it bleeds, the blood is considered 'Islamic blood'. The blood will then be wiped clean with a swab or a piece of fabric, which will later be placed under the pillar of the house. The genitalia will then be washed with floral water. Another method is to scrape the clitoris with knife. Some *Sando* also use a kind of incense called *mapaci*. The *Sando* will also chant some prayers, and then smear the foreheads of the parents with saliva and powder. The praying clothes and knives are provided by the family. The tradition still takes place until today.

5.2.8. East Kalimantan Province

Demography

East Kalimantan is located in the Easternmost part of Borneo Island. This province borders North Kalimantan in the North, Sulawesi Sea and Makassar Strait in the East, South Kalimantan in the south, and Central Kalimantan and Malaysia in the West. This province is the third largest province in Indonesia after Papua and Central Kalimantan. It is comprised of 7 regencies, 3 cities, 103 districts, and 1,032 villages (BPS Kalimantan Timur, 2016).

East Kalimantan is one of the gates to Indonesia in the East. The province is well-known for its timber products and mining. There are also hundreds of rivers in the province, allowing water transportation to flourish. The longest river there is Mahakam River.

The population of East Kalimantan grows every year. In 2015, BPS recorded 3,426,638 people residing there. From 2013 to 2015, the population grew by 2.3% (.ibid). Despite the growth, the population tend to be distributed unequally across the region. Samarinda Municipality, the capital of East Kalimantan, is the most densely populated, accounting for 23.71% of the entire population of East Kalimantan. FGM/C has been practiced for generations. The tradition remained popular up until now with prevalence rate reaching 80.5% (Kementerian Kesehatan, 2013).

Social and Cultural Profile

We picked Samarinda Municipality as one of our foci due to the presence of a regulation on retribution fee for FGM/C. Samarinda Municipality is a relatively developed region. Most of the people there are of Banjar tribe, Bugis ethnicity, and Javanese ethnicity. One of our key findings revealed that the people of Samarinda strongly believe that FGM/C is a mandatory religious tradition.

This practice is usually conducted either by a health worker or a shaman. Some shamans recommend circumcision to be performed after a baby's navel is off or together with hair-cutting ritual *(akikah).* But, most shamans would recommend to perform FGM/C after the baby has turned 1 year old, when the white part of the clitoris has become more prominent. The ritual is usually arranged in this order: bathing, *syahadat* prayer recital, circumcision. The swab which is used to cleanse the clitoris will then be placed under the pillar of the house. One of the prerequisites for the ritual include offerings, such as rice, red and white porridge, and a rooster. Unfortunately, the shamans did not detail how the circumcision is performed. In this area, there is a superstition that uncircumcised women will experience difficulty during labor. According to the shamans, most circumcisions are now carried out by midwives.

The midwives we interviewed admitted that FGM/C is considered a cultural tradition, especially for people of Bugis Tribe, that they need to accommodate. But they also accept requests for circumcision on girls of Javanese descent. Note that Kalimantan people, including the Dayak Tribe, do not practice FGM/C. Aside from ac-

commodating the supposed need of the immigrants, the mid-wives choose to perform FGM/C because they know that circumcisions carried out by shamans tend to be excessive and therefore cause bleeding. The midwives have been trying to talk the shamans through, so that they can take over the procedure. A circumcision ritual led by a midwife will include *syahadat* recitation without involving any kind of wounding, excision or mutilation. The midwife will merely touch the clitoris with a tip of a knife, and then immediately apply antiseptic swab. Requests for circumcision have been declining since the past 3 years.

5.2.9. Jambi Province

Jambi Province was one of our research targets. We narrow our research on Jambi Municipality because the region has a bylaw that regulates FGM/C.

Demography

Jambi Municipality acts as the capital of Jambi Province, which is located in Sumatra. The municipality is crossed by the famous Batanghari River, and has a motto that reads *"Tanah Pilih Pesako Betuah",* which basically means that the municipality agglomerates administrative, social, economic, and cultural activities and is bound by cultural values and tribal laws, as well as the legislation. Jambi Municipality spans 206.35 km^2 with a total population of 576,967, consisting of 289,713 men and 285 women (BPS Jambi, 2017).

Demographically, Jambi Municipality houses a wide variety of ethnicities, including Malay, Javanese, Minangnese, Bataknese, Chinese-Indonesia, and others. There are 478,361 Muslims, 23,359 Protestants, 19,535 Catholics, 6,919 Buddhists, 18,391 Hindus, and 4,629 others. They primarily speak Indonesian and Malay. Jambi Municipality is the most densely populated region in Jambi Province. The prevalence of FGM/C in Jambi is 74.5% (Kementerian Kesehatan, 2013). Shamans used to monopolize FGM/C but most people rely on midwives nowadays.

Social and Cultural Profile

Jambi Municipality is composed of 8 districts and 62 sub-districts. The districts are Baru City, South Jambi, Jelutung, Pasar Jambi, Telanaipura, Danau Teluk, Pelayangan, and East Jambi (BPS Jambi, 2017). Jambi Municipality cannot be considered as an agricultural

region; Most of the people there work in the trade sector (35,60%) and services (27,68%) (BPS Jambi, 2016).

As many as 1,830 people are currently employed in the construction sector. In 2015, 2,936 out of 130,570 households were considered unprosperous. Jambi Municipality has 17 hospitals, 20 Community Health Centers *(Puskesmas)*, 39 Supporting Community Health Centers *(Puskesmas Pembantu)*, and 453 Integrated Health Centers *(Posyandu*) (BPS Jambi, 2017). Most of the people are Muslims and of Malay ethnic group. As a result, Malay culture and Islam influence the daily lives of the people quite strongly. Cultural institutions and social bonds remain well-preserved.

FGM/C in Jambi Municipality is carried out either by a health worker or a shaman. However, the number of shamans performing female circumcision continue to decline. The shamans usually equip themselves with a pocket knife or a razor blade to perform circumcision. The tradition is called 'sunat', and is perceived as religiously mandatory.

Health workers carry out FGM/C by referring to a guideline stipulated in The Regulation of the Minister of Health Year 2010. Health workers used to use curved scissor to perform circumcision, but now they prefer needle to incise the clitoral hood, from which a white part will be removed. This procedure was created to accommodate the religious and cultural demand for female circumcision. The people of Jambi Municipality believe that FGM/C will reduce female libido in the future. In other words, uncircumcised girls will turn out flirtatious and 'naughty'.

Although they kept emphasizing the procedure as a religious and cultural tradition, the mothers we interviewed found it hard to explain the grounds for FGM/C. In an interview, a community figure explained that FGM/C is more of a religious tradition, which was brought to Indonesia along with Islam. Unfortunately, topics related to female sexuality are considered taboo. So, no one openly discusses female circumcision. As a result, most people are uninformed. The Malays used to call FGM/C as *'ke aek'* or 'to the water/river'. After the baby has turned 5–7 days old, a shaman would carry her to a river to be circumcised without the parents' presence. Her parents would hear their daughter's scream from distance, which indicated that the process had ended. The shaman would usually use a knife called *'garpu'.*

Although some of community figures admitted that the holy book cannot be interpreted literally, they still believed that female circumcision as mandated by Islam should not be merely under- stood as vulva cleaning, but as the mutilation of a certain part of the genitalia. They also mentioned the term *'Adat Basandi Syara', Syara' Basandi Kitabullah'* (ABSSBK), as a motto they cling to. They believe that ABBSK is not a compromise between religion and local culture, but instead a fusion of them, which then gives birth to the Malay culture. The people of Jambi transmits cultural knowledge from one generation to another through 'seloko-seloko' Jambi, a set of local advice. Unfortunately, most of the people fail to grasp the fact that traditions are simply repetitions which are passed from one generation to the next.

5.2.10. West Nusa Tenggara Province

Demography

West Nusa Tenggara houses a total population of 4.5 million people (BPS NTB, 2017). Three big tribes coexist in this province: Bima, Sumbawa, and Sasak Tribes. Most of them are Muslims. The province bears a title of 'the Island of a Thousand Mosques'. Currently, it aims to be a world-class sharia tourism destination. Although the prevalence of female circumcision is low, one regency—West Lombok—taxes (or apply retribution fee) to female circumcision. This fact then qualified the region as one of our research targets.

Social and Cultural Profile

In West Lombok, we visited Gunung Sari, Gerung, and Sekotong Regencies. There, local culture and religion blends inextricably. Community figures primarily acts to preserve local traditions. And local traditions are tribally regulated through a set of rules called *'awik-awik'.* Every member of the community must obey *'awik-awik',* including the obligation to circumcise daughters, a ritual called *'suci'* which cleanses the body from impurity, allowing the person to pray and be heard by God. The people consider uncircumcised girls non-Muslims, instead they call them Hindus or Balinese.

Although *'suci'* is generally considered religiously mandatory, especially for Muslim Sasak, some villages in Sekotong District no more practice it. They have stopped practicing FGM/C because no religious figure, nurse, or shaman *('belian')* preserve it.

'Suci' may be carried out by a midwife or a *'belian'*. Usually, the nurse will simply clean the vulva and pinch the clitoris with a tweezer so that the baby will cry. In that way, no bleeding will occur. This is usually practiced once the baby turns 7 days old. *'Pedak Api'* ritual may follow the circumcision. The ritual will usually involve cleaning the clitoris with a wet, warm swab while chanting some prayers.

If a *belian* performs the circumcision, he/she will pinch the tip of the clitoris using the point of a knife and a hand. The *belian* will then clean the vulva with lukewarm water and swabs. Since most childbirths are now assisted by midwives, most people choose to rely on midwives for female circumcision as welll.

5.3. FGM/C in Indonesia

Our research reveals that FGM/C is still practiced throughout Indonesia, especially among Muslim communities. We found no significant difference between urban and rural communities.

5.3.1. FGM/C Practice in Urban and Rural Communities

Generally, urban societies are characterized by weak social control and its orientation to modernity, whereas the rural societies are thought to possess higher social control and hold to their values and traditions very strongly. The stark difference give rise to two assumptions: that FGM/C is more commonly found in rural communities and that urban communities will tend to rely on health workers for performing circumcision.

Our findings falsify the first hypothesis. During our research, finding uncircumcised women were equally hard in both types of community, proving how normative and prevalent circumcision is in all regions.

In regards to the second hypothesis, our findings could not fully support it. For example, Cindamanik, Lombok Regency, and Meranti Regency can be considered as rural areas. But, the former tends to rely on health workers, whereas the latter relies more on shamans. To complicate the issue further, in Gorontalo and West Sulawesi, everyone seems to trust shamans regardless of whether they live in rural or urban area. These regions present themselves as anomalies in need of further explanation.

5.3.2. FGM/C and Poverty

Some provinces are among the poorest provinces in Indonesia, but some others are relatively well-developed. Specifically, 3 out of 10 provinces we studied rank below the national poverty line: Gorontalo, West Nusa Tenggara, and West Sulawesi. This fact cautions anyone against interpreting FGM/C as exclusively the problem of poor regions, although poverty may still be a factor.

In regions where FGM/C is followed by a big celebration, the procedure is usually performed on older girls. This pattern makes sense because the family needs to firstly save up to afford an expensive celebration.

5.3.3. FGM/C as Local and Religious Traditions

Our research also reveals that provinces that practice FGM/C tend to be Muslim-dominated. The overwhelming majority of Indonesia's population are Muslims. The non-Muslims are always outnumbered in every single province. Religion is indeed a sensitive issue, and so is a tradition that is entrenched in the collective psyche. We found that most of our informants who are Muslims, fully accept the procedure as a tradition. Efforts to eliminate FGM/C must respect the local traditions to be easily accepted.

Obviously, FGM/C has a strong correlation with Islam. But one should not lose sight of the influence of local norms and customs in understanding the phenomenon. Because not all Muslims (and regions) practice FGM/C in Indonesia. What we need is a reinterpretation of the holy book as there are various interpretation toward many things.

Freedom of religion still stands, but it should be exercised with regards to humanity. Our informants kept emphasizing the importance of obeying religion and participating in culture. Unfortunately, they did not state anything remote to the notion of human right or bodily autonomy.

5.3.4. FGM/C and Medicalization

We also found that FGM/C starts to be performed more often by health workers, and less by shamans. Medicalization modernizes the tradition, including by using modern tools, such as swabs, alcohol, betadine (antiseptics) and by sterilizing every tool beforehand.

An exception to this is Sulawesi, where the people believe FGM/C must be performed only by *hulango* (local shaman).

5.3.4. FGM/C and Fertility

It is noteworthy that provinces with the lowest fertility rates in Indonesia, according to SUSENAS, do not necessarily suffer from high occurrence of FGM/C. But, provinces with the highest prevalence of FGM/C have infant mortality rates above the national average. Such provinces include Gorontalo, West Sulawesi, West Nusa Tenggara, and South Kalimantan.

Chapter

6 Intersection Between Tradition and Modernity

Variations in Knowledge, Attitude, and Practice in Female Genital Mutilation/ Cutting in 10 Provinces 17 Regencies/Municipalities

The previous chapter portrayed the social, economic, cultural, and political landscapes of 10 provinces, 17 regencies/municipalities, in Indonesia. Such characteristics are important to better understand the tradition of FGM/C.

This chapter deepens the analysis by exploring different the people's perception of and attitudes towards FGM/C across regions and throughout time. They are crucial for understanding whether and how FGM/C will be sustained or eliminated. We document the variety of FGM/C practiced in different regions and how and why shamans and midwives tend to perform circumcision differently. Celebrations that usually follow the circumcision will also be discussed.

6.1. Shaping and Transmitting Knowledge on FGM/C: "When We Know and Understand"

This subchapter traces the history of FGM/C, describes how the traditional understanding of the practice is kept alive until today, and lastly explores the possibility of eliminating it. How FGM/C migrated from one place to another will be included as well.

6.1.1. Different Names for FGM/C and Its Interpretations

Female Genital Mutilation/Cutting is generally known as *'sunat perempuan'*, which can be readily translated to English as female circumcision. However, we found that local languages refer to the practice differently. One shaman in Pandeglang Regency named it "… *'sepitan',* which means pinch, because it is done by pinching. So, we call it *'sepitan'. 'Nyepitan*' is the politer variant in Sundanese." (SU, April 2017, Pandeglang, Banten)

In Gorontalo, FGM/C is called *'mencubit'* or *'cubit kodok',* which literally mean 'pinching' and 'pinching female genitalia' respectively, according to a shaman during an interview in Bone Bolango Regency. *'Kodok'* in the Gorontalo language *(Hulontalo)* means 'female genitalia' – not 'toad' as in Indonesian. The term *'cubit kodok*' is frequently used by shamans or community figures.

Some other terms, such as *'basunat', 'besunat'* and *'mansunna'*, point more straightforwardly to circumcision. Semantically, they strongly emphasize that 'circumcision' is what is required as opposed to mere 'pinching'.

'Sunat' is the general term used among Muslim Indonesians to refer to the religious ritual of (male and female) circumcision, which is intended to cleanse oneself from *najis* or impurity. In Lombok, FGM/C is called *'suci'* – which means 'pure' – to blatantly emphasize what the ritual is all about, purification.

The abundance of synonyms for FGM/C may reflect differences in what the procedure means to different people. The differences lie in ways in which the circumcision is performed and their underlying motivations. We then intuitively asked; where and how did each unique understanding about FGM/C come about in the first place? And how are they sustained? The next subchapter will specifically address those questions.

A VARIETY OF NAMES FOR FGMC/C

In every region we studied, FGM/C takes on different names, which convey slightly different meanings. For example, in Banten Province, FGM/C is known as 'sunat perempuan' (female circumcision), but the refined Sundanese addresses it as 'nyepitan' or 'capitan [pinching] … Because FGM/C is like pinching … In West Lombok, West Nusa Tenggara Province, it is known as 'suci' *[pure] because it is considered as a ritual to cleanse a girl from impurity. In Gorontalo, it is addressed as 'lemon bathing', 'pinching', or 'pinching female genitalia', which are referred to as* 'liho lolimo' *or* 'molu bingo' *n the Gorontalo language. In West Sulawesi, it is known as* 'mansunna'. *In West Dumai, South Kalimantan, it is called as* 'basunat' *or* 'besunat'. *In other regiions, including West Java, Jambi, Riau, Bangka Belitung and East Kalimantan, FGM/C is simply called* 'sunat perempuan' *or* 'khitan perempuan'.

A field note based on a compilation of interviews with mothers, shamans, midwives, teachers, community figures, religious figures, and tribe leaders in 10 provinces, 17 regencies/municipalities, April–May 2017.

6.1.2. The Origin of FGM/C: "How It Has Always Been"

Every member of the communities we studied had heard of FGM/C. The tradition was initially intended for males. But, the belief that circumcision can remove impurity then led the people into thinking that the practice is also necessary for females.

FGM/C in every province we studied has been around for generations with no clear source of origin. "…. Because it has been practiced for generations, no one really asks questions anymore," (RL, 59 years old, Bogor Regency). There seems to be a tendency to accept the tradition uncritically, with no questions on its origin and necessity being raised. "It has always been like this or it has always been a tradition of the people here," (RM, May 6, 2017, Majene) said a mother when asked about the history of FGM/C in Majene. In fact, we found similar answers everywhere in 17 regencies/municipalities. FGM/C had existed when they were born. It has survived through generations. According to Keller and Keller (1996) as discussed in sub-chapter 3.2, knowledge and action always interact. And such answers can be considered actions that are derived from and constitute knowledge. FGM/C has been entrenched in society, far more so than the knowledge on its dangers.

A teacher said, "The origin of circumcision stretches back to the age of sail. But, there is little clarity in the hadith and Koran on what [it means], but it is recommended as a part of the Abrahamic religions, but [I] do not understand the hadith," (MD, teacher, April 15 2017, Barito Kuala).

> *"According to a folktale, FGM/C appeared when an Islamic king* (sultan) *appeared. Men and women were circumcised to be Islamicized. Before that, no one was ever circumcised. The king used to circumcise [the penis] entirelyl, causing many people to die. The king was cornered because of that. Because he improperly circumcised many men by also removing their testicles. But, the king is of equal status with 'holy man'* (wali)*. So, when he was cornered, with his supernatural abilities, he hid by jumping into a hole that was then kept close with a palm fruit, which now becomes a site of pilgrimage. According to the tale, the sultan died inside during the dutch colonial era. The pilgrimage site is located in Batang, Jakarta. But, another tale says that the sultan did not die there. He came out with his supernatural ablities after the people who cornered him believed that he had died."*
>
> (Interview with SU, April 2017, Pandeglang Regency, Banten Province).

We encountered the story in an interview with a shaman in Pandeglang Regency. With no archieving and documentation of such stories, we were compelled to rely on folktales that are preserved orally. However, if we had not asked the shaman specifically, he would have not told us and his community the story. He basically claimed that FGM/C in Indonesia originated in Banten Province from king's era. The story told us that FGM/C had already been popular at the time. But the king eventually died after being confronted by many people for his maltreatments.

Sadly, instead of being eliminated, the tradition was 'perfected' so that it could be continued to be practiced and extended to include female circumcision. The teacher in Barito Kuala and the shaman in Pandeglang agreed that FGM/C is religiously exalted and mandated. And changing how FGM/C is performed help preserve and spread the practice, especially in the provinces where we conducted our study.

6.1.3. Tradition, Religion, Belief and Faith: "Why Does FGM/C Exist and Is Preserved or Eliminated?"

As we have discussed before, FGM/C is inherited intergenerationally. Based on the accounts of our interviewees, there are 3 reasons why FGM/C lasts until now: (1) tradition and religious recommendation; (2) religion; and (3) supportive local beliefs. Generally, the fact that FGM/C has been performed for generations appeared as the most prominent reason why the procedure survives until today. Though, some regions are exceptional. For example, in Jambi, women's morality and sexuality was expressed more often than other religious or traditional justifications. In contrast, West Lombok holds strongly onto religious grounds to practice FGM/C.

But, the variety of reasons to support FGM/C triggered confusion and doubt for many women who have undergone FGM/C in the past during interviews. They themselves did not seem to be able to articulate which reason applies to them the strongest. FGM/C has been widely practiced for so long that the motivation behind the tradition blurs. In other words, it seems that everyone simply follows everyone else. Because the failure to do so may result in a social condemnation from their immediate environment.

6.1.3.1. Becoming a Tradition and a Religious Recommendation: "Continuing the Existing Habit"

> *"I think it's habitual or simply a tradition because it has been practiced for generations … A woman has to be circumcised, but also because it's a habit and a tradition that I myself have carried out for my grandchildren in the past few months. So, I feel this is an obligation, an obligation as a Muslim. If [women] have to be circumcised, then [they] have to be circumcised." (J, 59 years old, Jambi)*

It tells us that the nature of FGM/C in Indonesia is both traditional and religious. Ibu J's account was also confirmed by a teacher in Barito Kuala and a midwife in Polewali Mandar. "There are three reasons why people perform circumcision. The first one is tradition. Second, it's encouraged by religion. And third, health-wise, the elders said that female genitals contain impurities, which will be easy to get rid of after being circumcised (MD, teacher, April 15 2017, Barito Kuala)." Another interviewee added, "Circumcision is a religious obligation, but I don't remember the source. Probably,

it has become a tradition. But it's true that Islam mandates it (JS, a midwife, May 3 2017, Polewali Mandar)."

Because it's culturally and religiously mandatory, FGM/C continues to be performed without regard to whether the benefits are true and its potential negative effects on women. In some regions, including Gorontalo, FGM/C is very ingrained in the local culture. The tribe leader warned that women who are uncircumcised will be sanctioned socially. He further explained that "religion must be prioritized, country must be glorified, self must be devoted, wealth must be donated, and life must be the stake (tribe leader, May 2017, Gorontalo)." The tribal laws in Gorontalo are based in the Malay culture, which refers to the Koran *(sharia)*.

In Lombok, FGM/C is a part of *'awig-awig',* a body of tribal laws in West Nusa Tenggara. During an interview, one of the tribe leaders said that parents whose daughters are uncircumcised will be punished according to the tribal laws. Although some pro-women laws are in place, Lombok still culturally obliges women to undergo FGM/C due to limited exposure to relevant information and strong religious influence (community figure, May 2017, West Lombok).

Most community figures whom we interviewed view FGM/C as a habit/tradition. Without any reminders or direct orders, members of the communities willingly circumcise their daughters. All midwives confirmed that finding during the interviews. Some believe that hadith and the Koran consider FGM/C as *'sunnah*' or encouraged—not compulsory. Despite its *'sunnah'* status, FGM/C is still widely practiced because the procedure has become an integral part of the local culture, according to a community figure in Lebak Regency. We concluded that the community figures in Indonesia tend to be accommodating in—or complicit to—the ritual of FGM/C. They will never endorse FGM/C to parents or order anyone to circumcise their daughters, but they will gladly jump in whenever a family needs help to hold the ritual. Their attitude is slightly different than those of religious figures and tribe leaders, who hold stronger political influence within the communities we studied (A community figure, April 2017, Lebak Regency).

6.1.3.2. Religion and FGM/C: "Valid as a Muslim and as a Noble Woman"

"[A WOMAN IS] NOT A TRUE MUSLIM IF [SHE IS] UNCIRCUMCISED."

"If a muslim is uncircumcised, it's not a problem. But, if they are circumcised, it's better" … [Someone] is not a muslim if uncircumcised …" Circumcision is a process of Islamisation. Female circumcision must be preserved [because] it's the characteristic of a muslim woman. She's a muslim after declaring shahada *…" …*'Basunat' *is tribal and religious traditions for muslims. It's mandatory because it has been practiced for generations …" …*'Basunat' *is good because it's mandated by religion …" … I disagree with the decision to disdain people who cannot afford circumcision because it's a sin. [But] I support female circumcision. Because a muslim woman has to be circumcised, depending on their own tradition though. But for Mandar Tribe, circumcision is practiced on infants. I do not know about other tribes. But [to us] circumcision marks Islamhood.*

Interviews with RS, shaman, April 14 2017, Banjar; AL, shaman, April 15 2017, Barito Kuala; MY, shaman, May 7 2017, Majene; GM, mother, April 15 2017, Barito Kuala; RM, a mother, May 6 2017, Majene.

The second most cited reason in support of FGM/C is religion. Our interviews revealed that FGM/C is considered a marker of islamhood. Statements similar to the ones cited above could be found in every region we studied. It seems like the belief that a 'true' Muslim woman must undergo FGM/C is held almost universally in Indonesia.

Some interviewees did express a belief that FGM/C is *'sunnah'* or encouraged. But, some others still thought that it's obligatory. We think that the interplay between religion and local custom creates the impression that FGM/C is obligatory to many people even though they themselves are not sure of which hadith or verse in the Koran that states so. A mother in West Sulawesi said, "Female circumcision places girls in the front of the Islamic line in the afterlife. Bleeding that is caused by circumcision is an Islamic blood ..." (Mother, May 2017, West Sulawesi) In short, being a Muslim and having beliefs related to the afterlife may strongly motivate someone to perform FGM/C.

Another religious ground to support FGM/C is the removal of impurity, which is required to validate a Muslim's religious activities, including the five-time daily prayers *(shalat)* and Koran recitation. There is this belief that the ablution *(wudu)* water (performed prior to *shalat*) will improperly purify the body if the person is uncircumcised. This belief then leads to making circumcision mandatory for boys and girls. During our research in Lebak, an interviewee said that "being uncircumcised makes a person an imperfect Muslim or even a non-muslim altogether like a Christian or Chinese (Shaman, April 2017, Lebak Regency).)."

"It is practiced, but no one knows the verse and the hadith"

Below are some quotes from various interviews with mothers, midwives, teachers, and one of the staff in the Public Health Offices on why FGM/C remains to practiced. Some of the intervieewes stated that Islam acts the main motivation. But, none of them could refer to the Koranic verse or hadith that commands the circumcison.

" ... [Female circumcision] does indeed exist in religion, which is why it's practiced. We simply need to refer to the existing rule. If it's allowed in the Koran, then it has to be practiced. But, the procedure must be detailed in such a way that does not harm women because the majority of people in Banjar Regency are muslims. But, [I] do not know which verse [orders female circumcision]. Probably, an ulema can tell you. If we refer to a hadith, then we will have to check whether the hadith is valid (sahih)*." (DW, a midwife and a staff in the KIA dan Gizi Dinkes, April 17 2017, Banjar)*

" ... [I] don't know the exact religious ground. There may be a hadith, but it's not like what is practiced here.The recommendation (Sunnah) *of the Prophet Muhammad does not include wounding, only cleaning .... " (NM, a midwife, May 7 2017, Majene).*

" ... It's not clear religion-wise, which hadith or Koranic verse [that orders female circumcision], but it's recommended as a part of the teaching of the Abraham. Bu, I do not know the hadith. (MD, teacher, April 15, 2017, Barito Kuala).

" ... Women must be circumcised. However, the Koran does not mandate circumcision, only cleaning ..." (EW, Mother, April 17 2017, Banjar).

Similarly, an informant in Lombok said, " ... [she is] a Balinese if [she is] uncircumcised (A father, April 2017, West Lombok Regency). Most Balinese in West Lombok identify as Hindus, and are not obliged to perform circumcision. In contrast, the Sasak people identify as Muslims and therefore practice FGM/C, applied to both the men and women. FGM/C may indicate a person's belonging to a particular community, including a faith group, and will thus alienate those who avoid circumcision. It may also provide a sense of relief for parents by making them think their [circumcised] children are devout Muslims. Female circumcision also tends to be compared to male circumcision, which has gained (almost) indisputable reputation of being mandatory in Islam. Some people think, because male circumcision yields health benefits, so will FGM/C.

An religious leader (ulema) *in Lebak explained that FGM/C is regulated in Fathul Muin Fiqh Islamic Book, specifically page 32. During an interview, he initially admitted that he lacked knowledge about the grounds for FGM/C. He tried to help us by referring to Fathul Muin Fiqh Islamic Book that he owned.*

Together, we read through the book, and found a part that reads, "There is a ground to support that circumcision is compulsory for men and encouraged for women... What is mutilated is a small part of what is called 'farji' *[vagina], above the hole where the pee comes out [urethra], that looks like a rooster's wattle.*

Interestingly, FGM/C and male circumcision are discussed in a chapter on 'qisas', *which means Islamic retributive punishment. In the case of murder, for example, qisas principle grants the family of the victim the right to demand death penalty for the murderer, as stipulated in the Koran, sura Al-Maida, verse 45. We asked the* ulema *why circumcision was included in the chapter and whether it serves as a form of punishment. The* ulema *could not explain anything further due to the lack of additional informations.*

Interview with AA, religious figures, April 2017, Lebak Regency.

Many religious figures we interviewed found it is hard to explicate the religious grounds for obliging FGM/C and how it should or should not be carried out. Their answers came off as shallow because they lacked thorough theological analysis and references. FGM/C has been taken for granted for

a long time, (mis)leading many people into thinking that the tradition warrants no reflection or critique. Not to mention, most of the religious figures we interviewed were also men, who understandably knew little about female circumcision.Based on a number of interviews with religious figures in 17 regencies/municipalities, we identified several religious grounds for justifying FGM/C:

The Koran, surah An-Nahl, verse 123: *"Then We revealed to you, [O Muhammad], to follow the religion of Abraham, inclining toward truth; and he was not of those who associate with Allah."*

The Abrahamic teaching includes the unity of God and mandatory circumcision. According to Islam, God ordered Abraham to perform circumcision at the age of 80 years old. Because Abraham was a man, many strictly interpret circumcision as an obligation for men. But, some others believe that the tradition also applies to women, disregarding the fact that males and females differ anatomically. It is believed that, in the case of males, the retractable roll of skin at the end of penis (foreskin) may inhibit proper ritual purification, making the person 'ceremonially unclean'.

Male circumcision also has several benefits. Circumcision in males is known to be able to help prevent many diseases. It also has the potential of making sex more enjoyable by increasing penile sensitivity. Contrastingly, females do not have such foreskin, allowing them to properly clean themselves after urinating and avoid diseases. Wounding or mutilating the clitoris can harm the reproductive health and impair their ability to experience sexual pleasure. The diversity in understanding FGM/C is summed up in the table above.

An Islamic preacher *(ulema)* in Pandeglang were aware of the fact that different school of thoughts view female circumcision differently. According to the Hanafi school, female circumcision is recommended *(sunnah)*. But for the Syafi'i school, it is compulsory. In Indonesia, most Muslims follow the Syafi'i school, and therefore find circumcision obligatory. This view is corroborated by various Islamic writings, including the one by Syeh Muhyidin an Nawawi, a haromain *ulema*, where circumcision is considered compulsory and prudent (a religious figure, April 2017, Kabupaten Pandeglang).

A religious figure in Bone Bolango Regency once explained to us, *"... If two* 'khitanan' *[circumcised humans] meet, they are obliged to take full-body ritual purification* ['mandi wajib']. *Both of them must take* 'mandi wajib'*. That means, women have to be circumcised as*

well just like the men …" (a religious figure, May 2017, Bone Bolango Regency). One of our informants in Jambi added that the Prophet Muhammad obliged circumcision for men and honored the women who are circumcised (SH, a religious figure, May 2017, Jambi Municipality).

Some other informants also thought that women have 9 kinds of [sexual] desire, while men only have 1. So, if a woman is uncircumcised, according to them, her desires are not 'cutt off' (controlled), and they can eventually harm her. A mother who is also a religion teacher in Pandeglang told us that the hadith can be found in *Uqud-ulujain* Islamic Book (April 2017, Pandeglang Regency).

Another informant once referred to the Sahih Bukhari and Muslim number 1889 and 257, which detail that there are 5 fire (natural dispositions) in Islam: circumcision, trimming the pubic hair, plucking the underarm hair, and shaving the beard. Some believe that those rules apply to women as well.

6.1.3.3. Belief, Faith, and FGM/C: "When Sexuality and Morality Become the Rationale"

The third kind of support for FGM/C is local beliefs related to female sexuality. FGM/C is thought to help women sexually and morally. FGM/C, to many, may improve the honorableness of a woman. The reasons are laid below.

1) "Easy to guide so that [they] will not turn naughty"

" … If a woman is uncircumcised, it's said that her desire will be higher. Clitoris acts as the source of sexual desire. So, if it's uncut, [the girl] will be a hypersexual. If it's cut too much, [the girl] will be frigid."

" … Female circumcision is good because there is 'najis' *[impurity] in female genitalia. If it's removed, the girl will be easier to be guided and educated. That is probably the belief. There is a belief that if a girl is uncircumcised, [she] will turn wild."*

" … If [a girl] is uncircumcised, her sexual desire will become high [because] that is where the female desire is located."

" … The fact is [some women] are still passionate even though they have been circumcised.

" … The midwives say that if a girl is uncircumcised, [she] will be promiscuous with boys, unruly, and coquettish."

" ... The ancestral belief says that circumcision is performed to prevent women from channeling their [sexual] desires recklessly."

(Interview with J, 59 years old, Jambi, DW, a midwife working at Banjar Health Office, Division of Mothers', Children's Health and Nutrition, [KIA dan Gizi Dinkes], April 17 2017, Banjar; NL, a teacher, April 13 2017, Banjar; RM, a mother, EW, a mother, April 17 2017, Banjar; FF, a midwife, April 15 2017, Barito Kuala; DP, a mother, April 15 2017, Barito Kuala; UW, a midwife, 7 May 2017, Majene; a mother May 6 2017, Majene)

Our interviews with mothers, midwives, the Regional Public Health Offices, and teachers revealed a uniform belief that FGM/C can contain [reducing] sexual desire and therefore prevent girls from turning promiscuous later in life. Many people also believe that FGM/C can make the vagina feels better when 'being used' for sex. Interestingly, in some other regions, FGM/C is believed to increase the women's own sexual satisfaction. In Jambi, sexuality-related reasons underlie most female circumcisions. Almost every mother we interviewed admitted to performing circumcision to prevent their daughters from being coquettish or flirtatious. One of the informants (NS, 44 years old) told us that her friend willingly went back all the way to Jambi to circumcise her daughter in hope that she would not be promiscuous later in life.

Our FGDs with the midwives from the Indonesia Midwives Association in 17 regencies/municipalities revealed various local notions about FGM/C: that midwives were also circumcised when they were little because their parents believed that it could help them not to turn promiscuous (Bogor, Pandeglang, Lebak, Jambi, Banten), that female circumcision helps prevent a woman from being naughty (Gorontalo), to help ease childbirth (Banjar South Kalimantan, Batola South Kalimantan), to reveal female aura (Banten), to reduce sexual desires (Bogor, Pandeglang, Lebal Meranti, Dumai, Polman, Jambi, Bone Bolango), and to validate Islam-hood, (Polewali Mandar, Meranti, Samarinda, Pandeglang). Female circumcision is considered a religiously sacred, intergenerational practice. But, for mothers, religious figures, and teachers, circumcision acts to counter excessive sexual desires. They believed there is a hadith stating that women have 9 desires while men only have 1. So, they think, if a woman is uncircumcised, she will turn wild (FGD 17 regencies/municipalities, April-May 2017).

2) FGM/C Removing Impurity from Female Genitalia

" ... The reason why people circumcise [girls] is, health-wise, the elders said that female genitals contain impurities, which will be easy to get rid of after being circumcised." (MD, a teacher, April 15 2017, Barito Kuala).

" ... (Female circumcision) maintains hygiene, similar to the case of male circumcision. [It] prevents the clitoris from growing long and becoming unsightly." (ER, a mother, April 14 2017, Bogor Regency).

FGM/C is considered important to remove impurities or 'najis'. FGM/C is then made equivalent to male circumcision, which is done to maintain hygiene after urinating. But, male genitals differ from those of females. Another motivation to consider is the belief that the clitoris will grow long and will therefore appear like a penis. In consequence, people find that penis and clitoris require the same treatment, circumcision.

3) "Easy to be educated, easy to conceive, ease in giving birth, and generally lucky in life"

FGM/C is also believed to be good for women for many reasons: making them easy to be educated and to conceive and providing ease during labor. A shaman in Barito Kuala said, *"According to my knowledge, a [female] Muslim must be circumcised so that [she] will give birth easily."* (AL, April 15 2017). Another shaman in Banjar Regency said, "*Her child will not be born in one night [because] it will get stuck."* (RS, a shaman, April 14 2017, Banjar Regency).

Many of our informants held similar views. A mother said, "*[Circumcision is done] to ease delivery. That is what most people say. If a woman has a problem with delivery, she will be talked about. The reason to circumcise women is so that [they] have children. That is what the elders say. If a woman is uncircumcised, she will not have a child, probably*." (GM, a mother, April 15 2017, Barito Kuala; RM, a mother, May 6 2017, Majene). Apparently, FGM/C is believed to be beneficial for women in many ways.

But a midwife in Banjar Regency expressed a disbelief in the superstition. Despite having been circumcised in the past, she still had to deliver her three children through C-sections.

" ... Female circumcision is good, because it makes daughters compliant and eases their deliveries [in the future]. But, I don't really believe it. Because I had been circumcised myself, but I still needed to give birth to my 3 children through caesarean deliveries. I'm sure that is not true. Either being circumcised or uncircumcised, women will still be able to give birth. It has nothing to do with childbirth." (ON, a midwife, April 17 2017, Banjar).

Another interesting finding was that FGM/C tends to be viewed as an obligation that women need to fulfill. According to many, the obligation, if fulfilled, will result in rewards like blessings or luck in life or a lucky charm. In contrast, uncircumcised women will receive punishments, including being labelled promiscuous, wild, and many others. Unsurprisingly, our informants almost never said anything about the integrity of the body. Even the midwives insisted that there are medical benefits to FGM/C that have yet to be proven scientifically.

6.1.4. Family and the Local Community: "How Does FGM/C Thrive in Indonesia?"

Idea about female circumcision is mainly inherited through families. Some mothers, shamans, and midwives admitted to having heard of religious 'explanations' about FGM/C from local religious leaders, including during communal Koran study called *pengajian*. However, the sermons tend to lack citation of the Koran and the hadith, making them illegitimate. One of the most frequently-cited religious scholar is Mamah Dedeh, a famous, Indonesian TV preacher *(ulema)*. Mama Dedeh is especially influential because she is one of the very few female preachers in Indonesia and she appears every day on a national TV show. In several occasions on her show, she argued that female circumcision is 'highly recommended' because it can elevate a woman's virtuousness. For mothers, shamans, and midwives whom we interviewed, her sermons strengthen their faith in FGM/C.

> *"I have been told by my family that a woman has to be circumcised. But also because it is a habit and a tradition that I myself have carried out for my grandchildren in the past few months. So, I feel this is an obligation, an obligation as a Muslim. If [women] have to be circumcised, then [they] have to be circumcised."* (J, 59 years old, Jambi)

The statement confirms that family is indeed the frontline agent of socialization in the context of FGM/C. Notions about female circumcision continues to be transmitted from one generation to another, allowing the practice to stand the test of time. Opinions of religious figures act as a reference that further pushes parents to circumcise their daughters. The social pressure to circumcise daughters usually comes from the grandparents and the environment, especially from midwives, shamans, and neighbors. When everyone else seems to endorse and has performed female circumcision, one understandably cannot escape the pressure.

> *[Those who suggest us to perform female circumcision are usually] our own parents and parents-in-law. I personally disagree, but I do not want to be the subject of local grapevine. Parents are the ones who usually hold the celebration [following circumcision]. Eliminating it is impossible. If [you are] trying to eradicate it, do not oppose our work. Most of the midwives who were above 30 years old admitted to having been circumcised when they were little by shamans,* 'paraji', 'juru sunat', 'syarifah' *(local terms in West Sulawesi which refers to religious teacher). These midwives were usually raised in an environment with a strong tradition that says female circumcision is mandatory according to Imam Syafi'i [with other prominent fiqh jurors being Imam Hanafi, Imam Maliki, and Imam Hambali] (FF, a midwife, April 15 2017, Barito Kuala).*"

Our findings reveal the importance of familial influence in preserving FGM/C. Pressure to perform FGM/C usually comes from couples' parents, and hits the mothers the hardest. The extended family tends to also be generous in providing moral, emotional, physical and financial supports to ensure the circumcision takes place successfully.

Such supports include attending the celebration early on to help around, giving some money to cover for the expenses, accompanying the mother to the hospital, holding the baby during the process of circumcision, and many others. The father is usually responsible for inviting other fathers to attend the celebration and asking a local religious figure to come and bless his daughter. Although fathers do take part, their role is limited in comparison to mothers and female relatives. FGM/C is considered 'women's business', and the men are therefore encouraged to stay away..

Interestingly, some mothers admitted to dismissing their husbands and other relatives who endorsed circumcision. Apparently, when a mother refuses to circumcise her daughter, her husband and her relatives will respect her decision. In other words, she is under no pressure to do something she disapproves of.

Notions about female circumcision are usually inherited from mothers to daughters, including to the in-laws. During delivery, the role of a shaman is simply making a gentle reminder that the baby girl needs to be circumcised immediately. The neighbors, especially other mothers, usually take up the same role. The importance of female circumcision is emphasized by the mother's immediate environment right before or after she gave birth to a baby girl. Apparently, women remind each other on the significance of FGM/C as a cultural tradition.

But, the final say on whether the baby will be circumcised lies on the mother, so is deciding who will carry out the circumcision. The opinions of the grandmothers of the child rank second as the most important. The extended family and the mother's immediate environment may also partake in influencing her to get her daughter circumcised sometimes.

FGM/C prevails in areas that we researched, so much so that it indicates piety of the family performing it. And the community is willing to help in any way they can to make it happen. The grandmother of the child, for example, may provide company or even money to help the parents afford the celebration financially. The communality of this tradition is key to its resilience.

6.1.5. Migration of FGM/C: Interregional, Interfaitfh, and Interethnic

We also investigated how FGM/C spread throughout Indonesia. We firstly traced where it originated, and then analyzed how it was exported from one culture to another. We identified two kinds of migration, geographic and 'religious' migrations.

Geographic migration concerns with the act of bringing the tradition of female circumcision to a new place where it was never practiced before. An example for this would be the case of the Javanese people in Meranti Islands. The Javanese migrated to Meranti Islands and adopted the dominant religion there, Buddhism.

Although FGM/C is not originally known in Buddhism, the Javanese continues to practice the tradition as a part of their Javanese roots. Consequently, in Meranti Islands, FGM/C is only carried out by the Javanese with the help of shamans who understand the Javanese culture.

Geographic migration also includes another scenario where a group of people who had never practiced female circumcision moved to a region where the tradition prevails, and then adopts the local culture. In Banten, a family of Chinese descent practices circumcision to follow the local culture, although they are not Muslim themselves. By practicing circumcision, they hope to be 'accepted' by the locals. We heard of this account only from a shaman because the family refused to be interviewed.

> *" ... Almost every midwife who participated in this FGD has been circumcised when they were little. One of the participants in Lebak was not circumcised. She was born in Banjarnegara, Central Java, where most girls are uncircumcised." (statement of a midwife during an FGD in Lebak Regency, April 2017*)

Migration does indeed influence the tradition of a family. A family that did not practice FGM/C may do so simply to assimilate with the new community where they now live. We could not confirm whether such families will undo the tradition once they return to where they originated or move to a new place that does not practice FGM/C. This topic of concern must be addressed in future research to understand whether and how the pressure to 'fit in' may influence one to perform circumcision.

'Migration of faith' concerns cases where people convert to a religion that mandates FGM/C.

A person who converts to Islam is called mualaf. In every regency/municipality that we studied, we encountered cases of mualaf going to shamans or midwives asking to be circumcised. We found an interesting case in a village in Flores about a 44-year-old woman named HH. She and her younger sister are Catholics who were circumcised when they were little because their mother was a Muslim. Aside from that, she also went through other Islamic rituals, marhabah and akikah. But, she decided not circumcise her own daughter because she has chosen Catholicism to follow her father. Flores and Catholicism do not recognized circumcision. So, there is no pressure for her to doit.

In Bangka Belitung and Gorontalo, FGM/C is a non-negotiable prerequisite for a woman to convert to Islam. Our mualaf informants underwent circumcision when they were adults to marry Muslim men. With regard to the procedure, adult circumcision differs slightly from those of children or infants. The difference lies in the recitation of *syahadat*, which is a declaration of Islamhood.

6.2. Attitude and Perception Decision-Making Behind FGM/C

This subchapter will discuss different attitudes toward and understandings about FGM/C, which cause dilemma for many people. For example, technological advancement has allowed female circumcision to be medicalized. Such advancement may confuse parents when trying to decide how to perform the circumcision. Inquiring how decisions related to FGM/C are rationalized will help us understand how the practice is preserved.

6.2.1. "Do You Agree, Doubt, or Disagree?"

Attitudes toward FGM/C can be subdivided into three: supportive, skeptical, and opposing. Most of the people we interviewed showed support for the tradition. But there were also people who admitted to being skeptical and even opposing it. The opposition to FGM/C may take different forms, ranging from vocal disagreement, polite or strategic disagreement, to keeping the opinions to oneself.

Supportive Attitude

Shamans and tribal figures consistently showed support for FGM/C in areas we studied. Their rationale mostly centered around culture and superstitions, as explained previously. In Gorontalo, for example, a tribal figure insisted that FGM/C is a cultural heritage that must be preserved.

> *As a community figure, I am actively involved in preserving local culture, [including] the one in the 149th rank, lemon bathing. So, I tell students, especially those in SMK [high school], to perform lemon bathing as soon as possible, for those who have not taken it. Everything is for the sake of women* (an interview with a male Tribal Figure in Bone Bolango Regency, Gorontalo Province).

Lemon bathing ritual is the 149th Gorontalo's cultural heritage that the province aims to preserve. His strong support for FGM/C is rooted in the belief that the tradition is beneficial for women and the fear of it going extinct, concerns there are also shared by a tribal figure in Polewali Mandar.

> *The government must preserve female circumcision because this is a tradition inherited by our ancestors. Do not let it go extinct. If eliminated, our culture will go extinct* (an interview with AG, a community figure, May 32017, Polewali Mandar).

A female tribal figure in Bone Bolango also shared the same opinion. She called upon old *biang* (shamans) to pass their knowledge to the younger *biang* in order to preserve female circumcision.

> *Lennon bathing, female circumcision, should never stop [being practiced], it must be preserved. Old* biang *must teach younger* biang*. It will never stop [because]* biang *know that one of their jobs is to find younger* biang *to prevent extinction. There are many young people who can be taught. This should not stop [because it is] for women's own sake. I am the leader of all* biang*, [and] I lecture to preserve culture*. (An interview with a female tribal figure, May 2017, Bone Bolongo, Gorontalo)

The training for younger shaman is an attempt to conserve the local tradition of female circumcision. The leadership of such figures allow them to be heard and respected, and therefore make FGM/C everlasting.

Different from shamans and tribal figures, religious and community figures did not seem to try to preserve FGM/C as aggressively. Some of them believed that everyone would do it eventually, so there was no need to be aggressive. Some others leaned more to the skeptical or the opposing side. Because FGM/C rarely results in life-threatening or emergency situations, it is infrequently discussed or criticized. As the consequence, most religious and community figures simply take the tradition for granted. Surprisingly, some Ulema whom we interviewed thought that it was necessary for the government to refrain from making female circumcision mandatory. But, they said they would welcome interventions that detail the technicalities of circumcision, such as regulating the procedure based on the hadith.

Mothers were just as divided as the community figures. However, based on our interviews, most of them supported the tradition, especially those coming from a strong religious background. We be-

lieve education has a marginal effect on attitude toward FGM/C because some mothers who supported and performed circumcision on their daughters were highly educated. Additionally, they tended to believe that FGM/C is *sunnah*, religiously encouraged but not mandatory.

> *I disagree with the decision to disdain people who cannot afford circumcision because it is a sin. [But,] I support female circumcision. Because a Muslim woman has to be circumcised, depending on their own tradition though. But, for Mandar Tribe, circumcision is practiced on infants. I do not know about other tribes. But, [to us,] circumcision marks Islam-hood* (RM, a mother, May 6 2017, Majene)

One of the most common supports for FGM/C that were brought up by the mothers was controlling female sexuality.

> *"Probably avoiding bleeding. But, there is no circumcision abroad because there are not many Muslims there. So, their sexualities become hyper. So, for the Muslims, probably we are circumcised so that we will not turn to be sex addicts."*

Believing that FGM/C marks Islam-hood and honors women motivates mothers to inherit circumcision to her daughters, and therefore make FGM/C even more difficult to get rid of.

> *"I am not sure whether circumcision is compulsory, but the elders said that [women] have to be circumcised. All three of my grandchildren have been circumcised. But, now, the circumcision is carried out by midwives. It used to be [carried out] by* 'paraji' *(shaman). The benefit [of circumcision] is becoming Muslim. I am afraid women who are uncircumcised are not yet Muslims* (FT, a mother, Bone Bolango).

The overwhelming support for FGM/C indicates that the tradition will not disappear anytime soon. According to the mothers, no one 'advocates' for FGM/C because everyone has readily known that it must be done. Religious and cultural reasons keep female circumcision alive. And, as long as most stakeholder endorses it, the practice will remain flourish even without overt and aggressive advocacy efforts.

We found that access to information and personal experience strongly influenced the decision of our informant mothers to circumcise their daughters. Mothers who had been previously ex-

posed to the alternative religious interpretation of FGM/C and had firsthand experience with the procedure were more likely to oppose the tradition. The following subchapter will discuss the topic further.

"Skeptical Without Clear Stance"

Some other mothers expressed skepticism against FGM/C and had no clear stance on it. They chose to circumcise their daughters under various kinds of pressure: pressure from the extended family, especially their own parents, pressure to conform to local tradition, and pressure from respectable religious and community figures. But, when they were asked about their personal stance, they revealed doubts. A mother in Polewali Mandar humbly admitted to us that she lacked knowledge on the matter, causing her to be inarticulate and indecisive.

> *I cannot say agree or disagree because I do not really understand the benefits and the harms. Because I merely followed tradition. I was so blind. I cannot choose an attitude.* (An interview with JS, a midwife, May 3 2017, Polewali Mandar).

One source told us that she was forced to circumcise her daughter due to familial and religious pressure. Parents and religious leaders hold a considerable amount of cultural power, which allows them to make sure the younger generations continue to perform female circumcision. But, without a thorough understanding of FGM/C, one may only hesitantly partake in the tradition.

> *"I am not sure whether circumcision is compulsory, but the elders said that [women] have to be circumcised. All three of my grandchildren have been circumcised. But, now, the circumcision is carried out by midwives. It used to be [carried out] by* 'paraji' (shaman). *The benefit is becoming Muslim. I am afraid women who are uncircumcised are not yet Muslims* (FT, a mother, May 2017, Bone Bolango).

Another source in Majene also questioned the tradition. She believed her religion never compelled [female] circumcision. She also knew that there is no health benefit to FGM/C. She thought of it more like a local custom. Religious figures in Majene said that each family has the final say in deciding whether female circumcision is beneficial or harmful. She said that [part of the advantages] of

circumcision is *'silaturahim'*, which means maintaining good relationships with friends and relatives.

> *Probably it is a tradition for women. Men are circumcised because there are impurities inside. Women do not have such impurities. But, it has become a part of culture. Our relatives will gather [to celebrate]. There is no benefit [to female circumcision] healthwise. But, 'silaturahim' is the benefit. Relatives will meet each other, which means there is 'silaturahim'. I do not think there is negative effects to it because no one here has ever suffered from pain or swelling. I do not know about the others though. But, we can maintain 'silaturahim' with relatives, friends, and colleagues ... It is preserved even without benefits. But, I do not know what other people feel though. I do not know the health benefits. But, this has been a part of the local culture. Those who should preserve it are families because families may reap benefits from it (An interview with DJ, a community figure/ toma, May 7 2017, Majene)*

One midwife in Belitung said that she finds it difficult to oppose female circumcision. The people in Belitung have been used to the practice and tend to view it as harmless.

> *I find it difficult to take a stand against it, even for performing mere [vulva] cleaning. Because the people have been used to it. If there is no benefit to it, and it may cause problems, a bold legal prohibition is very much needed. We would simply obey it*. (Secretary of local branch of Indonesian Association of Midwives [IBI], April 2017, Manggar Regency, Bangka Belitung Province).

Such indecisiveness partly stems from the lack of clear national or regional regulation on FGM/C and awareness of the potential harms of the practice. However, younger midwives in Bogor Municipality tended to express a disapproving attitude more boldly. They were aware of several existing regulations that condemn FGM/C, and understood that the practice may cause harms, especially because the clitoris is a sensitive organ that is densely surrounded by nerve endings, which may be damaged in the process of circumcision. (Focus Group Discussion, Bogor Municipality, April 2017)

"Outright or Subtle Opposition?"

Based on the in-depth interviews, we identified two kinds of oppositional stance against FGM/C: outright opposition and subtle opposition. Some informants, especially those who have undergone FGM/C and are/were traumatized by it, rejected the practice outright. Some others chose to be subtler in expressing their disapproval. We argue that diplomatic disapproval may resolve the problem of power imbalance associated with FGM/C and gradually uproot the practice from religion and local cultures.

"Outright Opposition"

Midwives who work for the Department of Family Health of the Ministry of Health uniformly expressed disapproval toward female circumcision. They had been made aware of the negative effects of circumcision on women's health as well as the Ministry of Health's regulation that prohibits FGM/C. They also understood that FGM/C has been a part of religion and culture in many regions in Indonesia, and sympathized with the midwives who are caught up in a difficult position.

There were also local midwives who spoke firmly against FGM/C. A midwife in Dumai, for example, admitted that she feels no benefit from being circumcised, and instead experiences less sexual pleasure due to the impairment caused to her reproductive organ. Her personal experience led her to change sides and convinced her to refuse any requests for female circumcision. A similar story was told by another midwife in Bogor.

> *My daughter is uncircumcised. Because there is no benefit. No benefit to the health. If anything, I am worried about the future sexual effect. I have a relative who experiences that. So, there is a proof. We will not experience climax [if circumcised]. We will just feel nothing. So, I wonder, 'is it because of it [circumcision]?'. I do not know exactly if it is the circumcision. But, she told me she does not experience it [orgasm] during sex. Even though we are women, sometimes, we can reach [orgasm] for several times.* (DS, a mother, 38 years old, Bogor Regency).

Such cases prove that FGM/C is detrimental to women's sexual health, and negative personal experience with the practice tends to seed firm opposition against it.

There is another mother in Majene Regency who strongly opposes FGM/C. She seemed convinced that FGM/C has no medical benefits, and is willing to support its elimination even though it is one of the cultural artifacts of where she lives. She said she would not be able to stand watching her daughter circumcised.

> *After knowing the risks, it [female circumcision] must be eliminated because it is probably a mere cultural tradition of Mandar Tribe, but not an obligation. I would not be able to stand watching my daughter circumcised. I do not have the heart. I feel sorry for the pain she would have to go through. If there is blood, then the kid is suffering. [If a girl is uncircumcised,] she will be talked about, 'She has grown up, but why has not she been circumcised?' The local belief says that circumcision may prevent a woman from channeling her sexual desires recklessly. But, that simply requires an early religious teaching. Why is it that there is no sympathy for our daughters, even when we have known that circumcision and piercing are painful and rob our daughters of their right to not be hurt. My concern is based on its [harmful] effects, especially if the tools used, such as the knife and the swab, are not sterile. The tribal law says that female circumcision must be carried out, but there is no ground for it. I think female circumcision is supposed to be eliminated because we have ignored the right our daughters from being hurt.* (An interview with DW, a mother, May 6 2017, Majene)

She also argued that FGM/C as a cultural and religious tradition is baseless. It is not backed up by any tribal or religious laws. She even dared to support its elimination. The physical pain caused by FGM/C and the possibility of unhygienic tools being used are the main considerations that put her at odds with other mothers in her region.

"Subtle Opposition"

Interestingly, we found various kinds of subtle and strategic oppositon against FGM/C during our research. Generally, strong social pressure to conform and religious influence force women to be skillful at negotiating the tradition. For example, in Barito Kuala, a midwife was socially forced to perform FGM/C on her daughter despite her rejection of the practice. She eventually had her daughter circumcised, but only symbolically. She trusted a more senior

midwife to carry out the ceremonial circumcision. By doing so, she managed to contest the authorities over their oppression on women.

She has also been refusing requests to perform circumcision for other girls. *"I do not perform circumcision. I am still young. I refer the patient to a more senior midwife. If someone asks me, I will refuse by saying that I do not have the tools, so that they will go to the community health center instead. Because I am prohibited to do it, I will just obey the rules, and subtly refuse [any requests for female circumcision]. When I was trained, there was also no training on female circumcision."*

Her excuses are clever because they leave no room for the parents to insist while not giving the impression of being confrontational.

A similar case was found in Majene, where a midwife refused to circumcise her daughter. She found no religious, cultural, and medical grounds to accept the tradition that is forced upon her. She subtly resists the tradition by celebrating the circumcision of her daughter without having ever performed it.

> *I reject female circumcision. I had to perform it on my daughter due to social pressure, so I did it symbolically. My dauther was four, and she was circumcised by a senior midwife. I know for a fact that she did nothing to her. [I did that] to simply avoid being gossiped about. I did not have the heart to circumcise her, so we did not wound [her]. Meanwhile, other parents ask for the blood to be kept in a plastic ice bag, which will later be buried under a tree rose and a tree jasmine, just like what they do to placentas* (An interview with FF, a midwife, April 15 2017, Barito Kuala).

Substitution: "Not Circumcision, Just Ceremonial"

> *"Female circumcision is supposed to be stopped because it benefits no one. The government has chosen to prohibit it, but its enforcement must be made clearer. If it is a tradition, then awareness of the public and health workers must be improved. Some midwives still perform circumcision on their daughters, indicating a low awareness [on the negative effects of FGM/C]. In Mandar, a baby girl of 1-2 months old must be circumcised already. [To them], a slight wounding is enough, nothing is removed. That is the culture. So, I performed the tradition, but*

I did not even let anyone take off the pants of my daughter. I held the ceremony to make my daughter happy. She got to wear a traditional dress, and be islamicized by performing ablution and declaring 'syahadat'. *But, no one took off her pants. After doing some medical and religious research, I found that there is no grounds for making female circumcision compulsory. Anatomically, female genitalia is already perfect. Circumcision is not needed. I followed the ceremony without taking off her pants, even though the elders said some bleeding must occur."*
(An interview with NM, a midwife, May 2017, Majene)

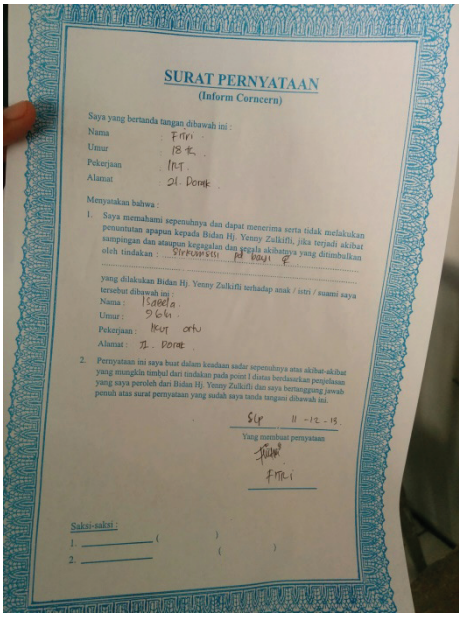
She implemented this approach in her community successfully without the slightest resistance or any social sanctions. She islami-zed her daughter and followed the accompanying rituals while refraining from wounding, touching, or even looking at her daughter's genitalia. Her strategy is similar to that of an NGO in Kenya, which aims to abolish FGM/C while retaining the accompanying ceremonies.

Another form of opposition appears in Jambi. A midwife in Jambi admitted to performing mere vulva cleaning when asked to perform circumcision on a girl.

Sometimes, one out of ten people will ask me, "Bu, do I have to circumcise [my daughter] now?". I will reply honestly and ask back, "Is that okay?". Because we as humans are not supposed to remove or wound our female organs. So, female organs, especially of the babies, must not be [removed or wounded]. When we try to explain it, some will understand and some will insist. They will say, 'our ancestors used to be circumcised.' So, it depends on how well we can reason with them. If they still insist, I will merely clean [the vulva/genitalia]. We will clean the labia of the babies that are dirty to [please] mothers who are stubborn. Nothing is removed, and they will understand. If they still insist, we will say, 'what can be removed if it is this small?'
(RA, a midwife, 49 years old, Jambi Municipality).

RA chooses to openly reason with mothers to inform them of the dangers of FGM/C. Some will understand. But, for those mothers who fail to do so, she will simply clean the labia of their babies to please them. The symbolic circumcision trick is used once again.

Picture 3 **An Informed Consent Form in Meranti Islands Regency**



SURAT PERNYATAAN
(Inform Corncern)

Saya yang bertanda tangan dibawah ini :
Nama : Fitri
Umur : 18 th
Pekerjaan : IRT
Alamat : Jl. Dorak

Menyatakan bahwa :
1. Saya memahami sepenuhnya dan dapat menerima serta tidak melakukan penuntutan apapun kepada Bidan Hj. Yenny Zulkifli, jika terjadi akibat sampingan dan ataupun kegagalan dan segala akibatnya yang ditimbulkan oleh tindakan : Sirkumsisi pd bayi P
yang dilakukan Bidan Hj. Yenny Zulkifli terhadap anak / istri / suami saya tersebut dibawah ini :
Nama : Isabella
Umur : 9 bln
Pekerjaan : Ikut ortu
Alamat : Jl. Dorak
2. Pernyataan ini saya buat dalam keadaan sadar sepenuhnya atas akibat-akibat yang mungkin timbul dari tindakan pada point 1 diatas berdasarkan penjelasan yang saya peroleh dari Bidan Hj. Yenny Zulkifli dan saya bertanggung jawab penuh atas surat pernyataan yang sudah saya tanda tangani dibawah ini.

Skp 11-12-15
Yang membuat pernyataan
Fitri

Saksi-saksi :
1. _____ ( )
2. _____ ( )

6.2.2. Dilemma in Performing FGM/C: "We Decide [to perform or not to perform FGM/C] in Doubt and Uncertainty."

While some people take extreme stances on FGM/C, some others are trapped in confusion. On one hand, they internalize social norms and take local and religious traditions seriously, including female circumcision. On the other hand, they have not found any solid grounds to neither oppose nor support the tradition, leaving them in a state of uncertainty.

> *"I did not know [what are the benefits of FGM/C] because [FGM/C} had been a custom, even though we did not know the benefits. After joining an NGO, where we talk about reproductive health and violence against women, no we recognize FGM/C as part of violence against women. The notion that uncircumcised women are flirtatious is made up by the people. But, logically, what is the relationship between flirtatiousness and circumcision? Being flirtatious is a behavior. But, there is no nerve that causes flirtatiousness."* (R, 35 years old, Jambi)

Clearly, she has made a conscious choice to advocate against FGM/C after joining an NGO. However, she was uniformed in the beginning. And there are many people who are still in doubt today.

We also documented cases where parents performed circumcision on their daughters despite feeling unconfident about their decisions. They did not necessarily believe the promised benefits of FGM/C, but they carried it out anyway for fear of something 'bad' might happen to their daughters in the future. For most cases, such confusion originates in the contradiction of the Ministry of Health's regulation versus Mama Dedeh's TV sermon. Contradicting information may produce a wide variety of understandings and attitudes. Some admitted to feeling compelled to dig more sources that they trust. Some others have now realized the harms of FGM/C. Interestingly, the rest stood even more strongly to support FGM/C after being exposed to opposing opinions.

Working as a dentist's assistant in a Community Health Center in Selat Panjang, LR was informed by her colleague that female circumcision had just been prohibited by the Ministry of Health. Feeling intrigued, she immediately looked for more information. She came across a hadith stating that the Prophet Muhammad once mandated female circumcision to prevent malignancy. He also required the circumcision to be adequate, neither too much nor too little. LR then chose to settle with the hadith and refused to research any further.

> *"Because the government program is man-made, whereas this is a life program. Why do not we obey? Even though the government has prohibited it, [I] will continue perform [FGM/C] because I have now known the religious ground."* (An interview with LR, 35 years old, Meranti Islands).

Dilemma may propel someone to conduct more research. But, researching does not always make one more aware of the harms of FGM/C. It can also reinforce pre-existing beliefs about the tradition. In the case of LR, the supposed divinity of religious grounds convinces her to sideline man-made laws.

One mother in Lombok—who is also a lecturer in an Islamic university in Mataram— told us that she came to a different research conclusion. She is fully aware of the position of the Ministry of Health on the matter, and knows that female circumcision stands on a

shaky religious ground. She chooses not to circumcise her daughter for fear of future health troubles.

> *As a lecturer in Mataram … Ibu first knew about the prohibition of FGM/C by the Ministry of Health from a newspaper. She understands that this decision was issued after a thorough research. She herself has had an experience of teaching female 'fiqh' [Islamic jurisprudence]. She concludes from various sources that female circumcision originated in a tribe in the Middle East way before the advent of Islam. And when Islam came, the tradition was maintained in an attempt to acculturate Islam to the local culture. This was considered a parole. A hadith then came out stating, 'Cut your clitoris for those who have it excessively, and spare some for the pleasure of your husband.' Though, the validity of the hadith is still questionable. Ibu thinks that Arabic women may have bigger clitorises than Indonesian women, whose clitorises are thin. She is worried that nothing will be left if the clitoris is circumcised. She is worried for the health and the future of her daughter if her daughter is circumcised.* (An interview with Ibu R, 41 years old, West Lombok Regency).

Meanwhile, a mother in Bogor insists on circumcising her daughter for fear of high sexual drive. Even though she has been warned by her aunt—who happens to be a feminist activist—that the practice may be dangerous for her daughter, she still clings resolutely to her opinions. She has done her own research on the internet. But, instead of giving equal weight to the opposing arguments, she chose to cite articles that only support her stance.

> *"The consequence of being uncircumcised is greater. WHO only says [that female circumcision] cuts nerve endings. They cannot explain what nerves that are being cut exactly. They have yet to make that explanation. But, the Prophet Muhammad is clearer in conveying that [women] must be circumcised and the consequences of not being circumcised. I choose the clearer one."* (AP, 28 years old, Bogor Regency)

Midwives also share the confusion. They said that they are trapped in a difficult position because of the Ministry of Health's rule on one hand and the societal pressure from the public who demands their service on the other. They are worried of receiving social punishments, including being labelled irreligious and sinful.

" ... Because it is [a part of] culture, it is hard to end. Very hard to end. We, midwives, must be smart so as not to be called infidels or sinful. [But,] do not let us cut with small scissors. Just do not." (An interview with a midwife, May 2017, Meranti Islands Regency)

" ... People who come [here] always ask to be circumcised. There are pros and cons. One side tries to obey the law, whereas the other struggles with culture. They say that they now turn to midwives from shamans for safety reasons ... Midwives will usually explain and give options. If they insist, the midwife will perform [symbolic] circumcision—not the bad circumcision, just cleaning without cutting (A midwife, April 2017, Manggan Regency, Bangka Belitung Province)

Midwives' roles as a health worker and a community member contradict each other when it comes to providing service for FGM/C. Cultural and religious norms grip them tightly, so much so that they are afraid of having to perform a procedure they know dangerous. Not to mention, when a midwife refuses to provide service for circumcision, the parents can easily bring their daughter to a shaman, who may not hold a high standard of hygiene.

Some regions can be very harsh for parents of uncircumcised daughters. Such family may become object to local grapevine and be called 'freak'. All informants in Gorontalo and Bangka Belitung, for example, were very sure that every girl in their area has undergone circumcision due to its compulsory nature there. And those who openly express their disapproval of FGM/C will be subject to social sanctions.

" ... Having one daughter who is uncircumcised ... is not a big problem for her. Because, according to a midwife she met, FGM/C is no longer allowed. But, mothers in her neighborhood were very surprised to know that her daughter is uncircumcised. They explicitly told her that [female] circumcision is compulsory. They went on by saying, 'Is it even possible for a girl to be uncircumcised?' and 'how do you feel for not being circumcised?'" (An interview with SR, 22 years old, Lebak Regency, Banten Province).

SR's experience proves that social sanctions for avoiding FGM/C does exist in some regions. But our research in Lebak Regency also

revealed that such sanctions will not apply to families that choose to be discreet about it.

Social control on FGM/C is not very tight. Proving whether a girl has been circumcised or not is difficult, if not impossible, unless it involves a physical examination. FGM/C is also rarely followed by a big celebration like in the case of male circumcision. The belief that every girl is circumcised is a mere assumption. If a family chooses to stay discreet about their uncircumcised daughter, they will remain protected from social sanctions. The only way of telling that a girl is uncircumcised is by checking whether she acts promiscuously or is a non-Muslim. Many people take those hints as indications of being uncircumcised.

6.3. The Variety of Female Circumcisions: In Between Tradition and Medicine

The ritual of female circumcision in Indonesia takes many forms. This chapter will discuss how the ritual is conducted, who is responsible for what, how they justify those decisions, and how much money the ritual usually costs. We utilize WHO's classification of FGM/C to capture the diversity of the tradition in Indonesia, specifically in 10 provinces, 17 districts/municipalities.

6.3.1. Who Performs FGM/C?

We roughly categorized practitioners of FGM/C into two, health and non-health workers. A health worker is anyone who dedicates his/her live in the health sector and possesses knowledge and/or skills obtained through some kind of health/medical science education (Law number 36 year 2014). In contrast, anyone who have never received such education is considered a non-health worker.

Currently, midwives perform FGM/C way more often than any other health and non-health workers with the exception of Gorontalo and West Sulawesi, where non-health workers dominate. Non-health workers have many names: *'dukun beranak', 'dukun bayi', 'mak berang', 'paraji', 'biang', 'belian'*, and *'hulango'*. Some prefer to call them *'dukun'* (shaman) as will be explained below.

6.3.1.1. Non-Health Workers: Shamans and FGM/C

Shamans perform most circumcisions in Gorontalo and West Sulawesi while midwives rule in the other 8 provinces studied. Shamans usually perform circumcision traditionally. Due to modernization and the declining population of shamans, many people start to turn to midwives who perform the procedure independently or in health clinics or Community Health Centers *(Puskesmas)*. A family's decision to pick shaman or midwife depends on many things, as our interviews revealed.

Families usually prefer shamans because (1) health workers are not available in their areas; (2) shamans are believed to possess special knowledge and supernatural skills that are inherited from one generation to another; (3) shamans can help with labor and delivery and perform female circumcision at once, making it practical for parents; (4) shamans will accompany the ritual with prayers and praises, such as *'basmala'* and *'sholawat nabi'* and a declaration of *'shahada'*; and (5) some parties may require them to prefer shamans.

In contrast, families turn to midwives usually because (1) health workers gradually become more available in their areas; (2) the available shamans can no longer perform circumcision due to age; (3) the number of shamans, especially those who can perform circumcision keeps decreasing, some of them can only provide service for baby massage.

6.3.1.2. Health Workers: Midwives and Other Health Workers

When we asked our informants who had circumcision performed on them when they were young, they usually replied either midwife or shaman. But, when we asked who performed or will perform circumcision on their daughters, most of them answered midwives. We also found a midwife who provides service for FGM/C in a Community Heath Center *(Puskesmas)* in West Lombok Regency. These facts reveal a trend in medicalizing FGM/C, a shift from non-health workers to health workers. The exception only applies to Gorontalo and West Sulawesi, where the ritual of 'lemon bathing' can only be performed by a shaman known as *'hulango'*.

There are various reasons that may motivate a family to prefer midwives over shamans: (1) midwives are more widely available in

their area; (2) they possess the necessary medical skills and knowledge that were obtained from a formal education; (3) their services are cheaper; (4) it is practical for parents to expect midwives to help with delivery, post-partum care, baby's care and circumcision at once; (5) the [circumcision] procedure is more modern i.e. hygiene is guaranteed, the tools used are sterile.

In contrast, here are various reasons that may discourage families from choosing midwives: (1) midwives refuse to perform circumcision; (2) midwives are difficult to find in some areas or not trusted enough by the people; and (3) local ritual which specifically requires shamanss.

6.3.2. Training for Performing FGM/C: "Where and How Did We Practice FGM/C?"

This chapter will discuss where and how did shamans and midwives learn how to perform FGM/C. The kind of knowledge they obtain will expectedly determine the way they practice female circumcision, which will later inform us in assessing how dangerous/safe the practices are.

6.3.2.1. Shammans and FGM/C: "Dream or Revelation?"

> *"We learned it from Nyai (*ulema's *wife or female* ulema*). My Nyai used to be the village shaman, the* 'galo-galo', *the shaman of all shamans. We are all her descendants. I actually did not want to be a shaman. [I am] the tenth generation ..."* (WS, 71 years old, shaman, April 2017, Jambi Municipality)

In the case of shamans, the knowledge and skills used to perform FGM/C are passed down filially. It is common to find a shaman whose parents or grandparents were also shamans. Shamans tend to pass down their knowledge to their selected offspring because they believe some of their offspring possess a natural talent in knowledge and skill on circumcision.

> *"... Inheritance [natural talent] is strong even without education. People would tell me [to be a shaman] because I am my mother's heir. My mother also had a brother and a sister. But, because they are not her heir, they cannot [inherit my mother's knowledge]. Allah is omniscient, which is why her brother did not become her heir. He could not even bathe or massage babies. He was scared.*

MIDWIVES: WE LEARN HOW TO PERFORM FGM/C

In Banjar, Pandeglang, Lebak, Meranti, Dumai, Bogor, junior midwives refer to their seniors performing FGM/C by removing white excrement from the clitoris. In Bogor, Pandeglang, Lebak , Meranti, Dumai, Banjar, Jambi, FGM/C is about opening labia majora to clean the clitoris using betadine or alcohol. In West Lombok, FGM/C is performed symbolically only by wiping turmeric to a girl's genitalia. (Compilation of data collected through Focus Group Discussion, April-May 2017, in 10 provinces, 17 regencies/ municipalities).

People kept coming to our house and ask, 'Bu, please help.' When Allah has decided, I become the heir. But, I cannot recklessly sell my power. 'Lilahi taala' *[Just for Allah] I inherit this knowledge from my mother ..."* (IH, April 2017, Bogor Municipality, West Java Province).

Every heir also has several requirements to fulfill, including fasting, to sharpen their skills. Most shamans that we met during research inherit their skills and knowledge from their parents of grandparents. They learned how to be a shaman by observing how their parents used to do rituals while helping them conduct it over and over again. When their parents had turned very old and they had felt skillful enough, they would start replacing their parents as the village shamans.

> *"... I dreamed about it on Thursday night. After that, my neighbor had a difficulty during labor. So, I came to help. The knife we used for circumcision were obtained from a sacred graveyard nearby (Buyut Asmaranda) when I was walking there ..."* (A shaman, April 2017, Lebak Regency, Banten Province)

The shaman told us her journey in becoming a shaman begun with a revelatory dream. The tool she used for circumcision was also found on a sacred grave of a spiritual leader, making her believe that she is destined to be a shaman. Other shamans reported similar stories with some kind of revelation in the beginning of their career.

Young shamans learn by watching and imitating their parents repeatedly. They will begin practicing seriously as a shaman after their parents have died or turned old. The skills and knowledge in circumcision are passed down to chosen offspring. Many mystical incidents tend to be involved in the beginning of a shaman's career,

such as a revelatory dream, a knife that obtained from a grave of a former spiritual leader. Based on terms used by shamans such as 'knowledge heir', 'revelatory dream', 'inspiration *(wangsit)* from a sacred graveyard' etc, imply that knowledge on circumcision is not for everyone. Destiny picks the individuals, as many believe, who have magical power and highly knowledgeable. Such a knowledge cannot be acquired from formal education. Only those with certain social status can master it.

6.3.2.2. Midwives and FGM/C: "Listen, Imitate, and Practice"

Every single midwife we interviewed admitted to receiving neither official education nor training on FGM/C. It is apparently not considered as one of the competence standards to be a midwife in Indonesia. Most of them first learned how to carry out female circumcision from senior midwives at work.

> *" ... There was no class on female circumcision in my school of midwifery. I improvise, because the only thing that matters is that the mother of the patient sees me holding tools ... I learned by watching the senior midwives, asking other fellow midwives and trying to imitate them, and then improvise."* (A midwife, April 2017, West Lombok Regency)

Midwives learn by observing other midwives and asking around. But, at the end, every junior midwife will have to trust themselves to improvise. The improvisation is meant to avoid actual wounding or mutilation by, for example, performing vulva cleaning or gently nicking a needle to the child's clitoris. In short, generally, there is no official guideline in Indonesia as to how female circumcision should be carried out.

Interestingly, one midwife in West Lombok Regency admitted to being taught about female circumcision during her diploma education in nursing.

> *"... When I was pursuing my diploma [circa 2001], there was a class on female circumcision, teaching us how to mutilate the clitoris a little bit by using a tweezer to pinch it. This lesson is a part of the nursing program."* (A nurse, West Lombok Regency, April 2017)

The absence of official guideline may further compromise the women's health. In Dumai, for example, we were notified of a case where a midwife 'improperly' circumcise a child.

Once, a midwife improperly circumcised a child because she did not know how to do it. She cut the labia minora instead. (A doctor in a circumcision clinic, May 2017, Dumai—Riau.)

In Polewali Mandar, West Sulawesi, a midwife claimed to learn how to perform circumcision from esteemed figures, including *'syarifah'* (a person of Arab descent), a Koran teacher, and a shaman. This came to us as a surprise because midwives in Polewali Mandar do not usually perform female circumcision. Though, this midwife does no longer provide the service for being too old.

6.3.3. The Variety of FGM/C

The World Health Organization defines FGM/C as "the practice of partially or totally removing the external female genitalia or otherwise injuring the female genital organs for non-medical reasons (WHO, 2008)." The Regulation of the Ministry of Health Number 1636/MENKES/XI/2010 refers FGM/C as *'sunat perempuan'* or 'female circumcision', which involves scraping of the clitoris without wounding.

Our findings revealed that clitoris—also known as *'klentit'*—is the main object of circumcision in Indonesia. We did not record any instance where labia majora or labia minora are wounded, except when a midwife in Dumai mistook labia minora as clitoris. Based on WHO's typology of FGM/C, practices of female circumcision in Indonesia fail to qualify as the type II or type III.

Mutilation or wounding of the clitoris qualifies as type Ia and Ib FGM/C, practices that may be medically necessary in certain circumstances. However, circumcision in Indonesia is based solely on culture and religion, and believed to be an important procedure for cleaning and purifying women.

Mutilation or wounding of the clitoris that are not for medical purposes are supposedly classified as Type IV. But informants would disagree with the claim that circumcision is dangerous. They would point out that no woman has ever complained about the effects of circumcision even though the tradition has been around for generations.

Both types of FGM/C are compared below:

Table 5 **Typology of FGM/C Based on Research Findings**

Type	Organ	Procedure	Purpose
Ia	Clitoris	Clitoral hood reduction or removal of the preputium	Medical (Clitoridectomy)
Ib	Clitoris	Removal of the clitoris and the preputium	Medical (Clitoridectomy)
IV	Genitalia (including the clitoris)	Dangerous procedures that may involve pricking, piercing, excision/incision, scraping, and cauterization of the genitalia.	Non-medical

6.3.3.1. The Proper Age for FGM/C

There is no standard for age deemed appropriate for undergoing FGM/C that holds universally throughout Indonesia. Different regions or even different persons may have different opinions as to when female circumcision must be carried out. Personal preferences may also be involved, such as when the mother has recovered from delivery, coinciding the ritual with other rituals or culturally-significant events, and the family's financial ability.

Most girls are circumcised before turning 1 year old or specifically at 2 months old. FGM/C is usually carried out by Muslim families as a part of their religious teaching. Unsurprisingly, some families choose to coincide FGM/C with other Islamic rituals, such as but not limited to *'akekah'* (usually held when the baby has turned 40 days old).

> *" ... We held* 'upacara naik ayunan' *[the swinging ritual] coincidently with circumcision. When [the baby] had turned one month old, [we also] held* 'akikah' *along with the piercing [ritual].* (An interview with RM, a mother, May 6 2017, Majene).

There are also cases where FGM/C is carried out on girls at school ages, around 6 to 10 years old, although they are very rare. Some choose to wait until the baby can squat—ranging from 0-3 years old—before circumcising them.

Based on our interviews, the preference to perform circumcision as early as possible is based on the fear that the girl may remember and will be traumatized by the procedure if it is performed at older ages. Furthermore, Ibu RM from Majene explained that *"female cir-*

cumcision is better if it is performed earlier so that the child will not feel pain. There are girls who are circumcised at the age of 3 years old. They must be in pain. A baby of 1 to 3 months old do not really feel pain. [They] will not cry. Just scrape it, not cut it." There seems to be a belief that early circumcision helps reduce pain, probably because the tissue is still very delicate.

Shame also drives parents to circumcise their daughters as soon as possible. In Jambi, a midwife recommends parents to circumcise their daughters after turning 6 months old so that it will become easier for her to spot the correct part that will be scraped. A shaman in Bogor recommends parents to circumcise their daughters before turning 2 months old because, to her, the clitoris is just like a drop of water, which requires no wounding or bleeding. Some mothers adjust the timing of the circumcision to coincide with their post-natal consultation with midwives (usually at their first or second visit).

Based on our interviews with mothers, shamans, and midwives, FGM/C is usually performed on girls at the following ages:

Bangka Belitung	7 - 44 days old
South Kalimantan	8 day - 3 years old
East Kalimantan	5 months - 1 year old
West Sulawesi	0-3 years old
Gorontalo	1-2 years old
Lombok	0-7 days old
Banten, West Java	40 days old - 3 years old
West Java	40 days - 1 year old
Jambi	5 days -1 day old

" ... 'Basunat' *[female circumcision], for it [the process] to be clean or comfortable, must be performed at the age of 9 months old. Because 9 months old is when the clitoris starts to be visible.*
(An interview with GM, a mother, April 15 2017, Barito Kuala*)*

According to GM, age that is appropriate for FGM/C is determined based on when the clitoris has become more easily noticeable, which is usually at the age of 9 months old. But, in several other regions, FGM/C may be performed on girls above 3 years old, either because the parents need to save up first or they want the circumcision to coincide with other cultural rituals, which will be discussed further in the sub-chapter of FGM/C Celebratory Ritual.

6.3.3.2. Procedure and Tools

This sub-chapter will discuss various techniques and tools used by shamans and midwives to carry out FGM/C. We also asked mothers, educators, and community members what they know about how the circumcision is carried out, how much the cost and its celebrations.

The Public's Understanding of FGM/C

Our interviews and FGD's revealed that most informants do not fully understand what midwives or shamans do to girls' clitorises. They said that they did not get to properly observe what happened because the mutilation/cutting was done so quickly. One mother vaguely explained to us that the procedure involves a 'small cutting'.

> *Women must be cleansed. Her blood must be taken a little bit … Here, women must be cut a little bit. How do we cleanse women? Cut a little bit. I do not fully understand myself, I do not know how to properly do it. [But,] here, [we], cut a little bit.* (An interview with EW, a mother, April 17 2017, Banjar)

Our source in Banjar Regency reported a similarly vague story. Because she was holding her daughter's head and the circumcision happened very quickly, she could not properly observe what was happening. All that she knew is the midwife scraped her daughter's genitalia.

> *" … My daughter was laid down … I held her head. The midwife [then] performed the circumcision by scraping. I could not tell if there was blood because there was a betadine. My daughter cried during the circumcision, but only for five minutes.*" (An interview with PT, a mother, April 17 2017, Banjar).

> *"I did not see [the process]. I did not know what the midwife did. I could not stand it. I did not see."* (An interview with DP, a mother, April 15 2017, Barito Kuala).

> *Parents wore traditional sarongs, and then took a prayer dress [to then be used to form a booth-like structure]. My daughter, the shaman, and me entered the room. The shaman circumcised my daughter using a knife. She scraped. I did not see anything because I was holding my daughter's head. I did not know what was scraped. I could not tell if there was bleeding. Probably there was a little blood, not as much as the boys [male circumcision].*

*I only knew she scraped, but I did not really see. (*An interview with RM, a mother, May 6 2017, Majene).

"... I did not know what was circumcised. There was a bump. The midwife revealed it. She did not cut it, she incised it. Nothing was removed." (An interview with MA, a religious figure, April 17 2017, Banjar)

Most mothers seem to be virtually clueless about what midwives or shamans did to their daughters. Some mothers may feel uncomfortable watching the entire process. Some rituals are done behind a piece of a prayer dress, preventing parents from taking a look. The rest may still find difficulty digesting what is done to what even when they can witness the circumcision.

"There is no danger [to being circumcised]. If anything, the uncircumcised [women] are dangerous. Their urinary tract will be blocked." (An interview with AD, a religious figure, April 15 2017, Barito Kuala)

Interestingly, a religious figure in Barito Kuala seems to believe that FGM/C influence women's urinary health. Somehow, FGM/C can help prevent urinary tract obstruction. Another religious figure in Polewali Mandar stated that FGM/C involves a removal of 'something' from the vagina.

"... Something is removed from the vagina. And [that thing] will be wrapped with a piece of swab and kept. No blood. Probably, there are cases involving bleeding because of wounding, which is why we always prepare a washbowl filled with water containing jasmine flower and pandanus leaves. The baby will be washed with that after the circumcision. To prevent the girls from crying, we give them a cellphone, and cover [the bottom half of their bodies] with a white prayer dress. The entire process takes less than 5 minutes." (An interview with AG, a community figure, May 3 2017, Polewali Mandar)

Below are remarks about the tools the midwives or shamans use for circumcision.

The tool used was a small knife, 'bisturi'. *The spine of the knife, not the cutting edge.* (An interview with EW, a mother, April 17 2017, Banjar)

"... My daughter was 5 months old at that time. [She] bled a little

bit. It was very scary because [the circumciser] scraped using something sharp, probably a small knife. I immediately put on a diaper. And when I took of the diaper, there was a little bit of blood. [But], after the circumcision, she immediately hopped on a swing." (An interview with DW, a mother, May 6 2017, Majene)

[We] use a small knife. We scrape three times. [In some cases], there is no bleeding. But some do bleed. We will apply a swab, which will later be disposed. (An interview with DJ, a community figure or 'toma', May 7 2017, Majene)

Usually, shamans use a small knife to perform circumcision. But, they use neither the cutting edge nor the tip, only the spine of the knife. Bleeding may happen in some cases according to our informants. None of the mothers, community figures, and religious figures could provide a detailed account on how circumcision is done because it is usually completed in such a short amount of time.

Non-Health Workers: Shamans and FGM/C

Shamans also found it difficult to articulate the way they circumcise girls. Instead of explaining it verbally, most of them chose to demonstrate their techniques with their hands. Not to mention, shamans also have many synonyms for the clitoris: a drop of water, the tip of nut, whitish membrane similar to the tip of a chick's beak, a grain of rice, crushed grain *(menir)*, nut, pimple, and many others.

"Many people ask, 'what is it that is circumcised?' .... hahaha ... There is something that we remove. [It is like] a drop of water. We will spot it. [Sometimes], without even looking for it, it is already there. Like a bump similar to a drop of water. [But], in the case of a 5-month-old baby, it has turned bigger. It will drip liquid. [We] use the tip of the knife." (NN, a shaman, 100 years old, Bogor Regency)

"The tip of a nut. I am embarrassed of saying it. Kelentit *[clitoris]. Haha ... There is a tip [of something]. We remove that thing from where it is attached to."* (WS, a shaman, 72 years old, Jambi Municipality)

"So, baby has something whitish. We clean that. The tip of it, the clitoris. A little bit. We cut it a little bit. Just the skin. The tip will be visible." (AY, a midwife, 24 years old, Bogor Regency)

"The tip [of the clitoris] appears like a white grain of rice. Some bump out, but some do not, depending on the baby. It is like a nut. As a prerequisite, we just touch it." (IK, a shaman, 76 years old, Rangkasbitung)

"The clitoris has a membrane, which needs to be cleansed." (PY, 39 years old, a midwife, Toboali)

"Before 6 months, the whitish bump will not appear. The one to be removed is inside the female genitalia. It is similar to the white tip of a chick's beak. Just remove it a little bit, the one that looks like acne." (MT, 76 years old, a shaman, Samarin*da)*

"The child will be carried by the mother, and covered by the mother's hijab. Her clitoris will then be scraped by a knife that is not bigger than a middle finger. The knife will be soaked in a boiling water. The nut will be scraped, and [we] will get a whitish thing like a wet flour. There was a case where it bled." (SJ, 57 years old, April 2017, Bogor Municipality)

There seems to be a belief that 'the whitish thing', which is a part of the female anatomy, must be removed due to its supposed impurity.

A healthy vagina usually secretes a translucent or whitish liquid known as the vaginal discharge, which plays a role in maintaining health and hygiene. Changes in color, volume, or viscosity of the liquid may indicate changes in the state of the individual's health. On the clitoral hood and other skin folds, there occurs the secretion of smegma, a sebaceous secretion that acts as a natural lubricant. Smegma is composed of dead skin cells, sebum, and sweat. It may appear white or as any other color depending on the skin color. If one finds it disturbing, they can clean it with a lukewarm water. This area is so sensitive that soap is not generally recommended.

Baby powder that is applied on the outerside of the genitalia may also turn into crusts or clots if it interacts with the vaginal discharge and/or smegma. According to a midwife in Bogor Regency, washing them away with lukewarm water will not be enough. The application of baby oil or any other lubricant before washing them with water will help.

Our findings also revealed a lack of understanding of the anatomy of the female reproductive system. Many people we interviewed used colloquial terms like 'whitish thing'. However, it is impossible

to be sure of what they truly refer to. They might be referring to smegma, the clitorical glans, the clitoral hood, or anything else. A separate anatomical study may be necessary to understand this phenomenon further. But, so far, we can be sure that practices of female circumcision in Indonesia do not qualify as Type II or Type III based on the WHO's classification. They are closer to the Type I or Type IV, with some notes to consider.

Shamans we interviewed use the following tools to carry out FGM/C.

***Table 6* FGM/C Practices and Tools by Shamans**

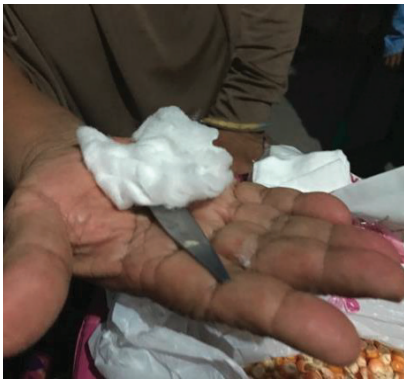
Riau	
Organ	Clitoris
Procedure	Removing something at the tip of the clitoris (improperly articulated)
Tool	A small knife, a scissor, or a razor blade
Process	Removing a white, small part by using a small knife. It may cause bleeding or not.
Jambi	
Organ	Clitoris
Procedure	Removing something white that is attached to the tip of the clitoris (it is unclear whether that means the clitorical glans or the clitorical hood)
Tool	A razor blade, a thumb of turmeric, alcohol/betadine, cotton swab, lukewarm water, and orange
Process	Turmeric is used to press against the clitoris while the razor blade is cutting the 'white part'. The razor blade will firstly be soaked into the warm water. The procedure may or may not result in bleeding. In the case of bleeding, a cotton swab and antiseptic are applied. The vulva will also be dripped with the orange water in hope to prevent abnormal vaginal discharge in the future.
South Kalimantan	
Organ	Clitoris
Procedure	Scratch or scraping
Tool	A small knife or 'bisturi', swab, betadine
Process	Scratch or scrape a part of the clitoris, which is considered an impure thing or 'barang haram', until it bleeds. The cotton swab and the antiseptic lotion will then be applied. It is recommended for a baby above 8 months old when the clitoris has become more noticeable

East Kalimantan	
Organ	Clitoris
Procedure	Scraping
Tool	A piece of white garment and a circumcision tool.
Process	The baby will be firstly laid on the white garment. Scrape the white part at the tip of the clitoris. It is unclear whether they meant the clitorical glans or the clitorical hood. It is recommended for a baby around 1 year old.
Banten	
Organ	Clitoris
Procedure	Gouge, scratch, or touch
Tool	A small knife, betadine, and a cotton swab
Process	Gouge or scratch the whitish or yellowish part at the tip of the clitoris, which is considered impure. It is unclear if they meant the clitorical glans or the clitorical hood. Touch the whitish part at the tip of the clitoris with a knife. No cutting or wounding is involved. This is done to fulfill the bare prerequisite of circumcision. Bleeding may or may not occur. In the case of bleeding, a cotton swab and betadine will be applied.
West Java	
Organ	Clitoris
Procedure	Touch, gouge, or tear
Tool	A small knife, a thumb of turmeric, a coin, betadine, and swab
Process	Use the turmeric or coin to press against the tip of the clitoris, and remove it. No bleeding. Shamans kept using the metaphor of 'a drop of water' to refer to the part that is removed. Apply cotton swab and the antiseptic lotion
West Nusa Tenggara	
Organ	Clitoris
Procedure	Cutting, scraping
Tool	A coin with a hole in the middle, a small knife
Process	The hole in the coin will help grip the tip of the clitoris and ease the scraping.
Gorontalo	
Organ	Clitoris
Procedure	Removing the white part of the clitoris. It is unclear whether they meant the clitorical glans or the clitorical hood.

Tool	Ablution water, a piece of white garment, lemon water, and a penknife.
Process	The baby will firstly be bathed with ablution water
	The white garment will be used by the shaman to cover the cutting
	Bathe the baby girl with lemon water
West Sulawesi	
Organ	Clitoris
Procedure	Pinch the clitoris
Tool	Ablution water, a piece of banana leaves, a pillow, a small knife, a prayer dress, a cotton swab
Process	The baby will firstly be bathed with ablution water
	She will then be laid on a pillow covered in banana leaves
	The prayer dress will be used to form a booth-like structure, where only the shaman, the mother, and the baby can enter
	The shaman will pinch the clitoris with the spine of the knife
	A cotton swab and antiseptic lotion will be applied
	The cotton swab will be kept under the pillar of the house
	Bathe the baby with floral water

Tools that are commonly used by non-health workers include a small knife or a penknife, coin, a thumb of turmeric, razor blade and coin with a hole in the middle. Some shamans use their hands to pinch the clitoris. The antiseptic used include hot water, alcohol, betadine, and turmeric. Other miscellany includes prayer dress, white garment, and etc.

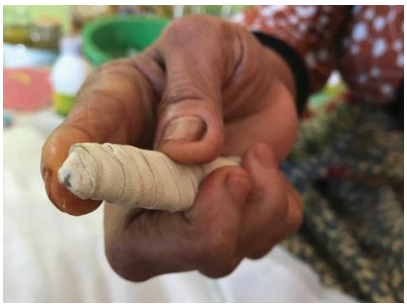
Picture 4 **A Small Knife (Bone Bolango, Gorontalo)**



Picture 5 **Coins with Holes (West Nusa Tenggara Barat)**

Picture 6 **A Small Knife**
(Barito Kuala, South Kalimantan)

Picture 7 **A Small,Knife**
(Samarinda, East Kalimantan)



Picture 8 **A Penknife**
(East Belitung, Bangka Belitung)

Picture 9 **A Penknife and A Coin**
(West Jawa)

Picture 10 **A Penknife**
(Lebak Regency, Banten)

Picture 11 **A Penknife**
(Lebak Regency, Banten)

Picture 12 **A Penknife**
(North Gorontalo Regency, Gorontalo)

Picture 13 **A Penknife**
(North Gorontalo Regency, Gorontalo)

Picture 14 **A Penknife**
(North Gorontalo Regency, Gorontalo)

Picture 15 **A Razor Blade**
(Jambi Municipality, Jambi)

Practices of FGM/C by Health Workers

Below are several techniques and tools that midwives use to carry out female circumcision

Table **7** *FGM/C Practices by Midwives*

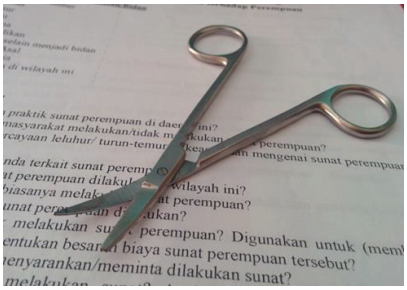
Organ	***Clitoris***
Procedure	Removing a thin membrane surrounding the clitoris (possibly the clitoral hood) by using scissor
Tool	A small scissor with a curved point Cotton swab, antiseptics, disinfectants, and betadine
Process	The clitoris will firstly be cleaned using the cotton swab and the antiseptics. The curved point of the scissor will be used to remove the thin membrane of the clitoris

Organ	***Clitoris***
Procedure	Removing a thin membrane surrounding the clitoris (possibly the clitoral hood) by using scissor
Tool	A small needle Cotton swab, disinfectants, antiseptics, and betadine
Process	The clitoris will firstly be cleaned using the cotton swab and the antiseptics. Use the needle to scratch the membrane of the clitoris a little bit Apply swab and betadine
Organ	***Vulva***
Procedure	Clean the vulva with cotton swabs and antiseptics. Some also use baby oil or any other lubricants
Tool	Cotton swab, antiseptics, disinfectants, baby oil, and other lubricants
Process	The vulva will be cleaned with water and antiseptics. For the hardened whitish gunk, baby oil may be applied to help remove them

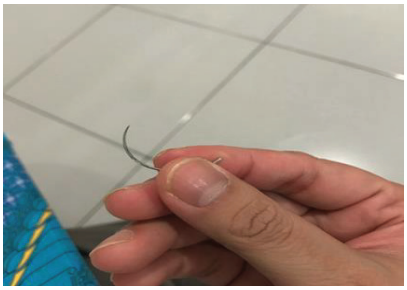
Sometimes, midwives may also use a scalpel, a surgical knife. We also found that some others do not really perform circumcision. Although they appear prepared with all the tools, they do not actually use them or inflict wounds of any kind. And many midwives find that dilemmatic.

> *Circumcision is a controversy not only among us, but also among the Ulemas. As a health worker, we are confused. Honestly, there is a regulation that prohibits it. But, a new Minister of Health's regulation* (permenkes) *issued in 2010 providing Standard Operating Procedure (SOP) [for female circumcision]. I first learned about that when I was doing research. We were never told of the regulation [instructing] how to carry out [female] circumcision ... We do not know the SOP. [All we know is] just applying betadine [to the clitoris/vulva]. Health wise, there is no benefits. If someone comes and feels like this is an Islamic regulation* (sharia)*, I will take betadine just for symbolic [circumcision]. They agree that [what I do] is in line with the* sharia*. We should not reject them because they may come to a shaman, who may cause bleeding* (AD, a midwife, April 2017, Bogor Regency).

Picture16 **Scissor with a Curved Point (Pandeglang, Banten)**



Picture 17 **Surgical Needle (South Bangka, Bangka Belitung)**



Picture 18 **Scalpel/Surgical Knife (Banjar, South Kalimantan)**

Most health workers who provide service for FGM/C use surgical needle, as required by the Procedures for Practicing Female Circumcision contained in the Regulation of the Ministry of Health issued in 2010.

> *When I was in school in 1981, I was taught that circumcision is done by using the surgical needle. This is deemed safer than scissor. Scissor can only be used by a more experienced person. Ibu Fatimah uses scissor because it satisfies the patient more.* (FS, a midwife, 58 years old, Dumai)

Not every midwife provides counterbalance information and a form of informed consent before performing FGM/C. They think they are just fulfilling parent's requests, which then enables them to assume consent. The consent in this context is therefore asked and given verbally. Furthermore, most midwives will explain the (absence of) medical benefits of FGM/C only when they are asked by the parents. This fact is concerning because we once received a report that a mother called off her plan to circumcise her daugh-

ter after learning from a midwife on duty that female circumcision has no health benefits. We therefore believe that such information must be readily and immediately given to any parents who wish to circumcise their daughters.

Midwives keep providing service for FGM/C mostly because parents still demand it. They are also under pressure to not let parents trust shamans. However, some midwives take the opportunity to perform vulva cleaning instead and demonstrate the proper maintenance of female genitalia to parents as a part of education.

> *It was impossible ... hahaha ... this is a girl. We could not wait until she asked [to be circumcised]. 40 days was the maximum, so I had to decide that day. So, I just said no* (DS, a mother, 38 years old, Bogor Regency)

Midwives who strictly perform vulva cleaning admitted to being aware of the presence of regulation that denounces the practice, although most of them could not tell us which regulation. They were also aware of the health risks, the fact that FGM/C is a form of violence against women, and the possibility of trauma caused by thrombosis.

> *If a patient comes here, I will only clean it [the vulva]. That is probably why not many people come here. Because I tell them I do not perform circumcision, just cleaning. There is a possibility of bleeding, which may hurt the girl. It is fine to be uncircumcised. I do not let circumcision here. Just see and clean it.* (ON, a midwife, April 2017, Banjar)

Consequently, parents who view circumcision more as a maintenance of hygiene are more likely to agree to strict vulva cleaning than those who view the ritual as a 'purification' of women.

6.3.4. Different Fees for Shamans, Midwives, and Other Health Workers

Most shamans said they do not charge a fixed number for their service. Shamans tend to trust parents to pay however much they see fit. Some may get as low as Rp 25,000 per ritual. But, most of them earn bigger, especially when they also help with other rituals and the delivery. One shaman told us that she did not charge anything once because the family she worked for was poor. Some shamans

have stopped practicing now because they cannot see clearly anymore.

Health workers also charge varyingly. Areas with reparation fee for female circumcision charge fixed numbers: Rp 70,000 in Jambi Municipality and Rp 50,000 in Meranti Islands Regency. However, in reality, many government-owned health facilities have stopped entertaining requests for FGM/C. But, independent practice owners still widely offer the service, and apply varying fees, ranging from Rp 30,000 to Rp 200,000.

A number of midwives who perform vulva cleaning either let parents decide how much is appropriate or charge nothing at all. They consider vulva cleaning a part of parenting education for puerperal women. In South Kalimantan, there is an option to pay midwives with *'pinunduk'* or the nine basic commodities. In Lombok, circumcision is included in the delivery service package because the ritual is usually performed immediately after birth (0–7 days).

6.3.5. FGM/C Ritual and/or Celebration

Sulawesi

- *Lemon bathing/'cubit'*. A ritual to remove a white, impure thing from a girl's genitalia. The ritual requires a *'hulande',* which consists of 5 different kinds of rice, 7 coins, 7 lemons, 7 eggs, 7 cloves, 7 plates with rice on top, *'milu',* and grasses.
- The baby will firstly be bathed with ablution water. The shaman will carry out the circumcision inside a booth-like structure made of white garments. The baby will then be bathed with lemon water, dressed in a traditional dress, and participate in the plate stepping ritual. The ritual ends with prayers and a feast.
- *Circumcision*. The shaman will chant prayers before the baby performs ablution with the help of the mother and the shaman. The girl will then be laid on top of a pillow covered with banana leaves. Circumcision is carried out while chanting basmala. The cotton swab that was used in the process will be kept under the pillar of the house as a talisman. Bleeding is considered good, because the blood is 'the Islamic blood'. The girl's vulva will finally be cleansed using floral water (West Sulawesi).

Kalimantan

- FGM/C is held simultaneously with the piercing ritual, the hair cutting ritual, and the swinging ritual. In South Kalimantan, the shaman will usually recite *Al-Fatiha*—the first chapter of the Koran—before performing the circumcision.
- The family is expected to prepare 'pinunduk', an offering that consists of money, rice, a specific variety of banana ('pisang raja'), and sugar. The *shahada* has to be recited for four times before the circumcision. And the salawat has to be recited afterwards (East Kalimantan).

Sumatra

- The family has to prepare a plain flour that is made of *pandanus* and other leaves, rice, yellow rice, grilled paddy, and face powder. The flour will then be spread all over the child's body. Prayers and praises will accompany the circumcision. The ritual has to be ended with *salawat* recitation (Riau).
- In Bangka Belitung, the *salawat* is recited prior to the circumcision
- Similarly, in Jambi, the *salawat* is recited before the circumcision. However, there is no celebration or feast that follows FGM/C, because families tend to think it is not something that can be exposed.

Nusa Tenggara

- FGM/C is meant for 7 days old babies and when the umbilical cord is off, alongside with Pedak Api ritual which includes ear piercing and naming ceremony (West Nusa Tenggara)
- Prior to the circumcision, the family of the circumcised baby prepares *andang-andang*, which consists of rice, betel leave and other ingredients (West Nusa Tenggara).

Java

- Circumcision
- FGM/C is performed when a baby has turned 40 days old, alongside with hair cutting ritual, naming ceremony, and ear piercing ritual. However, some families prefer to adjust the time for circumcision to coincide with *'salapanan'* ritual. There is no unique way of celebrating circumcision; The ritual simply begins with praying and ends with a feast (West Java).

- Procedure. Circumcision takes place on a rice container *('dulang')* in Banten or a bamboo woven mat *('gelodog')* in Pandeglang. In other regions, laying down the baby on a white garment suffices. In Banten, the ritual ends with prayers.
- *'Gedrag Kelapa'*. A unique ritual in Pandeglang, where people smash coconuts to the ground near the baby while chanting prayers. Through this ritual, the baby is expected to not be surprised so easily. And the prayers are expected to make the baby useful for and dedicated to the country (Banten).
- Circumcisions on 40 day old babies are usually held concurrently with *'marhabah'* and hair cutting ritual. Marhabah is a ritual where parents name their child and give charity to the poor as a means of conveying gratitude. In *'akekah'* or the hair cutting ritual, the head of the child will be shaved entirely. His/her hair will then be weighed, and the family will give cash charity based on the price of gold of equal weight. Usually, the family is also expected to sacrifice a goat. This series of ritual may cost a family Rp 3-7 million.

6.3.6. Effects of FGM/C

This subchapter discusses a variety of ways in which the practice of FGM/C and its norms may harm women. WHO's typology was actually formulated to gauge how different kinds of circumcision may harm women differently. [10] It is generally believed that the Type I has less adverse effects than the Type II. And the Type II is generally agreed to expose less severe harms than the Type III. However, the severity of adverse effects also relies on what and how much that is wounded or mutilated. In other words, it is possible for a case of type III circumcision to cause greater harms than another case of type I circumcision.

Physical Effects

Touching, scraping, cutting, and pitching the clitoris may cause damage depending on the intensity of the act. Bleeding is the most common sign of wounding. The damage may be even greater when capillaries are broken. Most midwives reported virtually no physi-

10 … Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO. WHO (2008)

cal side effects of female circumcision. Several midwives in Bogor Municipality compared circumcisions in Indonesia with those in Africa, which are categorized as Type II and Type III. They insisted what they practice here is not a form of mutilation like the ones in Africa.

We documented four instances of (possibly) deadly circumcisions that have occurred. First, a case where a midwife in Dumai mistook labia minora as clitoris. Second, a case in Bogor where a baby suffered from blood clotting after being circumcised by a midwife. Third, a case in Bogor Regency where the baby did not stop bleeding, possibly due to blood clotting or excessive wounding of the clitoris by the shaman. The shaman could not tell us anything further because a midwife immediately referred the baby to a hospital. Lastly, we documented a case of severe bleeding in Rangkasbitung, which led to death.

Psychological Effects

Babies usually respond with shock and crying, although not every baby does. Improper handling or restraint may traumatize the girl being circumcised. We documented one case where a person is traumatized by the circumcision she underwent in the past. Now, she experiences difficulty in having sex, and has developed abnormal anxiety over the word 'sunat'.

It is also possible that the ritual of circumcision will inflict new trauma on the mothers or brings them into a state of relapse. We try to stay open about this possibility because many mothers admitted to being unable to stand watching her daughter being circumcised. They ended up asking the grandmother to replace their role in holding and comforting the girl during the procedure. We suspect that many of them have developed unresolved and unrecognized trauma from their own personal experiences in the past. However, a separate study on this issue is required.

Sexual Effects

Generally, we failed to detect significant impairment to sexual functions that is caused by circumcision. Most of our informants admitted that they had never experienced any problems after being circumcised. To them, they are fine because they can still enjoy sex, get pregnant, and give birth.

Women who have had her clitoral glans and/or clitoral hood wounded excessively may experience less sexual pleasure. However, not every woman knows the role of clitoris in their sexual life.

> *I do not think so. Vagina is slightly on the lower side. But, the one that is circumcised is up there. The one that is circumcised is the clitoris. I do not think it [circumcision] will be disturbing [to sexual life]. The womb is down there, and the pee [urethra] is above it. On the upper side is the clitoris. There is no [effect]. The gap between [vagina and clitoris] is also far. The clitoris is up there. And the hole is down there. I do not think [circumcision] disturbs. So, women tend to please their husbands. They do not care about themselves. They do not even enjoy it sometimes. But, I do not think that is how it is supposed to be. Both must enjoy it.* (HS, a mother, 46 years old, Bogor Municipal)

Our informant thinks that low sexual satisfaction may be caused by marital rape or just the inability of their husbands to properly arouse them, disabling them from reaching orgasm. Our informants also admitted that they might be tired or just not in the mood sometimes.

However, we documented a small number of cases where sexual functions are impaired due to circumcision. A mother in Gorontalo admitted to experiencing difficulty in sex because of the excessive damaged caused to her clitoris. A midwife in Jambi also reported that one of her patients had the same complaint. Similarly, one informant in Dumai and another one in Pandeglang admitted to being unable to enjoy sex due to circumcision.

Chapter

7 Conclusions & Recommendations

7.1. Conclusions

- FGM/C is a dangerous practice, and is a form of violence against women. It violates the right to bodily autonomy first and foremost, because the decision to undergo genital mutilation or wounding is always made by the parents when their daughters are still very young. This practice also robs women of their reproductive and sexual rights because it may impair the reproductive/sexual health and cause long-term trauma. Not to mention, this ritual can be very expensive in some cases, and thus put burden on families unnecessarily.
- FGM/C is sustained and normalized for generations through a set of erroneous beliefs about female sexuality and what FGM/C can do. Oftentimes, FGM/C is treated as the marker of muslim-hood, a way of elevating the status of a Muslim as 'honorable'. This is linked to another belief that says there is something impure that is naturally present in female genitalia, which has to be removed. Our research also reveals that FGM/C may be motivated by the urge to control women's sexuality because of the notion that uncircumcised girls will grow up promiscuous. Together, these beliefs garner massive support from the public, and discourage people from opposing it. Familial and community pressure corner women even further by inflicting guilt, shame, and anxiety on women who are uncircumcised or mothers who refuse to carry on the tradition.

- However, challenging such beliefs are possible. It is reasonable to expect that people will stop practicing FGM/C once they realize it is unnecessary. The challenge lies in how to expose the risks of FGM/C to convince people to change their minds. Maternal death, for example, is a concrete problem that is easily recognized as such. And the perception of its seriousness certainly helps bring about a nationwide intervention program. Our research also documented a case where a midwife who has been made aware of the seriousness of the health risks of FGM/C stop inheriting the practice to the people she knows, especially her family. Such initiatives must be carried forward in order to activate an ambitious FGM/C eradication program.
- Unfortunately, the government does not seem to have a clear stance on FGM/C. The perfect example of that ambiguity would be the Ministry of Health's Regulation *(Permenkes)* Number 6 Year 2014, which prohibits health workers from performing FGM/C on one hand, but encourages the Council of Health and Syara'k Consideration *(Majelis Pertimbangan Kesehatan dan Syara'k - MPKS)* to formulate a guideline for female circumcision on the other hand. Not to mention, not every midwife knows about the prohibition. Some who do know about the regulation may have only heard it from a colleague, and never actually read it. We believe the socialization of Ministry of Health's Regulation (Permenkes) Number 6 Year 2014 has yet to reach all regencies and municipalities.
- Contradicting opinions confuse mothers, midwives, religious figures, and community figures, and government officials in every province and municipality/regency we studied. This confusion is understandable because most of our informants receive information uncritically by the word of mouth instead of making a thorough research. We believe the lack of clear stance on the government part contributes to this confusion.
- Midwives who refuse to provide service for circumcision are stigmatized and labelled sinful. Even when they can stand such shaming, midwives are still trapped in a difficult position. A family may look for shamans after being rejected by a midwife, potentially exposing the girl to greater health risks due to the unhygienic tools that the shaman uses.

7.2. Recommendations

- This study was conducted on provinces and regencies/municipalities with the highest prevalence of FGM/C based on National Basic Health Research (Riskesdas) 2013. Studies on other regions must be carried out in order to complete the picture of FGM/C in Indonesia.
- This study aims to partake in developing a national FGM/C eradication program, and thus helping Indonesia achieve SDG's.
- The Ministry of Health must further socialize Ministry of Health's Regulation *(Permenkes)* Number 6 Year 2014 about the Revocation of Ministry of Health's Regulation *(Permenkes)* Number 1636 on Female Genital Mutilation. The socialization must involve the regional governments as well as the Indonesian Midwives Association. The Ministry of Health should also bear the responsibility to formulate a guideline on prohibiting the medicalization of FGM/C. The guideline should detail how to involve and partner with shamans and midwives in order to create a powerful eradication program.
- The Ministry of Health along with the Ministry of Women Empowerment and Child Protection must continue making statements against FGM/C in order to raise awareness about its harms to women's sexual and reproductive health.
- Together, the Ministry of Education and Culture and the Ministry of Religion must develop a concept note on the Education of FGM/C Eradication. Students must be made aware of issues pertaining to sexual and reproductive health and the fact that FGM/C is a form of violence against women and a violation of human right. Pre-marriage education program must also cover this topic.
- The regional governments must socialize Ministry of Health's Regulation *(Permenkes)* Number 6 Year 2014 about the Revocation of Ministry of Health's Regulation *(Permenkes)* Number 1636 on Female Genital Mutilation and revoke any existing laws on FGM/C's retribution fee.
- The Ministry of Women Empowerment and Child Protection must maintain collaboration with the civil society, especially women and child organizations, in attempting to abolish this human right violation.

- In an attempt to fulfill the fifth point of SDG's, the Ministry of Women Empowerment and Child Protection must push other governmental bodies to cooperate against FGM/C. This step must include an advocacy strategy to convince community and religious figures.
- The Ministry of Religion, the Ministry of Education and Culture, Indonesia's Ulema Council (MUI), Indonesia Female Ulema Congress (KUPI) and other organization must hold a forum where existing religious interpretations of FGM/C can be dissected and criticized.
- Indonesian Midwives Association must socialize Ministry of Health's Regulation *(Permenkes)* Number 6 Year 2014 about the Revocation of Ministry of Health's Regulation *(Permenkes)* Number 1636 on Female Genital Mutilation and raise awareness of its dangers. This socialization program must target midwives in every regency/municipality and every village.
- The civil society must now focus on helping the wider public, especially religious and community figures and shamans, to understand why FGM/C is a form of violence against women that has been prohibited by the Ministry of Health's Regulation *(Permenkes)* Number 6 Year 2014.

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Glossary of Terms

Access to Healthcare

A right to access health services. Healthcare must be available to everyone, including to women, without geographical, social, economic, organizational, and language barriers. The geographical barrier can be measured by distance, travel time, transportation mode, or any other physical barriers that may inhibit someone in receiving health services.

Midwife

Anyone who has completed a series of education and training from an accredited institution to help take care of mothers and babies from pregnancy to infancy. Midwives work under the management and supervision of the Ministry of Health. They also have an association called Indonesian Midwives Association.

Baby Shaman

Anyone who is trusted to help take care of deliveries, puerperal women, and their babies. A shaman has never received formal education from any institution related to delivery and parenting. Their skills and knowledge are passed down through generations. Every region in Indonesia may have a special name for baby shaman, for

example: *'paraji'* (West Java), *'dukun kampong'* (Riau), and *'hulango'* (Gorontalo).

Durability

The ability for knowledge or a certain practice to withstand change despite resistance.

Excision

A medical term for a kind of wounding/mutilation of female genitalia used by the WHO. It refers to the partial or entire removal of the clitoris and the labia minora with or without the removal of the labia majora.

Fatwa (Religious Decree)

A decision made by an organization or a person whose authority is religiously recognized. In Indonesia, fatwa is issued by the Indonesian Ulema Council *(Majelis Ulama Indonesia – MUI)*, who is deemed responsible for providing responses or answers to any questions asked. A *fatwa* is not legally binding, although it is respected by many Indonesian Muslims.

Sexual and Reproductive Rights

A particular kind of universal human rights that is related to sexuality and reproduction. As universal rights, sexual and reproductive rights cannot be either ignored by a state or alienated from the individual. These rights intertwine with other rights and freedoms, such as the right to life, the right to health, the freedom from discrimination, the freedom from torture, including the freedom from drug experimentation, the right to privacy, the freedom to determine when to get pregnant, and the freedom from sexual violence.

The Economic, Social, and Cultural Rights

Universal basic rights that are contained in the International Covenant on Economic, Social, and Cultural Rights. Indonesia ratified the covenant in 2005 through Law Number 1 Year 2005. These rights are considered positive rights, which requires state's active involvement in its fulfillment, including in providing decent living, healthcare, education, etc.

Civil and Political Rights

Basic universal rights that are stipulated in the International Covenant on Civil and Political Rights. Indonesia ratified the covenant

in 2005 through Law Number 12 Year 2005. These rights are considered negative rights, which requires the state to refrain from interfering with them, including in freedom from torture and slavery and the right to assembly.

Sexually Transmitted Diseases (STDs)

Diseases that spread through a sexual contact with another person who has been previously infected. The sexual contact includes—but is not limited to—sexual intercourse, oral sex, and anal sex.

Infibulation

A medical term for a particular type of wounding/mutilation of female genitalia that is used by the WHO. It refers to the tightening of the vulva by modifying the labia minora or the labia majora. Suturing of the vulva and clitoridectomy may be involved as well.

Policy Paper

A particular kind of research that evaluates existing or planned policies and explores policy alternatives.

Sexual Violence

A type of violence against women that is related to sexuality.

Violence against Women

Any gender-based act that causes physical, sexual, verbal, and psychological suffering of a woman. Violence against women may include the threat of violence, coercion, or deprivation.

Inequality of Rights

Inequality in the attainment of rights, especially in the context of inequality between men and women.

Reproductive Health

A state of physical, mental, and social prosperity in relation to the reproductive system, functions, and roles (International Conference on Population and Development, 1994)

Sexual Health

A state of physical, mental, and social prosperity in relation to sexuality. This may include the state of being free from diseases, but is not limited to it.

Clitoridectomy

Partial or total mutilation of the clitoris, or in some cases the mutilation of the prepuce (the clitoral hood).

Clitoris

A medical term for a small, sensitive, and erectile part of the female genitals at the anterior end of the vulva. Clitoris is also known as 'kelentit' in Indonesian. It is sensitive because it contains many nerve endings.

International Human Rights Conventions

Worldwide agreements between states on human rights.

Female Victim

A victim of violence against women. The forms of violence women may suffer may include physical, psychological, or financial neglect.

Health Service

A provision of service with the aim of improving human's health

Handling

Comprehensive treatment for female victims that is directed towards reaching recovery and attaining the victim's rights.

Comprehensive Sexuality Education

A type of education that covers all aspects of sexuality, including its physicality, biology, sociology, and psychology, and is given to children and adolescence with the aim of enabling them to take control over their sexuality and to enjoy it. This type of education must be comprehensive to be helpful for children, covering both their emotional and social contexts, to enable them to acquire life skills which are useful to develop positive values and behaviors.

Knowledge

Information that is known by someone who is aware of the presence of that information. Knowledge may be acquired from and is usually a combination of personal experiences, education, social environment, etc.

Experience

A combination of knowledge and skills that are acquired from and is practiced through direct involvement in certain activities.

Female Genital Mutilation/Cutting (FGM/C)

A physical and symbolic wounding of female genitalia. FGM/C is a form of violence against women and a violation of women's and children's rights. FGM/C may be called differently in different regions. In Pandeglang and Rangkasbitung Regencies, FGM/C can be referred as *'nyepitan'* or *'sepitan'*, although the majority of people simply call it *'sunat perempuan'* or *'khitan perempuan*'. In West Lombok, it is named 'suci'. In Gorontalo, it is referred as *'mandi lemon', 'cubit kodok, 'lihololimo/molu bingo'*. In West Sulawesi, it is called *'mansunna'. 'Basunat'* or *'Besunat'* are used in Dumai, South Kalimantan. In many other regions, including West Java, Jambi, Riau, Bangka Belitung, and East Kalimantan, FGM/C is simply called *'khitan perempuan'*.

Retribution Law

A regional law that regulates fees for health services in public health facilities, including in *Puskesmas* (Community Health Center) and hospitals. Fees that are applied are intended to cover various needs, including the services of the health workers, the administration fee, and the regional tax. Private hospitals, private clinics, and independent practices are not bound to this law.

Permenkes

A regulation issued by the Ministry of Health in response to a health issue/problem.

Behavior

A patterned human activity in public or in private settings.

Policy Minutes

A summary of policy paper written in a manner that is short and clear. A policy minutes is intended to help stakeholders to make policy decision and develop a policy brief.

Attitude

An evaluative statement about an object, a person, a group of persons, or a phenomenon. Attitude reflects the individual's subjective judgement.

Perception

A series of acts that consist of structuring, recognizing, and interpreting any sensory information with the aim of building a picture

or an understanding about an environment. Past experiences help build our perceptions, and therefore make perceptions subjective.

Decision Making

The action of selecting one option out of many other alternatives. It is the result of a mental/cognitive process.

Medical Intervention

A health worker's act or attempt of caring for a patient to maintain their health or help them recover from sickness. This may include an act as simple as treating wounds.

Typology

A classification based on similarities and differences in character. In the context of FGM/C, the typology was formulated by the WHO, who subdivides FGM/C into four kinds.

Religious Figure

Anyone who possesses a considerable amount of knowledge in any theology of a religion. In the context of Islam in Indonesia, a religious figure is usually a graduate of a religious school or a *'pesantren'* (Islamic boarding school), and esteemed by his/her community. They play a role in FGM/C considering that the practice is commonly regarded as an Islamic tradition.

Community Figure

Anyone who is respected in a community, and whose opinions or wisdoms are sought for by the community members. There is no formal way of becoming a community figure.

Vagina

A tube leading from the external genitalia to the cervix of the uterus. Vagina may take different shapes and sizes.

Variety

The state of being different or diverse. In this report, variety is used in the context of price differences in carrying out FGM/C, the practice's different effects [of FGM/C] on different women and and different traditions from one place to another.

Vulva

The female external genitalia that consists of the urethral meatus, vagina, labia majora, labia minora, clitoris, Bartholin glands on both sides of the vagina.

Appendix

Appendix 1:
FGM/C Qualitative Research Manual

Introduction

The Ministry of Health issued a circular of Director General of Public Health Education number HK.00.07.1.3.1047a, year 2006 intended to prohibit female genital mutilation. In 2008, MUI responded with a religious decree *(fatwa)* of the Indonesian Ulema Council *(Majelis Ulama Indonesia—MUI)* number 9A year 2008 that discusses the Islamic interpretation of the practice. MUI believes that female genital mutilation is *'makrumah'* or honorable, and prohibiting it is an act against Islam. However, it is noteworthy that the Muhammadiyah, another influential, Islamic organization in Indonesia, disagrees with the *fatwa* (religious decree).

The disagreement eventually pushed the Ministry of Health to issue Regulation on Female Genital Mutilation/Cutting Number 1636 on 15 November 2010. But, instead of explicitly condemning FGM/C, the regulation endorses the practice in the name of the girls' own security and safety and details a procedure to guide health workers in carrying out the mutilation/cutting.[1] Our research is therefore undertaken with the following considerations:

[1] Compilation of Position Papers and Policy Study 2010 - 2013 (2014). National Commision of Violence Against Women (Komnas Perempuan).

1) This research tries to partake in the attempt of fulfilling SDG's, where FGM/C is considered one of the dangerous cultural practices that needs to be eliminated by 2030.
2) This research takes into account the fact that FGM/C is still prevalent in many regions in Indonesia based on 2013 basic health research *(Riskesdas)*.
3) This research is also motivated by the fact that many regions in Indonesia include FGM/C in their healthcare retribution laws.

Methodology

- This research is a qualitative, multidisciplinary research that combines several research methods, including several feminist research methods and policy research method.
- We analyze the practice of FGM/C and the relevant domestic laws by using the feminist perspective and the human rights framework.
- Our data collection methods are desk study, in-depth interviews, focus group discussions (FGDs), and feminist oral history or oral *herstory*.
- Desk study: tracing the history of FGM/C worldwide and in Indonesia, including the policy dynamics, traditions, religious interpretations, and relevant feminist, advocacy efforts.
- Oral *herstory* is used to try to picture the life cycles of women, including the traditions they go through from birth until marriage.
- We try to sharpen our methodology by consulting with human rights experts, religious figures, health workers, and social researchers.

Research Scope

This research is conducted in 10 provinces in Indonesia. Seven of them has the highest prevalence rate of FGM/C in Indonesia according to the 2013 basic health research *(Riskesdas)*. The rest are regions that include female circumcision in their healthcare retribution laws. Because by including the practice in their retribution laws, they recognize and support the tradition of female genital mutilation. The 10 provinces are:

Province	Regencies/ Municipalities	Data Collection	FGD Schedule*
Bangka Belitung	East Belitung	10-14 April 2017	Monday, 17 April 2017
	South Bangka	15-19 April 2017	Thursday, 13 April 2017
South Kalimantan	Barito Kuala	10-14 April 2017	Thursday, 13 April 2017
	Banjar	15-19 April 2017	Monday, 17 April 2017
West Java	Bogor	10-19 April 2017	Thursday, 20 April 2017
	Bogor Municipality		Thursday, 13 April 2017
Banten	Pandeglang	10-19 April 2017	Thursday, 13 April 2017
	Lebak		Tuesday, 18 April 2017
East Kalimantan	Samarinda	25-30 April 2017	Tuesday, 25 April 2017
West Nusa Tenggara	West Lombok	25-30 April 2017	Wednesday, 26 April 2017
Jambi	Jambi	25-30 April 2017	Thursday, 27 April 2017
Gorontalo	Bone Bolango	2-6 Mei 2017	Friday, 5 Mei 2017
	North Gorontalo	7-11 Mei 2017	Saturday, 6 Mei 2017
West Sulawesi	Majene	2-6 Mei 2017	Thursday, 4 Mei 2017
	Polewali Mandar	7-11 Mei 2017	Monday, 8 Mei 2017
Riau	Meranti Islands	2-6 Mei 2017	Thursday, 4 Mei 2017
	Dumai Munipacility	7-11 Mei 2017	Monday, 8 Mei 2017

*) tentative

Data Collection (Interviews and FGDs)

We will begin this research by contacting our partners who reside in the target regions to act as research gatekeepers. We will then coordinate with them to schedule interviews and FGDs. The research will be underway immediately after.

Meeting the gatekeepers will be the first thing we do at the field. Whenever possible, we will also arrange a meeting with the coordinator of the quantitative research team (Centre for Population and Policy Studies of Gadjah Mada University - PSKK UGM) to discuss our progresses and plan ahead accordingly. During the meetings, we expect to talk about women who potentially qualify to be our

informants for the oral history. If the field coordinator cannot find at least one informant, Komnas Perempuan will have no choice to look for one ourselves. The interviews and FGD's will take place afterwards based on the pre-determined dates and times, although some changes will be very likely to happen.

During the interviews and FGDs, the gatekeepers are expected to remain with the researchers. Because there is a possibility that some of the informants do not speak Indonesian fluently or not at all. In such event, the gatekeepers, who can speak the local language, may help interpret the conversation.

After the interviews, informants will receive souvenirs that have been prepared previously by the researchers. Researchers can start writing the report afterwards.

Gatekeeper

- Researchers contact gatekeepers for help
- Gatekeepers will help the researchers to connect with the potential informants and plan where the interviews/FGD's will take place
- Gatekeepers should be ready to act as interpreters when needed
- It is best to let researchers contact and invite the informants directly for efficiency
- A gatekeeper must be able to fulfil the following criteria:
    - Understand women issues, especially female circumcision
    - Raised in the area and possess local knowledge
    - Familiar with the region
    - Know the potential informants
    - Willing to be available for this research project
- There may be more than one gatekeeper in one, depending on how many informants there are and the availability of people who are willing to be a gatekeeper. We pay gatekeeper Rp 125,000 per day
- Gatekeeper will receive TOR related to their work, including the background of the research, our expectations of the informants, trip plans, etc.

Interviews

There are six parties that we need to interview with a total of 12–15 people:

- Mothers aged 15–49 years old
    - 3 mothers whose daughters are circumcised
    - 1 mother whose daughters are uncircumcised
- The regional government:
    - 1 staff of the Public Health Office of the Regency/Municipality
    - 1 staff of the Legal Department of the Regional Secretariat of the Regency/Municipality
- Midwife:
    - 1 midwife from a maternity hospital/labor & delivery
    - 1 staff of the regional Indonesian Midwives Association
- Religious figure/tribal figure/community figure:
    - 1 woman
    - 1 man
- Shaman (2 persons)
- Educators or religion teachers who endorse female circumcision. The person may also be a religious, tribal, or community figure at once (1 person).

Besides asking the research questions as previously determined, the researchers are expected to be sensitive about many other cues, including:

- The psychological state of the informant.
- Body language/gesture and facial expressions.
- The location of the interviews.
- The physical and the psychological well-being of the interviewer.

Notes:

- Interviews may be conducted one on one or together (in a team). Please adapt to the situation at the field.
- Remind the informants before the interview at least one day before it takes place.
- Prepare 1–2 back-up informants in case some informants cannot make it on the D-day.

Focus Group Discussion

Komnas Perempuan will work together with the regional offices of the Indonesian Midwives Association (IBI) to invite local midwives to FGDs. Midwives who have participated in the in-depth interviews will be disqualified from participating in the FGDs for the sake richness of our data. Midwives who participate in the FGD is also expected to be able to represent the regency/municipality where they work.

Komnas Perempuan will send letters of invitation to 10–15 midwives who have been recommended by IBI to participate in the FGD as scheduled by Komnas Perempuan. The midwives will be asked to RSVP to a person whose contact will be detailed in the invitation. Venue for the FGD does not have to be special as long as it can accommodate the number of people participating and has a conducive environment. It would be very convenient for us if we can use one of IBI's office room.

The FGD will be moderated by one of Komnas Perempuan's commissioners, who will be helped by a research associate. Gatekeeper is expected to help around before and during the FGD, especially for the logistics. There is a total of 20 people who will participate in the FGD. Food and beverages will be thought about later along with the venue reservation.

Interpreter

An interpreter will help ease the interview when an informant cannot speak Indonesian fluently. Our pre-test reveals that an interpreter may be too active or passive in bridging the interaction, and therefore possibly distort the output of the interview. We think, it is best to make sure when an interpreter is really needed. If it is truly impossible to carry out the interview without an interpreter, the researcher must firstly brief the interpreter and caution her/him

from straying too far from the original answers. To further improve accuracy, the researcher may show the interpreter the research questions beforehand. The interpretation must also be provided promptly after several sentences to make sure that the interpreter will not lose track of, forget, or reduce some answers.

Additions

Pictures and Videos

Komnas Perempuan will take pictures and videotape FGM/C rituals in some regions: Banten, South Kalimantan and Gorontalo. They will be done solely for the purpose of visual documentation.

Komnas Perempuan will also document other miscellaneous activities or objects, such as the location of the circumcision, the tools used, etc. This is important to help the research team describe the practice of FGM/C in Indonesia and enrich the research report with visual data.

Souvenirs

A bag of souvenirs will be given to each interview participant. But, they will not be given to the FGD's participants.

Tools to Bring to the Field

- Final revision instruments
- A voice recorder
- A notebook
- Souvenirs

Transportation and Accommodation

We will arrange the transports and the accommodations with the gatekeepers.

Appendix 2:

Research Instruments

Introduction

Good morning/afternoon/evening, Ibu. My name is … from the National Commission on Violence against Women, also known as 'Komnas Perempuan'. I come here today to see Ibu for a research project about rituals that women have to undergo.

I come here to ask you about rituals that women have to undergo in their lives from birth until marriage, the motives for the rituals, and how they are carried out. The information will be used to develop child and maternal health programs, which will later be useful for the people here. I will not be judging your answers. There is no right or wrong answers. You are free to say whatever you feel. I ask for your willingness to take part in this interview. Your willingness must be voluntary. I give you freedom to continue or quit this interview.

(Ask them further about female circumcision once she mentions it. If she does not say anything about female circumcision, then ask her about it.)

Procedure:

(The researcher must be sensitive to all cues, including facial expressions, gestures, the informant's living condition, etc.)

I would like to ask for your permission to use a tape recorder so that I can take note of everything that you say. And I will also guarantee the confidentiality of your statements. If you feel uncomfortable, please say so.

List of Questions for Mothers

Profile:

1. Name :
2. Address :
3. Years of living here :
4. Place of origin :
5. Husband's place of origin :
6. Phone number :
7. Religion :
8. Ethnicity/tribe :
9. Age :
10. Education :
11. Job :
12. Number of child :

No.	Children's sex	Children's age

Informant's Knowledge about and Attitude towards Female Circumcision

Knowledge

1. What is the local term for female circumcision?
2. What do you know about female circumcision?
3. Where do you know about female circumcision? (Probe more on the source of the information)
4. Since when is it practiced here?
5. Does/did the place where you used to live also practice female circumcision?
6. At what age are people usually circumcised?
7. Where is it usually performed?
8. Who carries out the circumcision?
9. Have you ever heard anything about female circumcision from a midwife/shaman/health worker?

10. If yes, when did you hear it?
11. Did you fully understand the explanation?
12. How is female circumcision carried out here?
13. What do you know about the benefits of female circumcision?
14. What do you know about the consequences of being uncircumcised? Will there be different treatments? (the researcher may improvise)

Attitude

1. What is your opinion on female circumcision? Why?
2. If you have never undergone female circumcision, why do you practice it now?
3. When do you think is the best time to perform circumcision?
4. What do you think is the best way to perform it?
5. Do you agree with the explanation given by the shaman/midwife/health worker?
6. What do you hope from the circumcision?
7. Will you recommend the circumcision to other girls?

Mother–Daughter Experiences

Mother's Experience

1. Have you undergone female circumcision?
2. When was it? At what age
3. Why were you circumcised?
4. Who circumcised you?
5. Where were you circumcised?
6. Do you remember the process? Has anyone ever told you the story?
7. How long was the process?
8. What was used for the circumcision?
9. How much did it cost your parents?

Physical and Psychological Effects of Circumcision on the Mother

1. What did you experience after being circumcised?
2. (When needed, ask this) Did you experience bleeding/fever/anything inconvenient?
3. How did you or your parents handle that?
4. What did you remember before the circumcision?
5. Are there any other complaints after being circumcised?
6. Do you think female circumcision affects your sexual life?

Daughter's Experience

1. How many of your daughters who have been circumcised?
2. Do you remember when were and at what age your daughters were circumcised?
3. Why did you circumcise them?
4. Did you use the same service and tools for all of the circumcisions?
5. Where were they circumcised? Why?
6. How much did that cost you?
7. Who performed the circumcision?
8. What did you hear from the midwife/health worker/shaman before the circumcision? (to assess the informed consent)
9. Did the shaman/health worker/midwife made a recommendation before they performed the circumcision?
10. Could you please detail how the circumcisions were carried out? Which part was wounded/removed, if any?
11. What did they use for the circumcision?
12. Did you witness the process?
13. How were your daughters during the circumcision?
14. What do you think or how do you feel about the procedure?
15. Did the shaman/health worker/midwife tell you anything about the aftercare?
16. Who decided the circumcision and how it was carried out?

Physical and Psychological Effects on the Daughter

1. How was the condition of your daughter after being circumcised? Was there any bleeding, fever, or anything inconvenient?
2. How did you handle or treat that?
3. Did she complain about anything awhile after the circumcision?
4. How did the circumcision affect your daughter?
5. Do you think the circumcision influences your daughter now? In what way? (E.g., trauma)
6. Has your daughter ever told you that the circumcision affects her marriage or sexual life? (In case her daughter is married)

Source of Information on Female Circumcision

1. Are you involved in an organization/group/community? (E.g., Koran study group).
2. How often do you meet them? How long each meeting usually lasts?
3. What is the name of that group/organization?
4. Is female circumcision discussed in the group/organization/community?
5. Is there anyone within the organization/group/community who supports female circumcision?
6. What are their reasons to endorse female circumcision? (If he/she is a religious figure, what religious ground that he/she uses to support. If she/he is a tribal/community figure, what local wisdom that he/she uses to support it?
7. What are the consequences of going against their advice?

Understanding on Sexuality

1. Do you believe that female circumcision is related to female sexuality, including but not limited to sexual life, the genitalia, hormones, menstruation, etc.?
2. How is your sexual life with your husband?
3. Do you think female circumcision affects your sexual life? (probe into whether she experiences orgasm)

Family Support

1. What do your relatives think of female circumcision?
2. Do your relatives support your decision to perform or not perform circumcision?
3. How do they express their support or disapproval?

Knowledge about the Laws on Female Circumcision

1. Do you know anything about the laws on female circumcision?
2. If yes, then what do you think of that law?
3. Do you think the government should preserve or abolish female circumcision?
4. Who do you think should abolish or preserve the practice?

List of Questions for Shamans

Profile

- Name :
- Age :
- Ethnicity/tribe :
- Religion :
- Education :
- Years of being a shaman :
- Years of living here :
- Other jobs :
- Phone number :
- Address :

Knowledge about Circumcision

1. Have you ever heard of female circumcision?
2. How do people call female circumcision? (Mention the typical characteristics of female circumcision first)
3. What do you personally think of female circumcision? Why?
4. Who usually tells mothers to circumcise her daughters? Why?

Practice

1. How is circumcision carried out here?
2. What if a person chooses to remain uncircumcised?
3. Why do people practice female circumcision? Religion? Ancestral beliefs?
4. Who tells mothers to circumciser her daughters?
5. How much does circumcision cost?
6. At what age are women/girls are usually circumcised? Why?
7. What are the rituals before and after the circumcision, if any?
8. How do you usually perform circumcision? What are the steps? (Probe what is being cut or wounded, if any)

Post-circumcision Complication

1. Have you ever received a complaint after a circumcision? What did you do? Or what would you do?
2. How do/would you treat a complication? What tools are you going to use?

Knowledge about the Laws on Female Circumcision, Its Religious Interpretations, or Relevant Tribal Laws

1. What do you know about the national and regional laws on female circumcision? What do you think?
2. What do you know about the religious interpretation of female circumcision? What do you think?
3. What do you know about the tribal laws on female circumcision? What do you think?
4. What do you think about female circumcision in general? Do you think the government should abolish or preserve it?
5. Who do you think should be responsible for its eradication or its preservation?
6. How did you know about the national, regional, religious, and/or tribal laws on female circumcision?
7. Have you ever received or heard of any socialization programs about any of those laws?

List of Questions for Health Workers/Midwives

Profile

- Name ` :
- Address :
- Age :
- Ethnicity/tribe :
- Religion :
- Education :
- Other jobs :
- Place of origin :
- Years of working :
- Years of working in this region :
- Mobile phone :

Practice

1. How is female circumcision usually carried out here?
2. What are the reasons which are apparent in the society with regard to the decision to circumcise or not circumcise their daughters?
3. Are there any ancestral/religious beliefs that are involved?
4. What do you personally think of the practice?
5. How long has it been practiced in this region?
6. At what age are people usually circumcised?
7. Where is it usually carried out?
8. How much does it cost? Why? What is that money for? Who sets the price?
9. Who usually endorses circumcision or asks to be circumcised?
10. Who usually performs circumcision? Have you ever performed it yourself? Why?
11. If you have, where and how did you learn to perform female circumcision? Have you ever received any formal training or education?
12. Do you ask for the parents' permission before circumcising their daughters?
13. How do you ask for permission? What do you say?
14. Do you offer delivery-circumcision bundle ere?
15. What are the medicines that you prepare prior to and after the circumcision?

16. Could you walk me through your steps to circumcising girls? (The specific steps, the tools, the duration, and how the steps differ from when it is performed by a shaman)
17. Do the patient's family watch the procedure?
18. Do you think there are effects to women's health?
19. Has anyone ever complained to you due to complication after being circumcised?
20. Could you please describe the complication? (Was there bleeding/fever/death involved?)
21. How did you handle the complication? Did you refer them to anyone else, possibly a hospital?
22. Are there any differences with how female circumcision used to be performed and how it is performed now?
23. Why do you think such changes happen?

Knowledge about the Laws on Female Circumcision, Its Religious Interpretations, or Relevant Tribal Laws

1. What do you know about the national and regional laws on female circumcision? What do you think?
2. What do you know about the religious interpretation of female circumcision? What do you think?
3. What do you know about the tribal laws on female circumcision? What do you think?
4. What do you think about female circumcision in general? Do you think the government should abolish or preserve it?
5. Who do you think should be responsible for its eradication or its preservation?
6. How did you know about the national, regional, religious, and/or tribal laws on female circumcision?
7. Have you ever received or heard of any socialization programs about any of those laws?
8. Do you report to the Public Health Office that you provide service for female circumcision? (We want to know whether the regional government is aware of this practice)
9. How do you cope with the high demand of female circumcision after knowing about the existing laws?

Organizational or Religious Affiliation

1. Are you involved in an organization/group/community? (E.g., Koran study group, professional association).
2. How often do you meet them? How long each meeting usually lasts?
3. What is the name of that group/organization?
4. Is female circumcision discussed in the group/organization/community?
5. Is there anyone within the organization/group/community who supports female circumcision?
6. What are their reasons to endorse female circumcision? (If he/she is a religious figure, what religious ground that he/she uses to support. If he/she is a tribal/community figure, what local wisdom that he/she uses to support it?

Migration (If the Midwife Moves Around for Work)

1. How is female circumcision performed at your place at origin?
2. Is there any link between female circumcision that is practiced there with the one here?
3. How has it been happening?

List of Questions for Tribal/Community/ Religious Figures

Profile

- Name :
- Age :
- Address :
- Duration of stay :
- Place of origin :
- Phone number :
- Education :
- Other jobs :
- Ethnicity/tribe :
- Religion :
- Role within the community :
- Affiliated organization :

(researcher's note: ask about what organization they are or have been a part of, their role within the organization, year, etc.)

Knowledge about Female Circumcision

1. How do people call female circumcision?
2. What do you know about female circumcision?
3. How long has it been practiced here?
4. Who performs it?
5. Where is it usually performed?
6. At what age are people usually circumcised?
7. Who tells parents to circumcise their children? Why?
8. Why do people practice female circumcision here? (What convinces them to do so?)
9. What do people think about the practice? Are there any disagreements? Why? How do you handle it as a figure here? (probe about the alternative interpretations to female circumcision)
10. How is the tradition usually carried out? What are the rituals involved? What are the tools used?
11. What do you know about the benefits of female circumcision?
12. What do you know about the effects of being circumcised? If a person chooses to remain uncircumcised, what would happen?

(probe about the social sanctions)

13. Would you recommend female circumcision? Why?
14. Could you please elaborate about the ritual of female circumcision here?

Knowledge about the Laws on Female Circumcision, Its Religious Interpretations, or Relevant Tribal Laws

1. What do you know about the national and regional laws on female circumcision? What do you think?
2. What do you know about the religious interpretation of female circumcision? What do you think?
3. What do you know about the tribal laws on female circumcision? What do you think
4. What do you think about female circumcision in general? Do you think the government should abolish or preserve it?
5. Who do you think should be responsible for its eradication or its preservation?

List of Questions for the Government Officials

Profile

- Name :
- Address :
- Age :
- Ethnicity/tribe :
- Religion :
- Education :
- Position/Rank :
- Years of working :
- Phone number :

Knowledge about Female Circumcision

1. How is female circumcision practiced here?
2. How long has it been practiced here?
3. At what age are people usually circumcised?
4. Where is it usually performed?
5. Who performs it?
6. At what age are people usually circumcised?
7. What are the common parent's reasons to circumcise or not circumcise their daughters?
8. Why do people practice female circumcision here? (What convinces them to do so?)

Policies on Female Circumcision

1. What do you think about female circumcision? (Probe about its benefits and effects)
2. Are there any laws on female circumcision here? (E.g., the retribution law, which include female circumcision)
3. Are there any laws on female circumcision above the regional laws?
4. Are you aware of the national or regional laws on female circumcision? If you are, what do you think?
5. What are the government's considerations to include female circumcision in the retribution law? Does the law charge reparation fee for the male circumcision, female circumcision, or both?

6. How much does it cost to perform female circumcision? Who sets the price?
7. How is the fee allocated in detail? How much of it goes to tax, to the hospital/clinic, to the midwife, or anything or anyone else?
8. Is circumcision one bundle with delivery service?
9. How effective is that law?
10. Do you think the practice should be abolished or preserved by the government? Why?
11. Who do you think should abolish or preserve the practice?
12. Where and how did you learn about the laws and/or the religious interpretations?
13. Has there ever been a public socialization program about the laws?

Focus Group Discussion Guideline

Participants

Midwives/paramedics, researchers, and Komnas Perempuan's commissioner, who acts as the moderator.

FGD Preparation

The gatekeepers and the research team will invite the participants, book the venue, and check the facilities of the building. They will also be responsible for the logistics of the event: papers, markers, whiteboard, camera or video recorder, etc.

The Process

1. The facilitator will firstly introduce him/herself, briefly explain the National Commission on Violence against Women (Komnas Perempuan), the research project, and the FGD.
2. To break the ice, the moderator will ask every participant to introduce him/herself. We will also be explicit about the principles under which the FGD will proceed. (A) EQUALITY means every participant must be treated equally. (B) PARTICIPATION means everyone must actively participate in the discussion, and voice out whatever one thinks or feels. (C) SPONTANEITY means everyone must speak spontaneously, honestly, critically, and responsibly.
3. If the large group discussion does not seem to be conducive, the participants may be subdivided into smaller groups (each consisting of 3), and asked the smaller groups to discuss different questions.
    a. How is female circumcision practiced here?
    b. Why do people practice female circumcision here? Please elaborate!
    c. At what age are people usually circumcised?
    d. Do you perform female circumcision? Why? Please elaborate!
    e. How do you perform it? What parts are removed or wounded, if any? Please elaborate!
    f. Do you inform anything to the parents (or the patient if she is old enough) before performing the circumcision? What exactly do you tell them?

g. Has anyone ever suffered from complication because of being circumcised? For example, bleeding, pain, etc.? How did you handle the complication?
h. Have you ever been officially trained to perform female circumcision? How did you first learn about it?
i. Have you ever discussed female circumcision with your colleagues? How did it end? What does the discussion entail?
j. Are there any local laws on female circumcision? Could you mention the laws?
k. Does the reparation fee apply to female circumcision? Do you know where the fee will go to or how it will be used?
l. Have you heard or experienced any negative remarks about you or poor treatments against you for refusing to perform female circumcision? Why do you think that happened?

Convey gratitude for the participation and please do not finish the discussion with any concluding remarks.

Please tell the participants that they can raise questions about Komnas Perempuan and the research project after the discussion.

The moderator will thank everyone for their participation. And do not forget to say sorry for any mistakes made during the FGD.

Appendix 3:
List of Informants

Mothers

	Initial	Age	Education	Job	Ethnicity	Interview Location	Date of Interview
1	ES	50+	-	Housewife	Sundanese	Batunungku, Pandeglang	April 2017
2	K	40	Elementary education	Housewife	Sundanese	Batunungku, Pandeglang	April 2017
3	NRF	49	Bachelor's	Madrasah teacher	Sundanese	Menes, Pandeglang	April 2017
4	A	35	Bachelor's	Madrasah teacher	Sundanese	Menes, Pandeglang	April 2017
5	R	41	Bachelor's	Pesantren manager	Sundanese	Menes, Pandeglang	April 2017
6	AN	27	Upper secondary	Shopfront Attendant	Sundanese	Maja, Lebak	April 2017
7	SR	22	-	'Warung' Owner	Sundanese	Rangkasbitung, Lebak	April 2017
8	OL	29	Lower secondary	Housewife	Sundanese	Rangkasbitung, Lebak	April 2017
9	LF	35	Upper secondary	Farm Owner	Sundanese	Maja, Lebak	April 2017
10	SA	34	-	Bamboo Craftsman	Sasak	Gunung Sari, West Lombok	April 2017
11	DA	39	-	Bamboo Entrepreneur	Sasak	Gunung Sari, West Lombok	April 2017
12	R	41	Doctor's	Lecturer	Sasak	West Lombok	April 2017
13	M	37	Elementary education	Head of Posyandu	Sasak	Sekotong, West Lombok	April 2017
14	S	40	Did not complete elementary ed	Housewife	Sasak	Sekotong, West Lombok	April 2017
15	MNA	40	Bachelor's	Lawyer	Minang-Java	Jambi	April 2017
16	R	65	Upper secondary	Private sector employee	Java	Jambi	April 2017

17	K	40	1 year diploma Program	Private sector employee	Malay	Jambi	April 2017
18	J	59	Upper secondary	Housewife, Activist	Betawi	Danau Teluk, Jambi	April 2017
19	NS	44	Master's	NGO Staff	Bataknese	South Jambi, Jambi	April 2017
20	DR	42	Bachelor's	NGO Staff	Minangkabau	East Jambi, Jambi	April 2017
21	HH	40	-	Housewife	Flores	Danau Sipin, Jambi	April 2017
22	R	47	Did not complete elementary ed	Janitor	Flores	Danau Sipin, Jambi	April 2017
23	F	35	-	Janitor	Flores	Danau Sipin, Jambi	April 2017
24	j	60	Elementary education	Housewife	Sundanese	Bogor Municipality	April 2017
25	F	49	Upper secondary	Housewife	Sundanese	Bogor Municipality	April 2017
26	HS	46	Lower secondary	Cadre of Family Welfare Movement	Sundanese	Bogor Baru, Bogor Municipality	April 2017
27	AP	28	Bachelor's	Housewife	Banten	Cibinong, Bogor Regency	April 2017
28	AI	36	3 year diploma program	Housewife	Malay-Sundanese	Bojong Gede, Bogor Regency	April 2017
29	DS	38	Upper secondary	Housewife, Tailor	Java	Bojong Gede, Bogor Regency	April 2017
30	ER	49	Upper secondary	Housewife	Sundanese	Bojong Gede, Bogor Regency	April 2017
31	RL	53	Upper secondary	Former private sector employee	Sundanese-Betawi	Bojong Gede, Bogor Regency	April 2017
32	R	37	Vocational education	Housewife	Kutai-Java	Lambung Mangkurat, Samarinda	April 2017
33	TU	27	Vocational education	Marketer	Java	Samarinda	April 2017
34	D	45	Upper secondary	Janitor	Banjar	Samarinda	April 2017
35	P	31	Lower secondary	Housewife	Java	Banjar	April 2017
36	SHP	43	Bachelor's	Lawyer	Banjar	Banjar	April 2017

37	EA	41	Bachelor's	Teacher	Java	Gambut, Banjar	April 2017
38	DP	33	Elementary education	Farmer	Banjar	Barito Kuala	April 2017
39	G	33	Lower secondary	Merchant	Banjar	Barito Kuala	April 2017
40	E	49	Upper secondary	Public servant	Banjar	Martapura, Banjar	April 2017
41	S	63	Lower secondary	Housewife	Malay	Manggar	April 2017
42	S	50	Lower secondary	Housewife	Malay	Manggar	April 2017
43	A	48	Lower secondary	Housewife	Malay	Manggar	April 2017
44	H	39	Upper secondary	Housewife	Malay	Manggar	April 2017
45	A	21	Lower secondary	Housewife	Malay	Teladan Dalam, Toboali	April 2017
46	CO	25	Vocational education	Housewife	Chinese-Indonesian	Teladan, Toboali	April 2017
47	M	40	Bachelor's	Teacher	Malay	Toboali	April 2017
48	N	49	Bachelor's	Public servant	Malay	Bukit Kapur, Dumai	May 2017
49	-	-	Elementary education	Housewife	Sakai	Mataram, Dumai	May 2017
50	S	41	Bachelor's	Public servant	Malay	Medan Kampai	May 2017
51	D	26	Bachelor's	Public servant	Malay	Sungai Sembilan, Dumai	May 2017
52	RR	36	Bachelor's	Dentist	Minang-Malay	Selat Panjang, Meranti Islands	May 2017
53	LR	35	Upper secondary	Doctor's assistant	Malay	Selat Panjang, Meranti Islands	May 2017
54	E	34	Lower secondary	Housewife	Malay	Selat Panjang, Meranti Islands	May 2017
55	S	-	Upper secondary	Housewife	Java	Sesap, Meranti Islands	May 2017
56	HB	39	Bachelor's	Midwife	Gorontalo	Puntolo Atas, North Gorontalo	May 2017
57	YH	48	Elementary education	Housewife	Gorontalo	Titido, North Gorontalo	May 2017
58	FB	49	Upper secondary	Cadre of a political party Partai	Gorontalo	Kwandang, North Gorontalo	May 2017

59	ANA	44	Upper secondary	Housewife	Manado	Kwandang, North Gorontalo	May 2017
60	SMS	26	Upper secondary	Housewife	Gorontalo	Kabila, Bone Bolango	May 2017
61	RH	35	Vocational education	Kindergarten Teacher	Gorontalo	Olohuta, Bone Bolango	May 2017
62	MA	40	1 year diploma program	Cadre of Posyandu	Gorontalo	Pauwo, Bone Bolango	May 2017
63	HK	33	Elementary education	Janitor	Gorontalo	Pauwo, Bone Bolango	May 2017
64	R	39	Upper secondary	Honorary Government's Employee	Mandar	Banggae Majene	May 2017
65	D	-	Upper secondary	Housewife	Mandar	Banggae, Majene	May 2017
66	H	52	Upper secondary	Housewife	Mandar	Luyo, Polewali Mandar	May 2017
67	S	35	Lower secondary	Housewife	Pattae	Andreapin, Polewali Mandar	May 2017
68	DM	28	Bachelor's	Clothing business	Bugis-Mandar	Mapili, Polewali Mandar	May 2017

Midwives/Health Workers

	Initials	Age (yrs)	Education	Work Experience (yrs)	Ethnicity	Interview Location	Date of Interview
1	AS	51	4 year diploma program	22	Sundanese Banten	Menes, Pandeglang	April 2017
2	TA	45	3 year diploma programl	23	Sundanese Banten	Menes, Pandeglang	April 2017
3	M	42	4 year diploma program	21	Sundanese Banten	Maja, Lebak	April 2017
4	SK	28	3 year diploma programl	1	Sundanese Banten	Maja, Lebak	April 2017
5	LM	46	4 year diploma program	21	Sundanese Banten	Rangkasbitung, Lebak	April 2017
6	SS	35	3 year diploma program	5	Sasak	Gunung Sari, West Lombok	April 2017
7	Y	37	Bachelor's	10	Sasak	Gunung Sari, West Lombok	April 2017
8	LM	44	Midwifery Education	24	Malay	Kurnia Jaya, Manggar	April 2017

9	RS	52	3 year diploma program	25+	Bataknese	Toboali	April 2017
10	M	42	3 year diploma program	22	Malay	Tjg Ketapang, Toboali	April 2017
11	P	39	3 year diploma program	20	Malay	Tjg Ketapang, Toboali	April 2017
12	HH	40	3 year diploma program	19	Malay	Belitung tung	April 2017
13	AP	42	Master's	23	Malay	East Jambi, Jambi	April 2017
14	A	43	3 year diploma program	-	Minang	Jambi	April 2017
15	S	65	1 year diploma program	44	Malay	Danau Sipin, Jambi	April 2017
16	NA	53	3 year diploma program	34	Malay-Minang	Palmerah, Jambi	April 2017
17	RA	49	3 year diploma program	20	Malay-Palembang	East Jambi, Jambi	April 2017
18	I	-	3 year diploma program	23	Sundanese	Pasirmulya, Bogor Municipality	April 2017
19	TR	50	4 year diploma program	27	-	Tanah Sareal, Bogor Municipality	April 2017
20	R	37	4 year diploma programV	-	-	Muliaharja, Bogor Municipality	April 2017
21	AS	24	4 year diploma program	2	Java	Cibinong, Bogor Regency	April 2017
22	FM	48	4 year diploma programV	27	Aceh	Bojonggede. Bogor Regency	April 2017
23	A	-	Doctorate	-	-	Bogor Regency	April 2017
24	NDS	24	3 year diploma program		Java	Tenggarong, Samarinda	April 2017
25	R	-	-	-	-	Samarinda	April 2017
26	R	46	3 year diploma program	26	Banjar	Gambut, Banjar	April 2017
27	OR	46	3 year diploma program	24	Java	Gambut, Banjar	April 2017
28	FF	27	3 year diploma program	6	Banjar	Barito Kuala	April 2017
29	US	58	Master's	35	Mandar-Java	Majene	May 2017
30	N	38	Master's	16	Bugis	Lembang, Majene	May 2017
31	A	31	Master's	-	Mandar	Lingkungan Tanangan, Majene	May 2017

32	J	51	Bachelor's	29	Mandar-Tator	Bulo, Polewali Mandar	May 2017
33	ARH	47	Master's	-	Mandar	Polewali, Polewali Mandar	May 2017
34	SH	-	Bachelor's	37	Minang	Dumai Municipality	May 2017
35	FS	58	3 year diploma program	40+	Malay	Rimba Sekampung, Dumai	May 2017
36	A	66	3 year diploma program	43	Malay	Dumai Municipality, Dumai	May 2017
37	K	28	Bachelor's	2	Malay	Selat Panjang, Meranti Islands	May 2017
38	N	31	4 year diploma program	9	Minang-Malay	Anak setatah, Meranti Islands	May 2017
39	PSL	-	3 year diploma program	10	Bataknese	Sesap, Meranti Islands	May 2017
40	S	56	4 year diploma program	37	Java	Selat Panjang, Meranti	May 2017

Shamans

	Initials	Age (yrs)	Education	Work Experience (yrs)	Ethnicity	Interview Location	Date of Interview
1	F	70	-	6	Sundanese Banten	Pandeglang	April 2017
2	S	56	Elementary education	-	Sundanese Banten	Pandeglang	April 2017
3	IK	76	Elementary education	30	Sundanese Banten	Maja, Citeras	April 2017
4	EK	46	-	25	Sundanese Banten	Maja, Citeras	April 2017
5	s	67	Did not complete elementary ed	24	Sundanese Banten	Citeras, Lebak	April 2017
6	SK	61	-	25	Sasak	West Lombok	April 2017
7	PR	90	Did not complete elementary ed	"long enough"	Sasak	Gunung Sari, West Lombok	April 2017
8	H	60+	Elementary education	10	Palembang-Malay	Danau Sipin, Jambi	April 2017

9	E	48	Lower secondary	13	Malay-Jambi	Danau Sipin, Jambi	April 2017
10	K	72	Elementary education	-	Malay-Jambi	Danau Sipin, Jambi	April 2017
11	SJ	57	Elementary education	-	-	Bogor Municipality	April 2017
12	J	60	Elementary education	-	-	Bogor Municipality	April 2017
13	IH	59	Elementary education	-	Sundanese	Bogor Barat, Bogor Municipality	April 2017
14	A	75	SR	-	Java-Sundanese	Tegalega, Bogor Municipality	April 2017
15	N	100	Did not complete elementary ed	-	Malay Pagelarang Gunung	Cibinong, Bogor Regency	April 2017
16	R	49	Did not complete elementary ed	30	Banjar	Banjar	April 2017
17	A	75	SR	35	Banjar	Barito Kuala	April 2017
18	R	70+	-	50+	Banjar	Barito Kuala	April 2017
19	D	98	Did not complete elementary ed	81	Java	Trans SPC, Toboali	April 2017
20	M	66	Elementary education	24	Malay	Ketapang, Toboali	April 2017
21	IP	72	Elementary education	19	Gorontalo	Kabila, Bone Bolango	April 2017
22	A	59	Elementary education	37	Banjar	Samarinda	April 2017
23	M	76	Elementary education	30	Banjar	Samarinda	April 2017
24	A	59	Elementary education	37	Banjar	Samarinda	April 2017
25	M	76	Elementary education	30	Banjar	Samarinda	April 2017
26	R	70+	-	50	Banjar	Alalak, Barito Kuala	April 2017
27	H	70+	Elementary education	20+	Pattae'	Tanro, Polewali Mandar	April 2017
28	A	-	Elementary education	-	-	Manggar	April 2017
29	Hj. M	80	Did not complete elementary ed	20+	Java	East Dumai, Dumai	May 2017

30	Nn	39	-	-	Java	Bukit Kayu Kapur, Dumai	May 2017
31	Nn	64	-	47	Bataknese	Mataram, Dumai	May 2017
32	M	44	Elementary education	20	Java	Mataram, Dumai	May 2017
33	K	52	Elementary education	27	Malay	Selat Panjang, Meranti Islands	May 2017
34	L	50+	Did not complete elementary ed	30+	Native	Sesap, Meranti Islands	May 2017
35	R	70+	-	50	Banjar	Alalak, Barito Kuala	May 2017
36	M	55	Upper Secondary	35	Mandar	Banggai Timur, Majene	May 2017
37	SJ	56	Elementary education	7	Mandar	Luyo, Polewali Mandar	May 2017
38	N	70	Elementary education	20+	Mandar	Lantura, Polewali Mandar	May 2017
39	WT	52	Elementary education	22	Gorontalo	Kwandang, North Gorontalo	May 2017
40	HA	80	Elementary education	50+	Gorontalo	Gentuma Raya, North Gorontalo	May 2017
41	MG	52	Elementary education	6	Gorontalo	Kwandang, North Gorontalo	May 2017
42	HT	50	Elementary education	5	Gorontalo	Kwandang, North Gorontalo	May 2017
43	RL	56	Elementary education	33	Gorontalo	Kwandang, North Gorontalo	May 2017
44	FT	68	Elementary education	38	Gorontalo	Kabila, Bone Bolango	May 2017
45	SH	63	Elementary education	15	Gorontalo	Kabila, Bone Bolango	May 2017
46	IP	72	Elementary education	19	Gorontalo	Kabila, Bone Bolango	May 2017

Tribal, Community, Religious Figures

	Initials	Age (yrs)	Education	Ethnicity	Role	Interview Location	Date of Interview
1	S	66	Elementary Education	Sundanese	Community Figure	Pulosari, Pandeglang	April 2017
2	AA	39	'Pesantren Salafiyah'	Sundanese	Religious Figure	Maja, Lebak	April 2017
3	MA	61	Upper secondary	Sundanese	Community Figure	Maja, Lebak	April 2017
4	ES	75	Upper secondary	Sundanese	Community Figure	Maja, Lebak	April 2017
5	MH	65	Bachelor's	Java	Religious Figure	Samarinda	April 2017
6	AP	47	Doctor's	Banjar	Religious Figure	Samarinda	April 2017
7	KHR	-	Master's	Sundanese	Religious Figure	Cigombong, Bogor Regency	April 2017
8	AMY	75	Bachelor's	Sasak	Religious Figure	Gunung Sari, West Lombok	April 2017
9	AS	67	Technical-Vocational Education	Malay	Religious Figure	Lalang, Manggar	April 2017
10	SH	51	Bachelor's	Malay	Religious Figure	Lalang, Manggar	April 2017
11	S	62	Bachelor's	Java	Religious Figure	Manggar	April 2017
12	UR	71	Religious Education	Malay	Tribal Figure	Toboali	April 2017
13	R	58	Senior Economics High School	Malay	Religious Figure	Toboali	April 2017
14	RST	51	Bachelor's	Gorontalo	Tribal Figure	Kwandang North Gorontalo	May 2017
15	HHT	68	Elementary education	Gorontalo	Religious Figure	Kwandang North Gorontalo	May 2017
16	AYT	42	Bachelor's	Gorontalo	Religious Figure	Kwandang North Gorontalo	May 2017
17	NLS	53	Bachelor's	Gorontalo	Religious Figure	Kwandang North Gorontalo	May 2017
18	ARH	62	Bachelor's	Gorontalo	Religious Figure	Kabila, Bone Bolango	May 2017
19	UA	68	Teacher education	Gorontalo	Tribal Figure	Tunggolo Selatan, Bone Bolango	May 2017

20	PSN	66	Upper secondary	Gorontalo	Tribal Figure	Kabila, Bone Bolango	May 2017
21	-	64	Bachelor's	Gorontalo	Tribal Figure	Tapa, Bone Bolango	May 2017
22	MZ	42	Bachelor's	Java	Religious Figure	East Dumai, Dumai	May 2017
23	LS	-	Doctor's	Malay	Religious Figure	Dumai	May 2017
24	AP	-	-	Native	Tribal Figure	Sesap, Meranti Islands	May 2017
25	J	-	-	Minang	Religious Figure	Meranti Islands	May 2017

Government Officials

	Initials	Age (yrs)	Education	Work Experience (yrs)	Ethnicity	Interview Location	Date of Interview
1	E	50	Master's	8	Sundanese	Pandeglang	April 2017
2	NS	45	Master's	2	Sundanese	Lebak	April 2017
3	E	-	-	-	Sundanese	Bogor Municipality	April 2017
4	DA				Sundanese	Kab Bogor	April 2017
5	O	-	-	-	Sundanese	Bogor Municipality	April 2017
6	D	43	Master's	24	Banjar	Martapura, Banjar	April 2017
7	EKN	40	3 year diploma program	11	Banjar	Martapura, Banjar	April 2017
8	DK	52	Bachelor's	30	Java-Banjar	Marabahan, Barito Kuala	April 2017
9	ASW	46	Master's	17	Banjar	Marabahan, Barito Kuala	April 2017
10	AS	56	Bachelor's		Mandar	Banggae, Majene	May 2017
11	S	36	3 year diploma program	2	Mandar	Pamboang, Majene	May 2017
12	SN	54	Master's	30	Bugis	Polewali Mandar	May 2017
13	E	40	4 year diploma program	7	Malay	Dumai	May 2017

14	R	-	3 year diploma program		Malay	Dumai	May 2017
15	RH	-	3 year diploma program	6	Malay	Selat Panjang, Meranti Islands	May 2017

Educators

No	Initials	Usia	Pendidikan	Ethnicity	Interview Location	Date of Interview
1	MS	81	3 year diploma program	Malay	Lalang, Manggar	April 2017
2	H	47	Bachelor's	Malay	Manggar	April 2017
3	RK	51	Senior Economics High School	Sundanese	Cibinong, Bogor Regency	April 2017
4	N	48	Bachelor's	Banjar	Martapura, Banjar	April 2017
5	N	48	Bachelor's	Martapura	Martapura, Banjar	April 2017
6	M	49	Bachelor's	Banjar	Barito Kuala	April 2017
7	NA	23	Bachelor's	Malay	Toboali	April 2017
8	K	29	Bachelor's	Bugis	Samarinda	April 2017
9	A	31	Master's	Mandar	Lingkungan Tanangan, Majene	May 2017
10	N	31	Upper secondary	Toraja (Pattae)	Andreapi, Polewali Mandar	May 2017
11	ARH	47	Master's	Mandar	Polewali, Polewali Mandar	May 2017

The practice of FGM/C can be traced back to as far as 6,000 years ago (Milos & Macris, 1992). A group of Dutch researchers found that FGM/C was practiced in Aceh, Java, and Gorontalo by the Sundanese, the Bugis, and the Minangkabau in the 18th century (Putranti, 2009).

However, Indonesian government had revised the policies related to FGM/C practices several times. In 2006, the Ministry of Health issued a circular of Director General of Public Health Education number HK.00.07.1.3.1047a, which prohibits health workers from medicalizing FGM/C. Enraged by the act, the Indonesian *Ulema* Council (MUI) issued a religious decree (fatwa) in 2008, stating that FGM/C is *"makrumah"* (honorable) and prohibiting FGM/C is against Islam. The *fatwa* puts MUI at odds with Muhammadiyah —another big Islamic organization—who condemns FGM/C (Komnas Perempuan, 2014). The disagreement eventually pushed the Ministry of Health to issue Regulation on Female Genital Mutilation/Cutting Number 1636 on 15 November 2010. Instead of condemning FGM/C, the regulation endorses the practice in the name of the girls' own safety and details a procedure to guide health workers in carrying out the mutilation/cutting (Komnas Perempuan, 2014).

This research may help formulate a set of recommendations about FGM/C for the central and the regional governments. Through this research we strongly expect the Government to fulfill the rights of women, specifically their reproductive and sexual rights, by prohibiting FGM/C, which is part of violence against women.

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