COUNTRY PROFILE

FEMALE GENITAL MUTILATION/CUTTING (FGM/C) IN INDONESIA

arrow
asian-pacific resource & research centre for women

ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

COUNTRY PROFILE:
FEMALE GENITAL MUTILATION/CUTTING (FGM/C)
IN INDONESIA

2025

ABOUT ARROW

ARROW is a regional non-profit women and young people's organization based in Kuala Lumpur, Malaysia. It was established in 1993 upon a needs assessment arising out of a regional women's health project, where the originating vision was to create a resource center that would 'enable women to better define and control their lives.

ABOUT ORCHID PROJECT

Orchid Project is an international NGO, with offices in Nairobi and London, working at the forefront of the global movement to create a world free from FGM/C. At the heart of our mission are grassroots organisations that are pioneering change, and by working together, one step at a time, we believe we can help to end FGM/C globally.

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This document presents the country profile of Indonesia and forms part of a larger research study on Female Genital Mutilation/Cutting (FGM/C) in Southeast Asia. The report covers FGM/C prevalence, trends, drivers, barriers, and forces for change in Indonesia. The report also includes detailed case studies on North Jakarta, East Jakarta, North Lombok, and Bandar Lampung.

This research was conducted by the Orchid Project in collaboration with ARROW (Asian-Pacific Resource & Research Centre for Women), in partnership with Kalyanamitra, who led the fieldwork in Indonesia. The study was supported by the South and Southeast Asia Research Innovation Hub (SSEARIH), the Foreign, Commonwealth & Development Office (FCDO), and the UK Government. The views expressed herein do not necessarily reflect the official policies of the UK Government.

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EXECUTIVE SUMMARY

Female Genital Mutilation/Cutting (FGM/C) is internationally recognised as a violation of human rights, particularly the sexual and reproductive health and rights (SRHR) of girls and women. It involves the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. **Globally, an estimated 230 million women and girls have undergone FGM/C, with an additional four million girls at risk each year.** FGM/C has no health or medical benefits. The harms caused are serious and lifelong, with recent evidence indicating that FGM/C is a leading cause of death among women and girls in practicing countries—exceeding fatalities from HIV/AIDS, measles, and meningitis. **The practice is documented in 31 countries across Africa, the Middle East, and Asia, underscoring its status as a global human rights and public health issue.**

In Southeast Asia, FGM/C remains significantly underreported. Asia accounts for at least 35% of the global FGM/C burden, affecting approximately 80 million[1] women and girls, with documented cases in India, Pakistan, Sri Lanka, Maldives, Vietnam, Cambodia, Thailand, Brunei, Singapore, Philippines, Indonesia and Malaysia.[2] In Indonesia, at least 70 million women[3] and girls are affected by FGM/C. Given the lack of comprehensive data, actual prevalence is likely higher. The absence of adequate data compounds the insufficient or non-existent legal protections, making FGM/C a critical issue requiring urgent attention in the region. FGM/C has no health or medical benefits and has no sound scientific basis, and the harm caused by the practice is recognised as a violation of child and women's rights. The sheer numbers of women and girls affected, make FGM/C a critical Child and Health Rights issue, highlighting concerns about consent, bodily autonomy and negative sexual and reproductive health outcomes, thus requiring urgent attention in the region.

This report presents key findings on FGM/C in Indonesia, focusing on its prevalence, drivers, barriers to change, and opportunities for intervention, including sub-regional and community-level dynamics. The study employed a mixed-methods approach, including desk review, data analysis, stakeholder mapping, interviews, focus group discussions, participatory methods, and field-based case studies in North Jakarta, East Jakarta, North Lombok and Bandar Lampung.

KEY FINDINGS OF THE REPORT

FGM/C remains widespread in Indonesia, with a national prevalence of 46.3% among women aged 15–49 as of 2024,[4] affecting approximately 70 million women and girls of all age cohorts (from infants to older women) and 34.3 million women and girls aged 15-49.[5] Despite the introduction of a formal legal ban in 2024, the practice continues across many communities. The National survey data shows a slight decline in prevalence from 50.5% in 2021 to 46.3% in 2024. However, prevalence among girls under 15 remains high at 55%, with 34% of these girls having undergone FGM/C despite their mothers not having experienced it. This intergenerational shift may indicate a resurgence of the practice and warrants further investigation.

The most common forms are Type 1 (partial or total removal of the clitoris gland and/or clitoral hood), accounting for 19%, and Type 4 FGM/C (pricking, piercing, incising, scraping, cauterisation), accounting for 18% of cases, when symbolic acts are excluded. Over 70% of girls in Indonesia undergo FGM/C before the age of six months, a trend linked to the medicalisation and bundling of the procedure with early childhood services.

Between 2021 and 2024, the prevalence of FGM/C declined in both rural and urban areas, with the most significant reduction observed in rural regions. The medicalisation and commercialisation of FGM/C may be contributing to its persistence in urban settings. Healthcare professionals in urban clinics have framed the practice as a standard medical service, thereby normalising and legitimising it under the guise of clinical safety

DRIVERS AND BARRIERS TO ENDING FGM/C IN INDONESIA

1. SOCIAL NORMS AND CULTURAL DRIVERS

Cultural acceptance of FGM/C remains a significant barrier to change. In Indonesia, societal discourse continues to favour the practice, which is often viewed as a rite of passage, a marker of adulthood, and a religious obligation. Pro-FGM/C narratives dominate social media, with limited counter-discourse. Approximately half of Indonesian women continue to support the practice.

Women family members play a key role in the perpetuation of FGM/C, which is most commonly performed within the first year after birth in Indonesia. The belief that FGM/C is a religious obligation is widespread, regardless of theological accuracy. This perception is reinforced by deeply held views linking the practice to physical hygiene and religious cleanliness. These are further compounded by beliefs that FGM/C is necessary to control female sexuality, or that it enhances health, fertility, or sexual satisfaction for either partners.

2. ROLE OF RELIGION

Religion plays a central role in shaping perceptions and practices related to FGM/C in Indonesia. The practice is widely believed to be a religious obligation, regardless of whether religious texts or leaders explicitly mandate it.

In Indonesia, the research identified a disconnect between community beliefs and the positions of many religious leaders. While community members often view FGM/C as a religious requirement, numerous religious leaders adopt more nuanced positions, with many acknowledging the absence of scriptural support and expressing openness to abandoning the practice due to its harmful effects on women and girls.

3. LEGAL AND POLICY FRAMEWORKS

Indonesia has taken formal steps to addressing the practice, including a government regulation enacted in 2024 that bans FGM/C, and a National Action Plan for Prevention of FGM/C 2030 outlining strategic actions toward its prevention. A technical regulation specifying the enforcement mechanisms and legal consequences is yet to be released. In the absence of clear regulations and a narrow focus on preventing FGM/C, rather than eliminating it, practitioners are likely to continue their existing practices.

4. MEDICALISATION AND THE HEALTH WORKFORCE

Medicalisation of FGM/C presents a growing challenge in the country. In Indonesia, nearly half of all FGM/C procedures are performed by midwives, often as part of standard maternity care packages. . While perceptions of safety, accessibility, and hygiene drive this trend, the integration of FGM/C into formal healthcare settings risks normalising the practice and may lead to increased prevalence and more invasive procedures. Health workers cite parental demand, fear of social exclusion, and alignment with community values as reasons for continuing the practice.

RECOMMENDATIONS

This report presents a set of recommendations which are informed by extensive consultation with local partners and grassroots organisations, and are shaped by the cultural, political, and operational realities of the country. The recommendations are tailored to reflect regional specificities.

RECOMMENDATIONS FOR INDONESIA

1. **Establish Reliable, Comprehensive, Consistent and Standardised Data Collection**
   - **Support the Ministry of Health (MoH) to reintegrate data on the prevalence of FGM/C into the periodic Indonesian Health Survey (SKI).** Collecting this data alongside other health indicators will provide critical evidence on the scope of the practice—particularly in light of the involvement of health professionals in performing FGM/C—and will strengthen the Ministry's capacity to enforce existing regulations and uphold medical ethics.
   - **Advocate and explore avenues with the Central Statistics Agency (BPS)** to integrate data on FGM/C into Indonesia's Sustainable Development Goals (SDG) monitoring framework—specifically under targets related to gender equality, health, and the elimination of harmful practices (SDG 5.3).
   - **Support the Ministry of Women's Empowerment and Child Protection (MOWECP) to integrate FGM/C prevention indicators into the Desa Ramah**

Perempuan dan Peduli Anak (DRPPA) programme. The programme aims to provide space for women to get involved in village organisations and government institutions and become active in village development planning deliberation (Musrenbang) activities. These include monitoring the proportion of women who receive counselling on female genital cutting during immunisation of a child or during an antenatal care visit.

2. **Strengthen National Legal and Policy Implementation and Healthcare Regulation on FGM/C**
   - **Enforce the prohibition of FGM/C in line with the National Action Plan for the Prevention of FGM/C 2030**, by issuing clear, binding guidelines with robust monitoring and accountable mechanisms, applicable to all healthcare settings, including private clinics, to curb the growing trend of medicalisation of FGM/C.
   - **Integrate FGM/C awareness into routine maternal and child health services.** This includes training healthcare providers to address the issue sensitively during regular visits while incorporating culturally appropriate educational materials tailored to local languages and contexts into child health books, national marriage books, and resources distributed through *Posyandu* and community health centres.
   - **Implement measures to ensure and meet the government's international commitments** to safeguarding the rights and well-being of women and girls, including but not limited to CEDAW and CRC recommendations

3. **Promote Religious Re-interpretation and Engagement**
   - **Facilitate structured engagement with religious authorities** at both national and local levels to build consensus to oppose the practice of FGM/C in Islam towards enforcing the prohibition of the practice as laid out in the National Action Plan (NAP).
   - **Support the development and dissemination of contextually relevant religious education materials.** This new religious education material can be used as an effective communication strategy that aims to educate people on the lack of religious support for the practice and its possible harms. The Indonesia Women's Ulema Congress (KUPI) has a significant opportunity to be involved in FGM/C advocacy, considering that KUPI has issued a *fatwa* stating that FGM/C is *haram*. However, members in strategic positions, like the managing official of the Istiqlal Mosque, must be engaged and supported to disseminate educational materials on FGM/C.

4. **Invest in Community Education and Behaviour Change**
   - **Implement targeted Community Behaviour Change strategies in partnership with organisations tailored to specific community contexts.** These should challenge entrenched social norms, dispel misconceptions, and promote positive narratives around bodily autonomy, health, and human rights through culturally sensitive messaging. Strategies could include integrating age-appropriate content on FGM/C into school curricula; developing youth-led advocacy programmes and peer education initiatives leveraging digital platforms, social media, and youth-friendly communication methods; and amplifying stories of resistance and change, such as young mothers choosing not to circumcise their daughters to inspire broader community reflection.

RECOMMENDATIONS FOR THE UK

The UK FCDO is encouraged to adopt a strategic, multi-level approach to support the elimination of Female Genital Cutting (FGM/C) in Indonesia, in alignment with national priorities and regional commitments.

POLICY ADVOCACY TO ELIMINATE FGM/C

1. **Support the Operationalisation of the 2025 Regulation Banning FGM/C in Indonesia**
   - **Advocate for the Enforcement of the 2025 regulation banning FGM/C**, in line with the National Action Plan for the Prevention of FGMC (2020-2030).
   - **Provide funding support for the next round of the Survei Pengalaman Hidup Perempuan Nasional / Violence Against Women Survey (SPHPN)**, which is facing budget constraints. Strengthening the analysis and use of regional data from SPHPN will be crucial to informing the implementation of Indonesia's 2020–2030 National Action Plan to Prevent FGM/C and ensuring that legal reforms are matched by evidence-based action.

2. **Support Indonesian Civil Societies to advance Community-Level Awareness and Behaviour Change**
   - **Strengthen partnerships with civil society organisations** that have strong local networks and understanding of the context to lead grassroots advocacy efforts on FGM/C, particularly in underserved and high-prevalence areas, including but not limited to the development and dissemination of culturally tailored Behaviour Change Communication

(BCC) strategies that challenge harmful social and cultural norms and promote rights-based narratives.
- **Support members of the Asia Network to End FGM/C** in participating in national CEDAW reporting processes. This includes contributing to consultations and developing a shadow report that integrates FGM/C into CEDAW submissions.
- **Support knowledge generation and evidence-based advocacy** by working with regional feminist and human rights organisations working on research, advocacy, and grassroots mobilisation, such as Asia Network to End FGM/C.

3. **Support UN agencies' programmes addressing FGM/C in Indonesia:**
   - **Building on existing support, continue strengthening UNFPA's efforts** to enhance midwifery education and professional development through the implementation of the National Midwifery Continuing Professional Development (CPD) Framework in Indonesia. This includes components focused on de-medicalising FGM/C and aligning midwifery training with International Confederation of Midwives (ICM) standards.
   - **Promote the expansion of Adolescent Reproductive Health Education (ARH Education) in collaboration with UNFPA**, the Ministry of Education, and key religious organisations such as *Nahdlatul Ulama* (NU), *Persatuan Islam* (PERSIS), and *Muhammadiyah* in Indonesia.
   - **Support Indonesia and UNFPA's forthcoming ethnographic study** exploring midwives' motivations for performing FGM/C, including thorough stakeholder engagement, technical input, and future implementation of its recommendations.

4. **Support and leverage Human Rights Mechanisms that call for the elimination of FGM/C**
   - **Leverage Global Accountability Mechanisms to advocate for the explicit inclusion of FGM/C under SDG 5** on gender equality, SDG 3 on Good Health and Well-being, and SDG 16 on Peace, Justice, and Strong Institutions.
   - **Support data collection efforts** being carried out in the country, aligning with International Human Rights Standards.

REGIONAL RECOMMENDATIONS ON POLICY PRIORITIES FOR GOVERNMENTS, HUMAN RIGHTS, AND DEVELOPMENT PARTNERS

- **Leverage the Beijing +30 and ICPD commitments**, which explicitly call for the prohibition and elimination of FGM/C, by reinforcing FGM/C as a violation of gender equality and SRHR, particularly in the areas of violence against women and girls (Critical Area D), women's health (Critical Area C), and the rights of the girl child (Critical Area L).
- **Support regional platforms and align stakeholders to advance shared goals** on gender equality and the elimination of harmful practices such as FGM/C. This includes supporting the 2025 regional convening organised by ARROW and UNFPA, supporting the DFAT–UNFPA Regional Accountability Framework Programme, and exploring collaboration with the Government of Australia through the Southeast Asia Gender-Based Violence Prevention Platform.
- **Leverage international human rights treaties to reinforce norms and standards that advocate an end to FGM/C**, particularly the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the Convention Against Torture (CAT). Both Malaysia (CEDAW) and Indonesia (CRC) are scheduled for upcoming reviews, presenting key opportunities to submit evidence, challenge harmful state narratives, and push for alignment of national laws and practices with international human rights standards. The next Universal Periodic Review (UPR) cycle presents an opportunity to challenge Malaysia's stance on FGM/C as a cultural practice and advocate for policy alignment with human rights obligations.
- **Strengthen international and regional partnerships with agencies such as ASEAN, WHO, and UNESCO**, and engage actively to ensure that FGM/C is integrated into broader gender equality and child protection agendas. This includes supporting ASEAN's renewed 10-year Gender Mainstreaming Strategic Framework and advocating for the explicit inclusion of FGM/C as a priority issue within its implementation under the ASEAN Commission of Women and Children (ACWC).
- **Support regional medical and midwifery associations in developing and promoting professional guidelines** that explicitly oppose the medicalisation of FGM/C. These include The Midwives Alliance of Asia (MAA), Asia & Oceania Federation of Obstetrics & Gynaecology (AOFOG), Asian Oceanic Society of Paediatric and Adolescent Gynaecology (AOSPAG).

1. INTRODUCTION

Female genital mutilation, Female circumcision, or Female Genital Mutilation/Cutting is the practice of partially or wholly removing the external female genitalia or otherwise injuring the female genital organs for non-medical or non-health reasons.[6] It is mainly carried out on young girls between infancy and age 15. The terminology applied to the FGM/C practice has undergone evolution(s) over time and in various contexts, indicating changes in how the practice is perceived and the variations in advocacy strategies. In 2019, the CEDAW and the Committee on the Rights of the Child (CRC) issued joint general recommendations on harmful practices, establishing a connection between the various terms and a single practice.[7]

The practice of FGM/C is internationally recognised as a gross violation of girls' and women's fundamental human rights, including their health rights, physical integrity, security and dignity, and is a manifestation of deep-rooted gender inequality. Although today a girl is **one-third less likely** to be subject to FGM/C than 30 years ago, a growing population in countries where FGM is practised means that **over 4 million girls are at risk of undergoing FGM annually**.

The World Health Organization (WHO) classifies FGM/C into four types – from a symbolic prick to the clitoris or prepuce, to the fairly extensive removal and narrowing of the vaginal opening.

- **TYPE 1:** Partial or total removal of the clitoris and/or the prepuce (clitoridectomy).
- **TYPE 2:** Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision).
- **TYPE 3:** Narrowing of the vaginal orifice with creation of a covering seal by cutting and re-positioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation).
- **TYPE 4:** All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterisation

FGM/C can result in severe complication. Types 1 and 4 are the most common in Indonesia and Malaysia. Physical complications of Type 1 include severe pain, genital swelling, haemorrhage, infection, tetanus, risk of septicaemia and death. Longer term complications include chronic pain due to trapped or exposed nerve endings, keloid scarring, neuroma causing pain during intercourse, cysts that can become infected and sexual dysfunction. The short- and long-term effects of Type 4 FGM/C are unreported and further research is required to unpack the harm caused by Type 4.

DEFINING TERMS

FEMALE CIRCUMCISION. Initially termed 'female circumcision' when it gained international attention, early anthropological research in Africa described it alongside male circumcision as part of adulthood rites. By the mid-1970s, this comparison was abandoned as focus shifted to its health impacts on women and girls. The practice was later addressed from both health and human rights perspectives, becoming known as "mutilation".

UNFPA[8] and UNICEF[9] emphasise that unlike male circumcision, which is used in Africa for HIV prevention, female circumcision offers no medical benefits and fails to convey its "severe physical and psychological impact on women."

In Malaysia and Indonesia, the term 'female circumcision' normalises the practice by falsely equating it with male circumcision and lending it unwarranted medical and religious legitimacy. *Sunnah* is an Arabic word meaning "recommended". *Sunat* is the Malaysian and Indonesian word for circumcision, which applied to both men and women. In Malaysia or Indonesia *"sunat"* can be either *"sunnah"* (recommended), *wajib* (compulsory), or *haram* (forbidden).

FEMALE GENITAL MUTILATION (FGM). The 2008 interagency statement[10] issued by WHO, OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF and UNIFEM clearly emphasises that *'The guiding principles for considering genital practices as female genital mutilation should be those of human rights, including the right to health, the rights of children and the right to non-discrimination on the basis of sex'*.

The 2008 statement terminology note indicates that the 'use of the word 'mutilation' helps to promote national and international advocacy for its abandonment'.

UNFPA, UNICEF and the UK use the term FGM.

FEMALE GENITAL CUTTING (FGC). The 2008 Interagency Statement also introduced the term "Female Genital Cutting." It explicitly emphasises that the use of "cutting" is not intended to minimise the mutilating and harmful nature of the procedure and notes that the term FGM may hinder the process of social change.

Researchers in Malaysia strongly advocate for the use of the term Female Genital Cutting, on the grounds that the term Female Genital Mutilation is culturally insensitive and does not accurately describe the practice as the type of cutting which is conducted in this region.

FEMALE GENITAL MUTILATION/CUTTING (FGM/C). The term FGM/C is used to highlight the significance of the word "mutilation" in policy contexts, while also recognising the need for non-judgmental language when engaging with communities that practice this tradition. In this report, FGM/C is the terminology used.

HARM REDUCTION, SYMBOLIC PRACTICES AND ALTERNATIVE RITES OF PASSAGE. In some parts of the world, for instance East Africa, alternative rites of passage or symbolic practices[11] are a popular strategy to encourage abandonment of FGM/C, although their effectiveness is contested and more evidence is needed.

Furthermore, the use of harm reduction to justify medicalised FGM/C is controversial. Harm reduction typically aims to minimise health risks through pragmatic, culturally acceptable alternatives, usually for individuals capable of giving informed consent and for reversible practices. As children cannot provide consent and FGM/C is irreversible, the principles of harm reduction do not apply. Promoting medicalised FGM/C as a safe and hygienic procedure risks legitimising and encouraging its continuation rather than preventing harm.[8]

Some advocate using symbolic rituals to eliminate harmful FGM/C, based on the premise that cultural norms can evolve. This gradual approach would transition from physically harmful procedures to symbolic acts without bodily harm.[12]

However, Dr. Maria Ulfah Anshor from Komnas Perempuan in Jakarta states, "Even symbolic (action) is violence, because this symbolic practice of circumcision departs from the same perspective: distrusting female sexuality."[13, 14, 15]

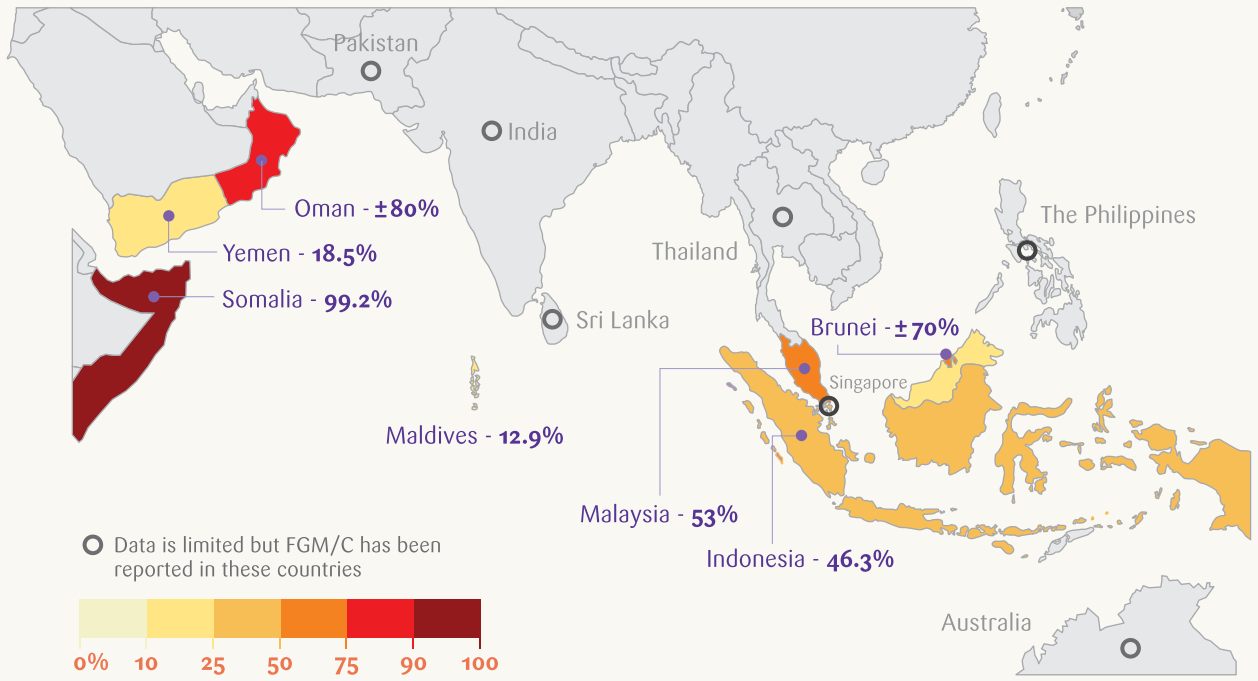
THE STATE OF FGM/C IN SOUTH AND SOUTH-EAST ASIA

Globally, it is estimated that over 230 million girls and women alive today have undergone FGM.[16] About 144 million (63%) cases of FGM are reported in Africa, followed by 80 million (35%) in Asia and 6 million in the Middle East and other small practising communities in the rest of the world.

Female genital mutilation/cutting (FGM/C) remains a significant yet underreported issue in Southeast Asia, with Indonesia and Malaysia alone accounting for approximately 70 million[17] and 7.5 million[18] affected women and girls, respectively—representing nearly 30% of the global burden. The practice, commonly known as *'sunat'* across the region, exists in at least 12 countries with particularly high prevalence rates amongst ethnic Malay communities (over 90% in Malaysia) and in specific Indonesian regions (reaching 81.2% in Sulawesi).[19] Prevalence also occurs in the whole of Asia, in countries such as India, Pakistan, Sri Lanka, The Maldives, Vietnam, Cambodia, as well as in Australia.

Despite its widespread nature, there is little regulatory provision across the region to prevent girls and women from being subjected to the practice. Data collection remains severely limited, with only Indonesia and the Maldives including FGM/C in their population surveys. The practice is increasingly being medicalised, particularly in Malaysia, where healthcare professionals perform the majority of procedures. In Southeast Asia, most interventions occur during infancy, with nearly 70% of Indonesian girls undergoing the procedure before their first birthday. Types 1 and 4 (according to WHO classification) are most common, with religious obligation frequently cited as the primary justification. Symbolic procedures take place in Indonesia and Sri Lanka. Like alternative rites of passage in Africa (such as pouring milk on a girl's pelvis), these procedures are physically non-invasive. In Indonesia, they include cleansing of the genitalia with Betadine or cutting turmeric.

MAP 1: THE PREVALENCE OF FGM/C IN ASIA



Data source: *Orchid Project.*

RESEARCH APPROACH AND METHODOLOGY

This report follows an iterative mixed-methods approach, combining desk reviews, stakeholder mapping, and both primary and secondary data collection and analysis. The methodology includes semi-structured interviews, focus group discussions (FGDs), participatory techniques, and case studies.

The overarching research question guiding this study is:

What are the key trends, drivers, and norms of FGM/C in Malaysia and Indonesia (including within sub-regions and communities), what are the forces for change and what actions could the UK take to reduce the prevalence, including working with and through national and regional actors?

The following sub-questions support this central question:

A: Prevalence of FGM/C: What are the prevalent trends of FGM/C and what types are most common in Malaysia and Indonesia (including within sub-regions and communities)?

B: Drivers and Norms: What are the key drivers of FGM/C in Malaysia and Indonesia (including within sub regions and communities)? What do we know about the social, legal and wider norms that underpin FGM/C in these contexts?

C: Barriers to change: What factors sustain and continue the practice of FGM/C in these contexts? What factors pose as the biggest barriers towards abandonment of FGM/C? What are the socio-cultural risks involved in moving towards abandonment? What are the risks to those who seek to oppose the practice? What are the risks to the other work of organisations (local and international) if they also oppose FGM/C?

D: Government responses to FGM/C: What local and national action has been taken to date (both positive advancements and rollback/setback)? What is the country's record in key multilateral forums? Does their domestic record influence their international stance?

E: Community/Civil society responses to FGM/C: What local and national actors are seeking to tackle FGM/C? Who are the positive voices for change (women's rights organisations and movements, progressive religious leaders, etc.)? Are these forces for change aligned/coordinating or are there significant differences in approach? What has been promising/effective?

F. International and regional response to FGM/C: What activity is underway by international organisations to support national community level action to combat FGM/C? What is the wider regional action across borders? Has it been effective? Are there examples of regional and international actions having caused harm/increased risks for communities?

G: Lessons from other regions: What can we learn from regions with similar experiences such as North-east Africa and the Middle East (both in terms of the FGM/C practice and the wider political economy)?

STUDY SITES IN INDONESIA

Data collection in Indonesia involved a combination of **focus group discussions (FGDs)** and **key informant interviews (KIIs)** across four key locations:

Data collection in Indonesia involved a combination of focus group discussions (FGDs) and key informant interviews (KIIs) across four key locations:

- **Penjaringan:** A densely populated urban village situated in North Jakarta, characterised by significant religious diversity where Islam is predominant, followed by Buddhist and Christian communities.
- **Cipinang Besar Utara:** An urban village in East Jakarta with multiple neighbourhood associations, featuring a religiously diverse population predominantly following Islam, with smaller Christian, Catholic, and Buddhist communities.
- **Sigar Penjalin:** A predominantly Muslim village of Sasak ethnicity in West Nusa Tenggara Province, identified as a region with a high prevalence of FGM/C practices in Indonesia.
- **Kaliawi:** A diverse urban community in Lampung Province representing multiple ethnicities, including Lampung, Javanese, Sundanese, and Chinese populations, with Islam as the majority religion and a significant portion of households classified as economically disadvantaged.

In total, **24 key informant interviews (KIIs)** were conducted. These included midwives from health centres (Puskesmas), male and female religious leaders, traditional birth attendants, community leaders, women's rights activists, academics, youth, and retired teachers or community cadres. The KII's, along with **four focus group discussions (FGDs) with 61 community women**, explored participants' sociodemographic backgrounds, their knowledge and personal experiences of female genital mutilation/cutting (FGM/C), and their perceptions of the practice.

2. KEY FINDINGS

2.1 FGM/C PREVALENCE, TRENDS, DRIVERS AND NORMS

2.1.1 PREVALENCE OF FGM/C IN INDONESIA

KEY FINDING 2.1.1

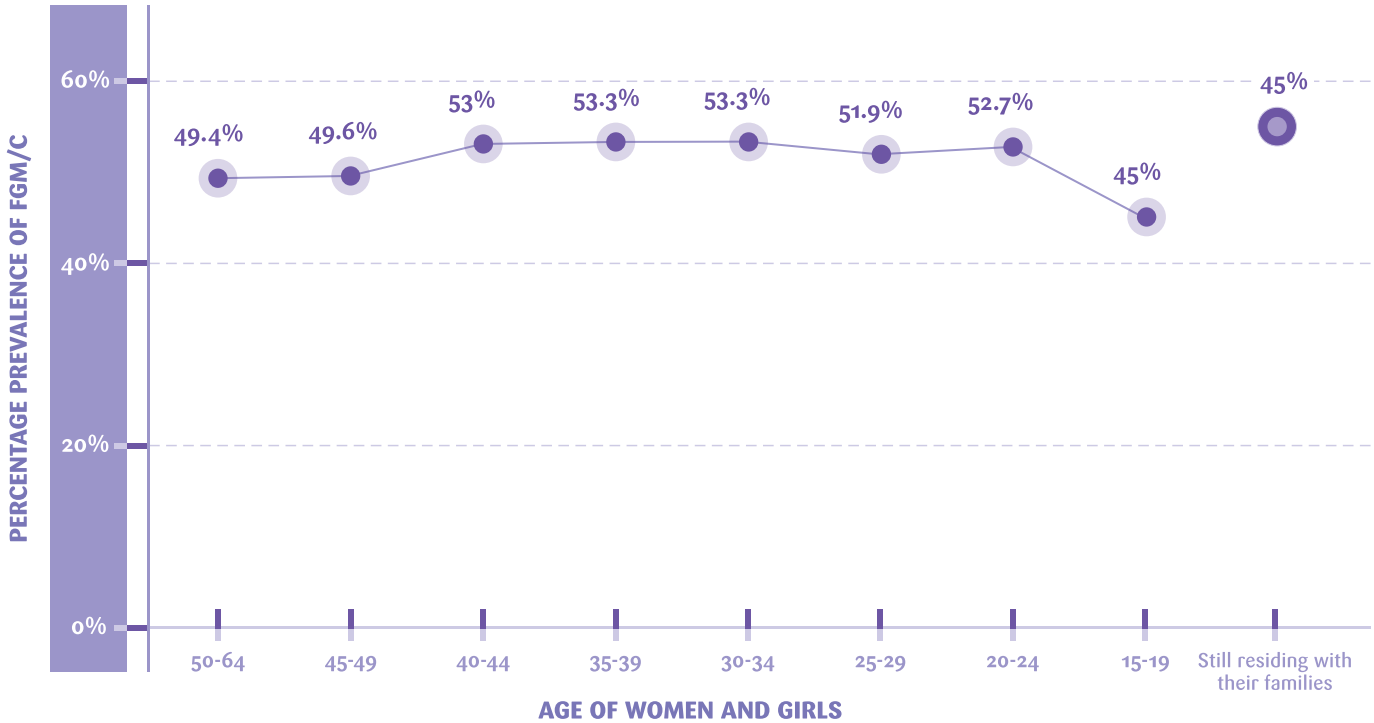
In 2024, the national prevalence of FGM/C among girls and women aged 15-49 years was **46.3%** (34.3 million).[20]

Indonesia is one of only two countries in Asia, alongside the Maldives, that includes Female Genital Mutilation/ Cutting (FGM/C) in its national population surveys. Data from the 2021 and 2024 National Women's Life Experience Surveys indicate a modest but encouraging decline in prevalence, from 50.5%[21] in 2021 to 46.3%[22] in 2024.

Disaggregated data by age group reveals concerning patterns. The prevalence among girls under the age of 15 stands at 55%, which is significantly higher than the national average. Notably, 34% of girls who have undergone FGM/C have mothers who were not subjected to the practice themselves. This intergenerational shift may signal a potential resurgence of FGM/C, suggesting that overall prevalence could rise in the absence of effective interventions.

FIGURE 1: FGM/C PREVALENCE BY AGE COHORT IN INDONESIA

Data source: *2021 SPHPN National Survey.*



2.1.2 REGIONAL PREVALENCE

Between 2021 and 2024, the national survey data indicate a decline in the prevalence of FGM/C across both rural and urban settings in Indonesia. Notably, the most significant reduction has been observed in rural regions.

Urbanisation and the medicalisation of FGM/C appear to be key drivers sustaining the practice in urban settings. In particular, healthcare professionals in urban clinics have increasingly framed FGM/C as a routine medical service, thereby normalising and commercialising the procedure. This medical framing lends perceived legitimacy to FGM/C by presenting it as a clinically safe and socially acceptable intervention.[23] Symbolic forms of FGM/C, such as pricking or superficial incisions, are more prevalent in urban areas, further complicating efforts to monitor and address the practice.

Data source:
***Figure 2** - 2021 SPHPN National Survey.*
***Figure 3** - Riskesdas, 2013.*

FIGURE 2: PREVALENCE OF FGM/C IN INDONESIA IN 2021 (Including Symbolic Procedures)

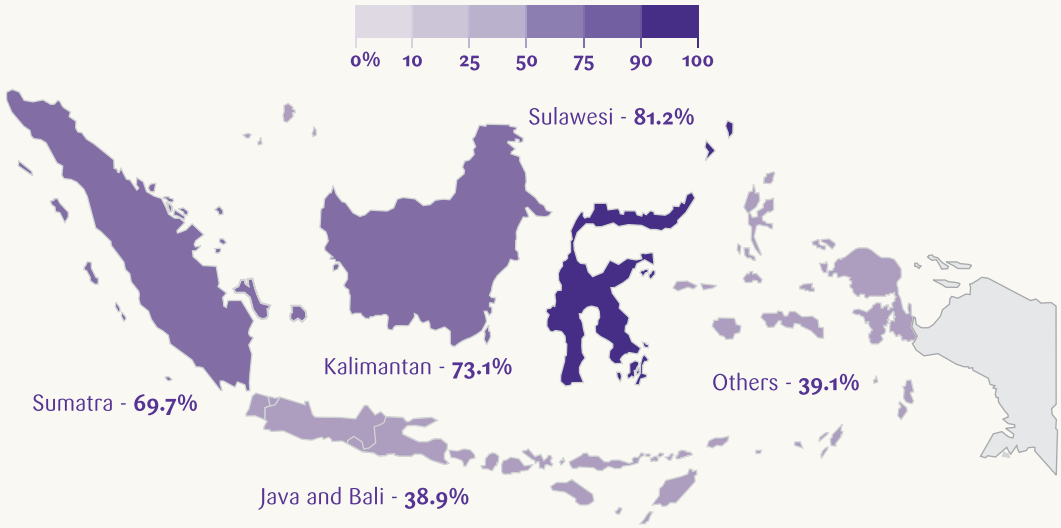
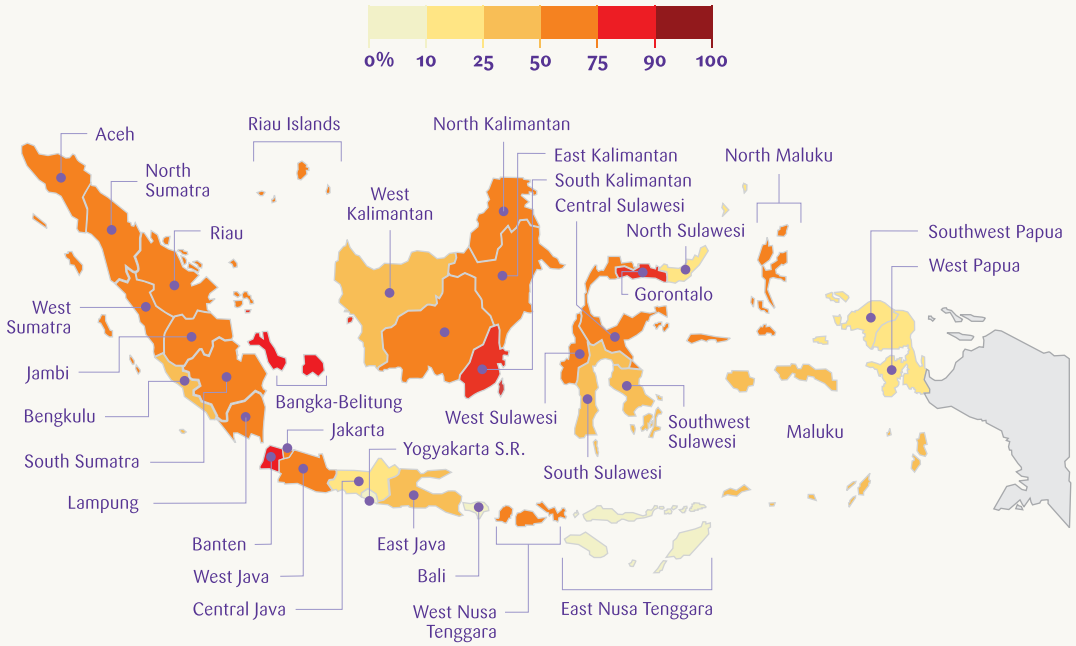


FIGURE 3: PREVALENCE OF FGM/C PER PROVINCE IN INDONESIA IN GIRLS AGED 0-11 IN 2013



Regional data from the 2021 SPHPN National Survey reveal significant disparities in the prevalence of FGM/C across Indonesia. The highest rates were recorded in Sulawesi (81.2%), Kalimantan (73.1%), and Sumatra (69.7%), above the national average of 50.5%. In contrast, the lowest prevalence was observed in Java and Bali (38.9%) and in the eastern regions, including West and East Nusa Tenggara, Maluku, and Papua (39.1%).

2.1.3 TYPE OF FGM/C IN INDONESIA

KEY FINDING 2.1.3

The most common FGM/C type in Indonesia is **Type 4**, with invasive forms as well as symbolic procedures. Symbolic procedures represent **56.2%** of the performed FGM/C in Indonesia.[24]

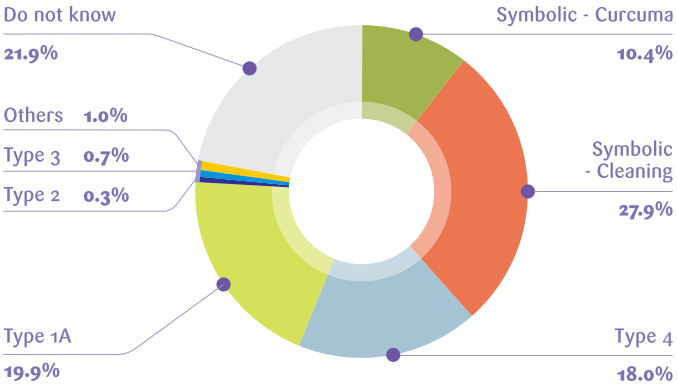
FGM/C practices in Indonesia primarily correspond to Types 1 and 4, as classified by the World Health Organization (WHO). Indonesia is one of only two countries in Asia, alongside Sri Lanka, where symbolic forms of FGM/C are practiced. These symbolic procedures, such as cutting turmeric or cleansing the genital area with antiseptics like Betadine, do not result in physical injury. Whilst technically categorised under Type 4,[25] Indonesian national surveys present data on symbolic procedures[26] separately from other FGM/C practices, despite their inherent connection.

The classification of Indonesian symbolic practices within the Type 4 category as per the WHO framework remains a subject of national debate. Some religious leaders argue that *sunat perempuan* (female circumcision), as practiced locally, should be viewed as a distinct cultural or religious tradition, separate from what is often perceived as a foreign and harmful practice associated with parts of Africa.[27] The Indonesian authorities use the Bahasa Indonesia term, '*Pemotongan dan/atau Pelukaan Genitalia Perempuan* (FGM/C - translated as Cutting and/or Injuring Female Genitalia)' as an equivalent to FGM/C.[28] This narrative contributes to resistance against framing Indonesian practices within the global discourse on FGM/C.

The 2024 Indonesian National Women's Life Experience survey (SPHPN 2024) identifies a wide range of practices currently performed in Indonesia, including:

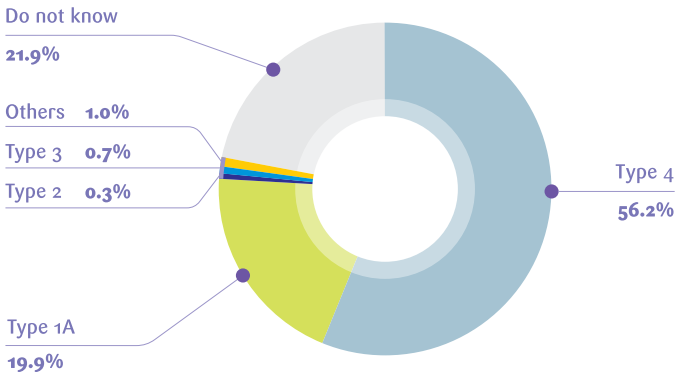
- Pricking, piercing, cutting, scraping clitoris until injured
- Slightly cutting off the clitoral hood
- Cutting and sewing part of the clitoris and labia minora
- Cutting and sewing part of the clitoris, labia minora and labia majora)
- Symbolically cutting turmeric
- Scraping the clitoris without inflicting injury

FIGURE 4:
TYPES OF FGM/C IN INDONESIA



Data source:
Violence Against Women Survey 2021, 2021 SPHPN National Survey.

FIGURE 5:
TYPES OF FGM/C IN INDONESIA, WITH SYMBOLIC ACTS INTEGRATED INTO THE TYPE 4



Data source:
Violence Against Women Survey 2021, 2021 SPHPN National Survey.

FGM/C practices in Indonesia predominantly fall under WHO Types 1 and 4. When symbolic procedures are statistically separated, Type 4 accounts for 18% of reported cases. However, when symbolic acts, such as cutting turmeric or cleansing with antiseptics, are included, the prevalence of Type 4 rises significantly to 56.2%. These symbolic procedures, while not physically invasive, are culturally significant and often performed during private, low-key rituals, particularly on infants. As a result, 21.9% of women surveyed reported being unaware of the specific type of FGM/C they had undergone, reflecting both the secrecy surrounding the practice and the lack of formal education on female anatomy and sexuality.

Urban–rural comparisons reveal notable differences in the nature of FGM/C practices:

- In urban areas, symbolic procedures are more prevalent, accounting for 41% of reported cases, compared to 34.4% in rural regions.
- Conversely, rural areas exhibit a higher incidence of physically invasive procedures (Types 1 and 4), with 43.3% of cases, compared to 35.3% in urban settings.

2.1.4 AGE OF FGM/C IN INDONESIA

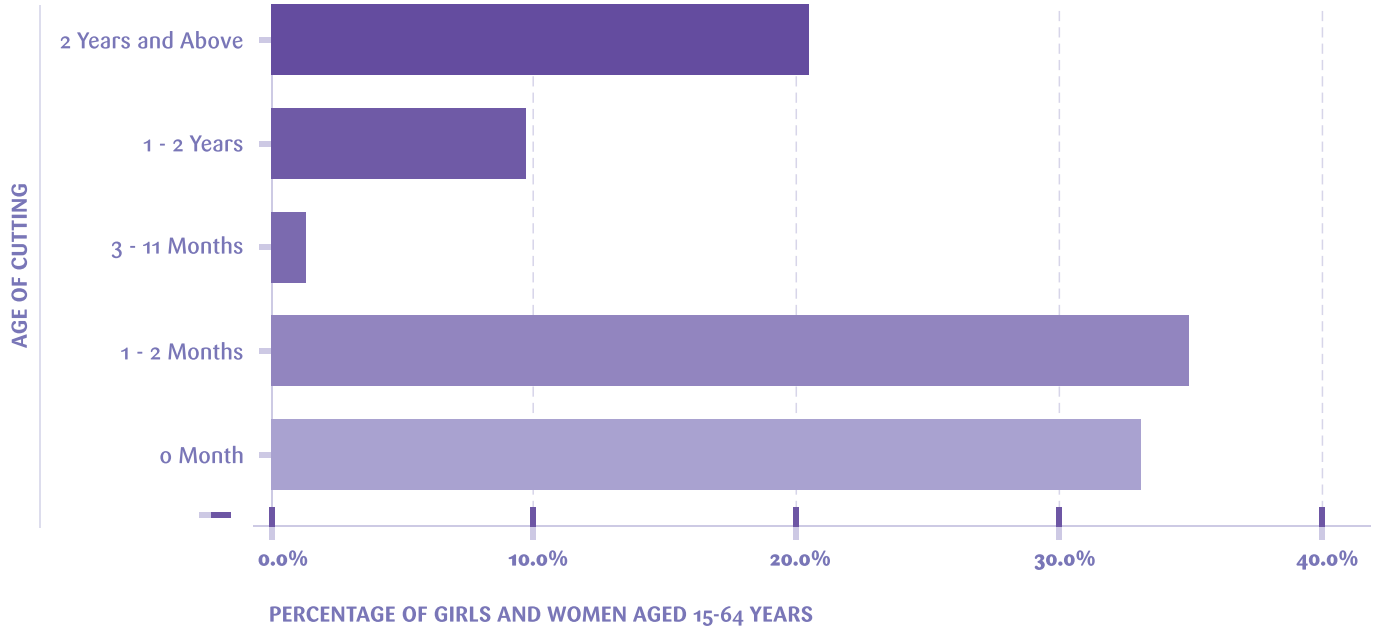
KEY FINDING 2.1.4

70% of girls undergo FGM/C before the age of **6 months**.[29]

The trend toward performing FGM/C at increasingly younger ages in Indonesia may be partially attributed to the 2010 health regulation that permitted licensed medical professionals to conduct female circumcision. This regulatory shift has contributed to the medicalisation of the practice, particularly in urban areas, where FGM/C is often bundled into postnatal "delivery packages" alongside services such as ear piercing. This packaging makes it easier for parents to consent to the procedure during the early stages of infancy.

FIGURE 6: AGE OF FGM/C IN INDONESIA

Data source: *2021 SPHPN National Survey.*



National data indicate that the majority of FGM/C procedures across both urban and rural settings are performed before girls reach two months of age. However, rural areas show a higher proportion of delayed procedures, with 25.8% of girls undergoing FGM/C after the age of two, compared to 16.6%[30] in urban areas. These findings suggest that while early-age FGM/C is becoming more common nationwide, rural communities may still adhere to more traditional timelines for the procedure

FIGURE 7: EXAMPLES OF DELIVERY PACKAGE PROMOTIONAL MATERIALS[31]

Note: Translation of text in the image

We cater for female circumcision for children/babies. Of course, with specialised female doctors who are experienced in handling female circumcision. Circumcise your daughters comfortably and safely with Kliniksunat123.

2.1.5 DECISION-MAKERS OF FGM/C IN INDONESIA

KEY FINDING 2.1.5

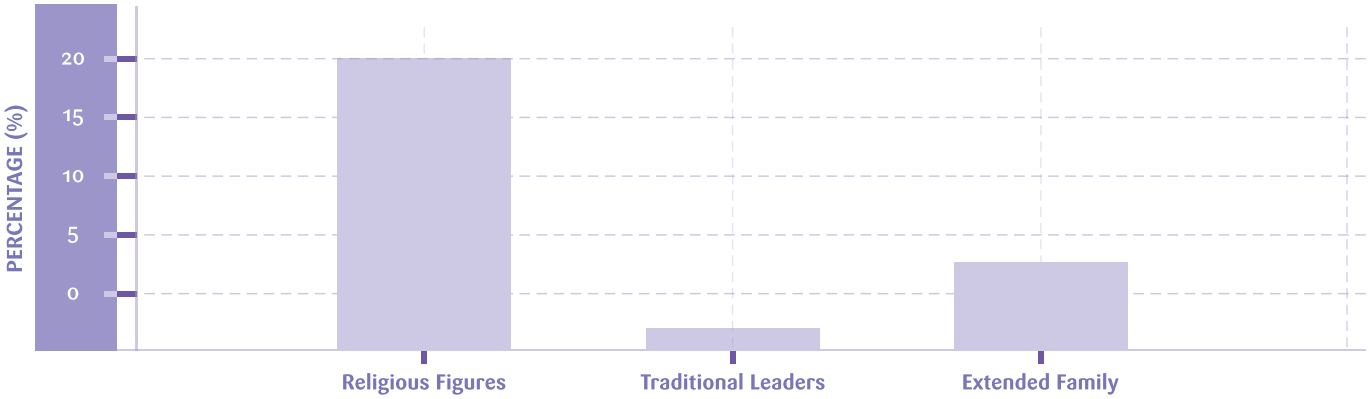
Mothers and grandmothers are the primary decision-makers in the continuation of FGM/C practices in Indonesia.[32, 33, 34, 35]

In Indonesia, decisions regarding FGM/C are primarily made within the household, with mothers and grandmothers playing a central role in endorsing and perpetuating the practice. Women are often seen as custodians of tradition, and their influence is particularly strong in communities where FGM/C is viewed as a normative rite of passage. Social pressure from peers, especially neighbouring mothers, can reinforce conformity, even when individual families express reluctance.

In contexts where fathers oppose the practice, they may find themselves unable to intervene effectively, as custom often overrides paternal authority. Although men typically hold dominant positions within household and community structures, their limited involvement in FGM/C decision-making highlights a missed opportunity. Increasing male engagement through targeted education and awareness-raising efforts could help shift social norms and reduce the prevalence of this practice.

FIGURE 8: STAKEHOLDER INFLUENCE ON FGM/C DECISION-MAKING IN INDONESIA

Data source: *Riskesdas, 2013.*



According to a 2013 study,[36] religious leaders influenced FGM/C decisions in approximately 20% of cases, while traditional leaders (1.8%) and extended family members (6.3%) played a minimal role. These findings suggest that while religious narratives may shape broader community attitudes, the immediate decision-making power lies predominantly with women within the family unit.

BOX 1:
CONSIDERING REGIONAL DIFFERENCES IN DECISION-MAKING REGARDING FGM/C

Decision-making authority around Female Genital Mutilation/Cutting (FGM/C) in Indonesia varies by region and is shaped by complex intra-household and community dynamics. In provinces such as West Java, Riau, and East Java, the decision to subject a girl to FGM/C is often made jointly by both parents. In contrast, in South Sulawesi, decision-making authority extends beyond the nuclear family to include extended family members and religious leaders, reflecting a more collective approach rooted in community and religious structures.[37]

A 2018 qualitative study conducted in Java and Madura[38] examined the power dynamics among traditional birth attendants, midwives, circumcised girls, parents, village elders, and community leaders. The study found that FGM/C is deeply embedded in traditional and religious belief systems and, in some cases, is performed without the full knowledge or consent of parents. Parents may be misled into believing that only symbolic procedures such as the application of cotton wool and antiseptics are being performed, when in fact more invasive procedures may occur. Practitioners sometimes use this strategy to minimise confrontation while maintaining the practice.[39]

The study also revealed that younger parents often continue the practice due to pressure from older family members, particularly grandmothers. In some communities, FGM/C is incorporated into religious instruction, such as Quran recitation lessons, and persists due to strong community trust in religious leaders.

These findings underscore the importance of addressing intergenerational influence, misinformation, and the role of religious and community institutions in sustaining the practice.

2.1.6 PRACTITIONERS OF FGM/C IN INDONESIA

KEY FINDING 2.1.6

The practice of FGM/C is nearly equally carried out by both **qualified medical personnel** and **traditional practitioners**.[40] Among healthcare professionals, midwives constitute the primary group involved in performing the procedure.

In Indonesia, practitioners of FGM/C fall into two broad categories:

1. **Professional Medical Practitioners:** This group includes medical doctors and healthcare professionals such as midwives *(bidans)*, nurses, and paramedics.
2. **Traditional Practitioners:** These include traditional birth attendants (TBAs), *dukun sunat* (specialised female circumcision healers), and *tukang sunat tradisional* (traditional circumcisers).

90% of girls in both rural and urban areas undergo FGM/C at the hands of three main types of practitioners: midwives, nurses, and paramedics (45.8%), traditional birth attendants (27.7%), and female circumcision healers (16.5%). Medical doctors are involved in only a small fraction of cases (2.7%), typically in major urban centres such as Jakarta.[41]

Over the past two decades, Indonesia has witnessed a gradual shift toward the medicalisation of FGM/C. While in some regions, such as Gorontalo, the practice remains the exclusive domain of traditional providers, other areas are experiencing a transition.[42] In 2003, traditional practitioners performed 68% of FGM/C procedures nationwide.[43] This figure declined to 61.7% in 2017[44] and further to 50.8% by 2021.[45] If this trend continues, midwives are likely to become the primary providers of FGM/C in the near future. This shift presents significant challenges. **Medicalisation risks legitimising the practice, reinforcing perceptions of safety, and potentially leading to more invasive procedures. Furthermore, as FGM/C becomes embedded within formal healthcare systems, it becomes more challenging to monitor, regulate, and eliminate.**

The 2025 health regulation[46] banning FGM/C presents a critical opportunity for the health system. It can serve as a platform to raise awareness among healthcare professionals about the harms of FGM/C and the legal prohibitions surrounding it. Given the increasing role of midwives in performing FGM/C, it is essential to engage midwives through targeted efforts to build their understanding, shift social norms, and support their role in the elimination of FGM/C practices across Indonesia.

FIGURE 9: PRACTITIONERS OF FGM/C IN INDONESIA IN RURAL AND URBAN ENVIRONMENTS

Data source: *2021 SPHPN.*

2.1.7 KEY DRIVERS AND NORMS FOR FGM/C IN INDONESIA

KEY FINDING 2.1.7

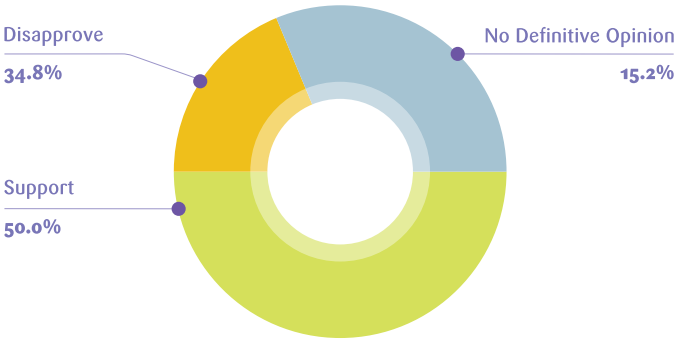
FGM/C is supported by **one in two Indonesian women**, for reasons including traditional practices, and beliefs in health benefits.

FGM/C practice in Indonesia is deeply embedded within a complex cultural framework, where intergenerational traditions, ancestral ties, and life cycle rituals converge. The practice is often upheld for its perceived symbolic value, honour, and social status, with many families continuing it without questioning its origins or religious justification. FGM/C is commonly performed as part of birth-related rituals, alongside ceremonies such as the seven-month pregnancy celebration, placenta burial, naming, ear piercing, and hair cutting. These practices serve to connect children to their ancestral lineage and reinforce communal bonds. While religious observances in Indonesia frequently blend doctrinal elements with local customs, the association between FGM/C and women's life cycles varies across communities, highlighting its cultural rather than universally religious significance.

A widespread belief in the harmlessness of FGM/C contributes to its persistence.[47] The practice is not universally perceived as physically or emotionally harmful. Public awareness of its negative health impacts remains limited.[48] For instance, a 77-year-old traditional healer from Madura maintains that FGM/C poses no health risks, citing the application of antiseptics like Betadine as sufficient post-procedure care.[49] The religious and cultural beliefs are so strong that the 'minor' short-term effects and the psychological impact are considered unimportant.[50] In a local survey conducted in Madura, 57% of respondents reported no complications following circumcision, 24% believed it improved health, and 12% associated it with enhanced reproductive well-being.[51]

Cultural norms are further reinforced by perceived health benefits. Approximately 50% of both men and women in Indonesia cite medical reasons for continuing FGM/C, with women more likely to hold this belief. Commonly held views include the belief that FGM/C improves general health, enhances fertility, prevents gynaecological diseases, and contributes to the health of future generations.

FIGURE 10:
INDONESIAN WOMEN'S ATTITUDES TOWARDS FGM/C



BOX 2: PERCEIVED BENEFITS OF FGM/C

In Indonesia, the practice of FGM/C is sustained by a wide range of local beliefs that attribute cultural, spiritual, and health-related benefits to the procedure. In Bima, FGM/C is believed to support a child's maturity, health, and physical development, while in Ketapang, it is thought to protect the child's soul from disturbance. Certain communities in Poliwali Mandar associate the practice with enhancing a woman's ability to protect herself, reflecting a belief in its role in fostering resilience. In West Java, FGM/C is perceived to offer health benefits similar to those of male circumcision, including disease prevention and the control of labial growth.[52]

These region-specific beliefs reinforce the normalisation of FGM/C and contribute to its persistence, often under the assumption that it is beneficial or harmless. **The diversity of these justifications underscores the cultural, rather than the non-universal religious nature of the practice, and highlights the importance of context-sensitive approaches to community engagement and behaviour change.**

Religion and religious identity play a significant role in the continuation of female genital mutilation/cutting (FGM/C) in Indonesia. The practice is often perceived as both a religious obligation and a form of spiritual purification, rooted in the belief that bodily cleanliness is a prerequisite for proper Islamic prayer. This belief system holds that inherent impurity *(najis)* must be removed, and that uncircumcised individuals require repeated ablution before prayer. Traditional practitioners often draw a symbolic drop of blood to signify lifelong purification, reinforcing spiritual and social acceptance. FGM/C is also seen as a marker of Islamic identity, whether for adult converts or children born into the faith.[53, 54, 55, 56] Family members and religious authorities frequently promote the practice by linking it to religious identity and the broader process of Islamisation. The absence of unified religious decrees condemning FGM/C further complicates efforts to challenge these beliefs. In addition to religious factors, gender norms and notions of purity and sexual control significantly contribute to the persistence of FGM/C.

Gender norms and the need to control women's sexuality also play a significant role in perpetuating FGM/C. Traditional beliefs often label uncircumcised girls as "unclean" or lacking value, and portray women as inherently lustful. While earlier literature emphasised sexual control as a primary motive, the 2021 national survey indicated a decline in this rationale, suggesting growing awareness. Nevertheless, some communities continue to believe that FGM/C enhances marital satisfaction, reduces female libido, preserves virginity, and prevents promiscuity. In rural Aceh, it is thought to prolong sexual pleasure, maintain family honour, and help women endure periods of celibacy. Surveys reveal that 63% of young men prefer circumcised partners, associating the practice with fidelity, despite limited understanding of its actual effects.[57]

Although younger generations increasingly question the religious and medical justifications for FGM/C, prevailing social norms continue to blur the lines between sexual duty and rights. A contradictory view of female sexuality persists, portraying women as both passive and dangerous, requiring control. These attitudes remain influenced by historical teachings, such as those of medieval Islamic scholar Imam Al-Ghazali, who linked women's virtue to broader social stability.[58]

2.1.8 COMMUNITY-LEVEL FINDINGS IN JAKARTA, LOMBOK, AND LAMPUNG

This study examined the practice of FGM/C across four distinct locations in Indonesia: Penjaringan (North Jakarta), Cipinang Besar Utara (East Jakarta), Sigar Penjalin (North Lombok), and Kaliawi (Bandar Lampung). Drawing on qualitative data from focus group discussions (FGDs) and key informant interviews (KIIs), the analysis identifies patterns, commonalities, and regional divergences in the manifestation of FGM/C, its underlying drivers, and potential avenues for intervention.

- **Prevalence: FGM/C persists across all four research sites, despite national regulations prohibiting the practice.** However, significant variation exists in terms of the age at which the procedure is performed, the methods employed, and the types of practitioners involved. In the urban sites of Jakarta, FGM/C is predominantly conducted on newborns up to three months of age, typically by midwives within medical settings. In contrast, in Sigar Penjalin and Kaliawi, the practice spans a broader age range, including early childhood and, in some cases, adulthood, particularly among religious converts.
- **Type of FGM/C: A growing trend of medicalising FGM/C is evident, particularly in urban areas where it is increasingly incorporated into routine neonatal care.** These risk normalising the practice within formal healthcare systems and conferring it with undue medical legitimacy. Procedures across all sites align with WHO Type 1 and 4 classifications, ranging from symbolic piercing to more invasive cutting, especially in rural settings.
- **Sociocultural and Religious Drivers:** Across all research sites, FGM/C is supported by an intricate web of religious interpretations, cultural traditions, and gendered social norms. However, the relative weight of these factors varies by region.
  - > ***Religious Justifications: All sites reference Islamic teachings as justification for FGM/C.*** However, the cross-case analysis reveals a significant disconnect between community beliefs and the interpretations of religious authorities. ***While community members widely believe FGM/C to be religiously mandated, religious leaders (particularly in Jakarta and Lombok) often characterise it as optional, preferred but not obligatory, or even contrary to Islamic principles when harmful to women's health.***

> *Cultural Traditions*: Intergenerational transmission of practices emerges as a powerful driver, with mothers, grandmothers, and mothers-in-law frequently identified as decision-makers and enforcers. This suggests that FGM/C functions partly as a mechanism for maintaining cultural identity and continuity.
> *Gender and Sexuality:* Beliefs about controlling female sexuality appear more prominently in Cipinang Besar Utara, Sigar Penjalin, and Kaliawi, where respondents explicitly mentioned reducing women's sexual desire or ensuring male sexual pleasure as motivations. This reflects deeply embedded gender norms that prioritise male pleasure and female sexual restraint.

- **Social Enforcement Mechanisms: Social consequences for non-compliance with FGM/C norms vary significantly between urban and rural contexts.** In Jakarta, participants reported minimal social sanctions, with the practice increasingly framed as a private family matter. In contrast, **Sigar Penjalin exhibits strong social enforcement mechanisms, including ostracism, gossip, and religious stigmatisation**. Kaliawi represents an intermediate case, where emotional pressures such as maternal guilt and fear of social stigma are more prevalent than overt sanctions. These findings suggest that urbanisation may weaken traditional enforcement mechanisms without necessarily reducing the prevalence of the practice, which is often reframed in medical or hygienic terms.
- **Knowledge of Regulatory Environment: A consistent finding across all sites is the widespread lack of awareness regarding national regulations prohibiting FGM/C.** This highlights significant gaps in policy dissemination and implementation, particularly at the community level. The disconnect is especially evident in the healthcare sector, where, despite regulatory prohibitions, FGM/C services continue to be offered, particularly in private clinics. While government health facilities *(Puskesmas)* in Penjaringan reported compliance with the 2008 ban on FGM/C practice, **community members reported accessing FGM/C services through private midwives' clinics, revealing a regulatory blind spot.**
- **Openness to Change:** In all locations studied, participants demonstrated a willingness to reconsider the practice of FGM/C, particularly when made aware of legal prohibitions or when informed that the practice is not a religious obligation.

2.2 BARRIERS AND OPPORTUNITIES FOR CHANGE

2.2.1 SOCIAL NORMS

KEY FINDING 2.2.1

Social sanctions in Indonesia play a significant role in the continuity of FGM/C with many families **feeling pressured to conform** due to religious, societal, and medical beliefs.

The research reveals that in Indonesia, FGM/C is predominantly upheld as a social, cultural, and gender norm. Uncircumcised women are often perceived as having lower social status,[59, 60, 61, 62] and their parents may be morally condemned for failing to fulfil perceived religious obligations.

In West Java, FGM/C is believed to prevent promiscuity and protect against negative societal stereotypes. In Madura, women who have not undergone the procedure are frequently regarded as impure, unsuitable for marriage, and not fully Muslim. **Similar beliefs are prevalent in regions such as Sulawesi, Ambon, Bima, and Medan, where uncircumcised women may be excluded from mosques, subjected to ridicule, or labelled as sexually immoral.** In Jakarta and its surrounding areas, marrying an uncircumcised woman is sometimes considered sinful. Midwives also face significant societal pressure, with refusals to perform FGM/C potentially resulting in accusations of being irreligious or sinful, underscoring the deeply entrenched religious and communal enforcement of the practice. In Padang, it is customary for girls to visit traditional practitioners before Ramadhan to be "cleansed" in preparation for fasting. This is rooted in the belief that an uncircumcised Muslim cannot properly pray, marry, or bear children. **The practice is continually reinforced by family members and religious leaders, further entrenching its association with religious identity and the broader process of Islamisation.[63]**

Regressive gender norms and prevailing notions of sexual purity are further reinforced by the limited availability of education on women's anatomy and sexuality. Cultural and

religious values in Indonesia have largely discouraged open discussions about sexuality, deeming them inappropriate in social settings, formal education, and within families. Literature on the subject remains scarce; and existing regulations, including those related to sex education, are predominantly shaped by religious beliefs and convictions.[64]

This lack of medical understanding regarding female anatomy and the biological determinants of sexual desire has, paradoxically, led some researchers to misinterpret religious guidelines. In certain cases, FGM/C has been wrongly promoted as a means of enhancing female sexuality and cleanliness, with attempts made to introduce the practice into non-practising communities under the guise of religious merit.[65]

2.2.1.1 Opportunities for Social Norm Change in Indonesia

Recent studies, including Setiati et al. (2023), indicate encouraging trends that suggest a gradual shift away from the practice of FGM/C in Indonesia. The study notes: "Female circumcision has begun to be abandoned because of the pain and polemic regarding female circumcision in terms of health and gender, which affects the young parent's habitus and the schemas towards their daughters."[66]

Approximately half of Indonesian girls and women do not undergo FGM/C.[67] Several factors influence the decision to not opt for the procedure:

- Nearly 50% of women in Indonesia do not consider FGM/C a religious obligation
- In some regions (North Sulawesi (25%), South Sulawesi (38%), Southeast Sulawesi (31%), Bengkulu (37%), Maluku (32%), West Papua (18%), Papua (3%), East Nusa Tenggera (2.7%), Central Java (25%), Yogyakarta (9%), Bali (6%)), non-practice is the norm, with most residents choosing not to circumcise their daughters, thereby encouraging others to follow suit
- FGM/C is not recognised as a family custom, and families who opt out of FGM/C face no social repercussions
- The practice is not recognised as a customary family tradition in certain communities
- Scientific evidence highlighting health risks is increasingly accepted, and claims of medical benefits such as increased maturity, fertility, or libido control are widely rejected
- **Indonesia stands out in Southeast Asia, with 7.1% of respondents citing trauma as a reason for non-participation**.
- Some communities prioritise social interactions and religious freedom over traditional beliefs, especially amongst younger generations who have more knowledge on sexual and reproductive health and women's rights, creating space for advocacy against FGM/C.

The study identifies government authorities, healthcare professionals, and religious leaders and (to a lesser extent) community leaders as the most influential stakeholders in efforts to eliminate the practice.

BOX 3:
INSIGHTS FROM KEY INFORMANT INTERVIEWS IN NORTH LOMBOK AND LAMPUNG

FGM/C is perceived as a mechanism for preserving cultural identity and continuity, serving both as a transmission of cultural heritage and a marker of community belonging. This was clearly articulated by a retired teacher in North Lombok, who explained that the practice is passed down through maternal lines. Mothers are acutely aware that girls who remain uncircumcised risk religious marginalisation, scrutiny during marriage negotiations, and social bullying. She emphasised that while community elders possess the authority to challenge the practice, external actors often lack the credibility and influence to do so effectively.

Interviews with four community leaders and women's rights activists in Lampung revealed the pervasive nature of community pressure surrounding FGM/C. Neighbours frequently enquire whether the procedure has been performed on newborns, creating a strong expectation of social conformity even among migrant families. Uncircumcised children are often stigmatised, with behavioural issues attributed to the absence of the procedure.

Two university students shared that they had undergone FGM/C at the hands of midwives, coinciding with ear piercing and the issuance of birth certificates. They recounted experienced midwives from their mothers' generation actively identifying uncircumcised girls, even those of primary school age, and arranging for them to be circumcised to avoid being labelled un-Islamic. **The students viewed the practice as a means of controlling female sexuality, reducing libido, and ensuring fidelity to future husbands.** One of them expressed a willingness to circumcise a future daughter, perceiving no adverse consequences from the procedure.

2.2.2 THE ROLE OF RELIGION

KEY FINDING 2.2.2

Doctrinal differences among Islamic scholars and communities in Indonesia **significantly influence faith-based organisations' positions** on FGM/C.

While Southeast Asian Shafi'i jurisprudence generally endorses FGM/C,[68] **a growing number of Indonesian scholars are adopting alternative Islamic doctrines.**[69] These include:

- ***Maslahah and Mafsadat:*** Evaluating practices based on public interest and potential harm.
- ***Maqasid al-sharia:***[70] Protecting well-being through principles that uphold women's agency in religious expression, protection from harmful practices, freedom of thought and political expression, healthy sexuality, and reproductive rights.

Regional variations in interpretation are evident. For instance, scholars in Madura often apply *qiyas* (analogical reasoning) to equate male and female circumcision, thereby limiting theological flexibility. In contrast, the Indonesian Women *Ulema* Congress (KUPI) has issued a *fatwa* opposing FGM/C, grounded in principles of *mubadalah* (reciprocity), *keadilan hakiki* (true justice), and *makruf* (virtue).[71]

2.2.2.1 Syncretic Islam and Its influence on FGM/C Prevalence

Syncretic Islam combines Islamic, Hindu, Buddhist, and animist elements, affecting FGM/C perceptions in Indonesia, especially in Central and East Java.[72] **Orthodox Muslims (Shafi'i) generally support FGM/C, while syncretic Muslims often reject or consider it optional.** In syncretic traditions, FGM/C is viewed as a pre-Islamic Javanese custom marking religious adherence, adulthood, and fertility. Symbolic alternatives include cutting a turmeric root or a cock's comb instead of female genitalia. Research from the early 2000s revealed near-universal FGM/C prevalence in orthodox regions like West Sumatra, while in syncretic areas such as Yogyakarta, prevalence was below 50%.[73] This indicates that syncretic traditions have had some role in influencing FGM/C practices, challenging notions of religious uniformity.

2.2.2.2 The Influence of *Fatwa*-Issuing Bodies on the Practice of FGM/C

KEY FINDING 2.2.2_2

***Fatwas* play a pivotal role in shaping FGM/C practices in Indonesia**, with religious organisations and religious leaders adopting nuanced positions.

Although Indonesia is home to the world's largest Muslim population, its legal system is grounded in national legislation rather than religious doctrine. *Fatwas*, while not legally binding, serve as influential spiritual guidance for many Muslim communities. Prominent religious organisations such as *Muhammadiyah*, *Nahdlatul Ulama* (NU), and the Indonesian *Ulama* Council (MUI) are frequently consulted on both religious and everyday matters, often offering differing interpretations of the same scriptural sources.

Among these, *Muhammadiyah* stands out as the only major body, to not recommend FGM/C, citing principles of gender equity and justice. In contrast, both NU and MUI have historically supported the practice. The Indonesian Women *Ulema* Congress (KUPI), a pioneering female-led religious body, has issued a *fatwa* declaring FGM/C *haram* (forbidden), grounded in values of justice, reciprocity, and ethical virtue.[74]

Research from the early 2000s revealed near-universal FGM/C prevalence in orthodox regions like West Sumatra, while in **syncretic areas such as Yogyakarta, prevalence was below 50%**. This indicates that syncretic traditions have had some role in influencing FGM/C practices, **challenging notions of religious uniformity**.

TABLE 1: RELIGIOUS ORGANISATIONS IN INDONESIA AND THEIR DOCTRINAL POSITIONS ON FGM/C

RELIGIOUS ORGANISATIONS	DOCTRINAL ASSESSMENT BEHIND THE RESPECTIVE FATWAS	POSITION ON FGM/C
MUI (2008)[75]	Circumcision is part of the natural order *(Fitrah)* and activities of religious devotion *(Syiar)*.	FGM/C is not obligatory, but highly recommended
NU (2010)[76]	Formalist *Fiqh* reasoning. Interpretation of the jurisprudence rather than the Scriptures.	FGM/C is not obligatory, but recommended or permissible
Fatayat NU (NU's women branch)[77]	Cannot issue fatwas but believes that FGM/C does not have any ground in religion.	Promotes abandonment of FGM/C
Muhammadiyah (2010)[78]	Direct interpretation from the *Quran* and *Sunnah*.	FGM/C is not recommended
KUPI (2022)[79]	Interpretation of Islamic texts with strong gender perspective and women's life experience	Forbids FGM/C

Although cultural customs primarily drive FGM/C, many Indonesians continue to believe it is a religious obligation. **The convergence of *fatwa*-issuing bodies on its prohibition opens new opportunities** to engage religious leaders in reinterpreting religious texts and challenging the practice.

Excerpts from the discussion covered by Prof Marcoes (2024) cover the diverse range of opinions in the room:

"Muhammadiyah affirmed that female circumcision is not recommended. First, because the hadith used as the legal basis are weak; second, because the Prophet himself never recommended it or had it done to his daughters.

NU and MUI share the position that, based on the hadith that they use as a reference, female circumcision cannot be prohibited. However, if it turns out that the procedure gives rise to damage (mudarat) then the state is obliged to ensure that it is not harmful.

In contrast, KUPI conducted a very strict critique of the references and concluded that female circumcision is haram. It posits that circumcision on men is very different from that on women. Female circumcision, it said, has unclear standards and is very risky since it involves a vital organ.

All four religious organisations agree that maslahah or well-being is the highest ethical standard in any action based on religious views."

Although cultural customs primarily drive FGM/C, many Indonesians continue to believe it is a religious obligation. The convergence of *fatwa*-issuing bodies on its prohibition opens new opportunities to engage religious leaders in reinterpreting religious texts and challenging the practice.

The involvement of the Indonesian Women Ulema Congress (KUPI) in public discourse reflects a broadening of religious interpretation and contestation in a society experiencing a conservative shift. The Majelis *Ulama* Indonesia (MUI), which receives state funding, operates autonomously and has become an increasingly influential and traditional actor in the political landscape. Meanwhile, *Muhammadiyah* and *Nahdlatul Ulama* (NU) have faced internal pressures from more conservative factions. As a result, progressive and feminist interpretations—such as those advanced by KUPI often struggle to gain visibility and institutional recognition.[80]

BOX 4:
INSIGHTS FROM INTERVIEWS WITH RELIGIOUS LEADERS IN NORTH LOMBOK AND EAST JAKARTA

A religious leader from North Lombok characterised FGM/C as a cultural tradition lacking a clear basis in Islamic doctrine. He explicitly noted that the wives and daughters of the Prophet Muhammad were not circumcised, challenging common religious justifications for the practice. However, he acknowledged that he does not address FGM/C in his sermons and is unaware of relevant government regulations, reflecting a passive stance that neither endorses nor opposes the practice.

A second religious leader, while also recognising that FGM/C is not a religious obligation, described the practice as "not prohibited" and "optional." He reported choosing to have the girls in his family undergo FGM/C, indicating personal support despite acknowledging its non-mandatory status. He rejected the belief that contact with uncircumcised women invalidates ritual ablutions, thereby challenging a widespread social misconception. He recommended that **religious gatherings be used as platforms for education on the harms of FGM/C**.

In East Jakarta, another religious leader described FGM/C as a private family matter that is rarely discussed publicly. He clarified that Islamic law considers female circumcision *makruh* (discouraged) and better avoided if harmful rather than obligatory. Nevertheless, the practice persists due to entrenched family traditions and a lack of understanding of Islamic texts. He identified the reduction of women's libido as the primary cultural rationale for its continuation.

2.3 LEGAL, REGULATORY AND POLICY FRAMEWORKS

KEY FINDING 2.3

The 2025 Ministry of Health Regulation[81] No. 2 of 2025 **bans FGM/C** in a decree covering all ages.[82]

Historical resistance to FGM/C regulations in Indonesia indicates a **strong likelihood of opposition** within communities to the forthcoming 2025 Government regulation.

Indonesian law is founded on shared principles that embrace unity amidst diversity. The country's legal framework, including its constitution, is secular in nature.[83] **In a significant step forward, the Indonesian government issued a Government Regulation that bans FGM/C.** This regulation marks a pivotal shift in national policy and aligns with growing concerns about public health and human rights.

Previously, Indonesia's 2010 health regulation permitted licensed medical professionals to perform symbolic female circumcision, specifically by scratching the clitoral frenulum without injuring the clitoris itself, purportedly ensuring safety while adhering to religious requirements. However, this regulation failed to prohibit WHO-classified forms of FGM/C or establish penalties for violations, thereby legitimising the practice within healthcare settings under both medical and religious justifications. The 2025 regulation by the Minister of Health represents a reversal of this stance and offers a legal foundation for broader advocacy and enforcement efforts aimed at eliminating FGM/C in Indonesia. This regulation (No. 2) is a derivative regulation from the Government Regulation, No. 28 of 2024, particularly, articles 100-102.

BOX 5:
HEALTH REGULATION NO. 2 OF 2025[84]

Article 6

(1) Promotive efforts for the health of the Reproductive System of infants, toddlers, and preschool children are aimed at parents, families, guardians, caregivers, teachers, educators in early childhood education, and children.

(3) **Promotive efforts as referred to in paragraph (1) are implemented through the provision of communication, information, and education, at least including:**
   e. the abolition of the practice of female circumcision.

(4) **The elimination of female circumcision practices as referred to in paragraph (3) letter e is limited to female circumcision practices that endanger the Reproductive System, which include:**
   a. cutting and/or wounding of the clitoris, labia minora, labia majora, hymen, and/or vagina, either partially or completely; and
   b. other actions that cause damage to the clitoris, labia minora, labia majora, hymen, and/or vagina, either partially or completely.

(5) **The elimination of the practice of female circumcision as referred to in paragraph (4), does not only apply to infants, toddlers, and preschool children, but also applies to school age and adolescents, adults, and the elderly.**

(6) The Central Government, Regional Governments, and community stakeholders shall conduct advocacy, socialisation, and community movements on the provisions of the elimination of the practice of female circumcision.

Although the Indonesian government has issued a regulation banning FGM/C practice, the technical regulation specifying the legal consequences and practical context is yet to be issued. As a result, there are currently no significant legal implications, and in the absence of dissemination, implementation, and enforcement mechanisms, medical practitioners are likely to continue existing practices.

Indonesia has a poor track record in implementing and enforcing existing regulations on FGM/C. For example, FGM/C as a harmful practice could have been prosecuted under several existing Indonesian laws, notably: Law No. 7 1984 on the Verification of the Convention on the Elimination of all Forms of Discrimination Against Women; Law number 36/2009 on Health; Law number 23/2004 on the Abolition of Domestic Violence; and Law number 35/2014 on Child Protection. In addition, FGM/C practices violate medical ethics. Despite this, there appear to be no cases of prosecution to date.[85] The knowledge and the enforcement of the various regulations (2006, 2010, 2014) have been inconsistent, and this may also be a risk for the 2025 regulation.[86]

The 2014 Ministry of Health regulation encountered several challenges,[87] **including a lack of clarity, ineffective implementation at the local level, and non-compliance by midwives due to community demand.** These shortcomings highlight the importance of learning from past experiences to avoid similar pitfalls with the 2025 regulation. A proactive approach to addressing potential resistance through community engagement and clear communication will be crucial for the success of the 2025 regulation.

There is evidence that regions with entrenched FGM/C traditions such as Gorontalo, South Sulawesi, West Nusa Tenggara, and Banten may strongly resist the 2025 regulation.[88] A 2020 study in Jambi found that around 80% of respondents would likely oppose a ban.[89] In West Java, Garut's 2016 regulation faced poor implementation due to limited awareness, cultural persistence, and lack of enforcement mechanisms (Setiati, Muslim and Sabri, 2023). Similarly, in Gorontalo, initial support for anti-FGM/C efforts waned as religious influence by Majelis *Ulama* Indonesia, historical identity, and inconsistent localisation led communities to reject external norms.[90]

2.4 MEDICALISATION OF FGM/C

KEY FINDING 2.4

Midwives perform both more invasive and symbolic forms of FGM/C, influenced by a combination of **respect for tradition** or **religious beliefs, medical training,** and **financial incentives**.

Midwives in Indonesia perform both invasive and symbolic forms of FGM/C. The delegation of circumcision responsibilities to midwives has contributed to an increase in both physically intrusive procedures and symbolic acts intended to reduce harm.[91] As early as 2003, midwives reported conducting more severe forms of FGM/C than traditional practitioners, including incision and excision.[92]

Findings from the PSKK-UGM 2017 survey[93] highlight several key trends:

- **Approximately half of health practitioners (51.7%) are not affiliated with religious organisations.** Among those who are, 38% are associated with the pro-FGM/C Nahdlatul *Ulama* (NU), while only 8.6% are linked to the anti-FGM/C *Muhammadiyah*.
- **Although non-injurious cleaning is the most common practice (80%), invasive procedures remain prevalent (43.3%)**, meaning that some midwives proceed to both forms of FGM/C.
- **Midwives are twice as likely to incise rather than amputate clitoral tissue, and twice as likely to scratch or scrape the urethra.**
- **About half of the midwives (46.1%) reported performing FGM/C involving injury or cutting.** The most frequent method is scratching the clitoris until injury (43.3%), followed by cutting the prepuce (23.8%).
- Practitioners acknowledge the associated risks, including pain, bleeding, infection, trauma, and potential fatality.

Some midwives adopt symbolic rituals to shield girls from invasive procedures. Those familiar with FGM/C research are generally aware of their regulatory obligations. Many avoid performing FGM/C altogether, as it is not part of their formal training, opting instead to clean the genitals often without informing parents.

In Jakarta and surrounding areas, healthcare providers have exploited ambiguities in the 2010 and 2014 Ministry of Health regulations, as well as the *Majelis Ulama* Indonesia (MUI) *Fatwa*, to promote FGM/C through digital platforms. Marketing materials, including maternity packages, emphasise that Indonesian FGM/C is conducted by medical professionals, distinguishing it from African practices and framing it as 'female circumcision' rather than 'female genital mutilation'. These providers justify their services by referencing the 2010 regulation and the 2014 Health and Sharia Advisory Council guidelines, operating legally since 2016. Regulation No. 6/2014 permits FGM/C by health workers using specified syringes, despite the absence of detailed procedural guidance and its exclusion from medical curricula.

Medical practitioners justify continuing FGM/C for three reasons:

1. Parental demand, with some midwives reporting potential exclusion from communities if they refuse. Health workers continue to face social pressure to perform FGM/C, with refusal often resulting in stigmatisation, accusations of religious non-compliance, and families turning to traditional practitioners.
2. Belief that medical professionals perform more hygienic procedures than traditional circumcisers
3. Assurance that their 'medical interventions' comply with Regulation No. 16/2014, with some clinics highlighting female doctors or offering additional services.

As early as 2003, midwives reported **conducting more severe forms of FGM/C** than traditional practitioners, including incision and excision.

Some midwives **adopt symbolic rituals to shield girls from invasive procedures**. Those familiar with FGM/C research are generally aware of their regulatory obligations. Many avoid performing FGM/C altogether, as it is not part of their formal training.

BOX 6:
INSIGHTS FROM INTERVIEWS WITH RELIGIOUS LEADERS IN NORTH LOMBOK AND EAST JAKARTA

A midwife at the *Puskesmas* (community health centre) in North Jakarta reported that the facility has not provided FGM/C services since 2008, in accordance with the Ministry of Health's 2006 regulation prohibiting the medicalisation of FGM/C. Midwives at the centre actively inform patients of this prohibition when such services are requested. However, they are unaware of subsequent regulatory developments issued by the Ministry of Health or the Indonesian Midwives Association. The midwife recommended that counselling be extended to the eight independent midwifery clinics in the area to prevent the continuation of FGM/C practices.

This account aligns with findings from focus group discussions, which indicate that FGM/C persists primarily through private midwifery clinics rather than government health institutions. This suggests a potential gap in regulatory enforcement, as private clinics may not have received adequate information regarding the 2006 regulation or the forthcoming 2025 regulation that prohibits the medicalisation of FGM/C.

In North Lombok, a midwife at a community health centre reflected a shift in medical practice. She ceased performing FGM/C in 2021 and now only conducts symbolic cleaning with sterile gauze when under pressure. She emphasised the importance of educating families about the health risks associated with FGM/C and noted that individualised counselling is more effective than community-wide approaches. Her testimony underscores the disconnect between policy and practice. While she is aware of the Ministry of Health's regulations, she noted that it has not been effectively disseminated to the community.

Marketing materials, including maternity packages, emphasise that **Indonesian FGM/C is conducted by medical professionals, distinguishing it from African practices** and framing it as 'female circumcision' rather than 'female genital mutilation'.

3. KEY ACTORS AND THEIR RESPONSES TO FGM/C

3.1 GOVERNMENT RESPONSES TO FGM/C IN INDONESIA

KEY FINDING 3.1

The Indonesian government has a **comprehensive roadmap** to end FGM/C.

Between 2013 and 2023, the Indonesian Government implemented extensive strategies to address FGM/C, including public education, policy advocacy, and stakeholder coordination.[94] Building on these efforts, a comprehensive 2020–2030 Roadmap for the Elimination of FGM/C has been developed, led by the Ministry of Women's Empowerment and Child Protection (MoWEC) in collaboration with the Ministries of Health, Religious Affairs, Education and Culture, National Development Planning, and Home Affairs. Key national institutions such as the Indonesian Child Protection Commission (KPAI), the Central Bureau of Statistics, and the National Commission on Violence Against Women *(Komnas Perempuan)* also support the initiative.

The roadmap is structured into three phases:

1. **Phase 1 (2020–2024):** Establish formal systems, raise public awareness, and integrate FGM/C prevention into national research and development strategies.
2. **Phase 2 (2025–2028):** Expand formal and informal education, strengthen community engagement, and improve data collection.
3. **Phase 3 (2029–2030):** Validate data, embed FGM/C prevention into national and global strategies, and enhance public education efforts.

See Annex A for a more detailed description of the roadmap.

Key ministries are actively working to prevent FGM/C by integrating awareness into medical and religious education, enforcing legal protections, and monitoring compliance with Indonesia's international human rights commitments, including CEDAW and the Sustainable Development Goals (SDGs). While progress has been made, further engagement is needed from institutions such as the National Human Rights Commission (Komnas HAM) and the Coordinating Ministry for Legal and Human Rights Affairs to frame FGM/C more explicitly as a human rights issue. Strengthening implementation and coordination across government remains essential to achieving the roadmap's objectives.

3.2 CIVIL SOCIETY RESPONSES TO FGM/C IN INDONESIA

Indonesia's civil society plays a vital role in efforts to eliminate FGM/C, engaging a wide range of actors including healthcare professionals, religious organisations, civil society groups, and grassroots initiatives. Midwives, doctors, and obstetricians are actively involved in implementing legal frameworks and conducting public education campaigns. Professional associations, such as the Indonesian Midwives Association (IBI) and the Indonesian Medical Association (IDI), are leading advocacy efforts, while others, **like the Indonesian Paediatrics Society (IDAI) and the Indonesian Society of Obstetricians and Gynaecologists (POGI), remain under-engaged but represent strategic opportunities for future action**.

Religious organisations present a mixed stance: *Nahdlatul Ulama* (NU) and *Muhammadiyah* have adopted progressive positions opposing FGM/C, whereas the Indonesian *Ulema* Council (MUI), which has historically supported the practice, is gradually shifting towards a health-based perspective. Civil society organisations, such as PKBI, Rahima, and KUPI, are actively advocating for policy reform and public awareness, while youth-led groups like the Youth Coalition for Girls (YCG) are leveraging social media to amplify anti-FGM/C messaging. At the community level, grassroots movements such as GUYUB REMEN are working to eliminate FGM/C from the village level. While these actors are broadly aligned in their opposition to FGM/C, their strategies vary, ranging from legal reform and religious reinterpretation to direct community engagement.

TABLE 2:
KEY GOVERNMENT STAKEHOLDERS AND THEIR ENGAGEMENT

INSTITUTION	ENGAGEMENT STATUS	KEY OPPORTUNITIES
GOVERNMENT MINISTRIES		
Ministry of Women's Empowerment and Child Protection (MoWEC)	**Positively engaged**	Leads FGM/C prevention efforts; compiles CEDAW report (due Nov. 2025).
Ministry of Health	**Positively engaged**	Enforces health regulations against FGM/C; integrates awareness into medical training.
Indonesian Health Council	**Neutral; Enquiry ongoing**	Oversees medical professional standards; opportunity to regulate health worker involvement in FGM/C prevention.
Ministry of Religious Affairs	**Positively engaged**	Integrates FGM/C prevention into religious education and marriage counselling.
Ministry of Home Affairs	**Positively engaged**	Prevents local governments from endorsing FGM/C; opportunity for MoU to reinforce this.
Ministry of Education, Culture, Research, and Technology	**Positively engaged**	Embeds FGM/C prevention into school curricula and anti-violence policies.
Ministry of Foreign Affairs	**Positively engaged**	Reports Indonesia's FGM/C commitments to the UN (CEDAW, SDGs, etc.); opportunity to strengthen Indonesia's global advocacy.
Ministry of National Development Planning (Bappenas)	**Positively engaged**	Integrates FGM/C prevention into national development strategies and SDG targets.
Coordinating Ministry for Human Development and Cultural Affairs	**Positively engaged**	Oversees multiple ministries engaged in FGM/C prevention.
Coordinating Ministry for Legal, Human Rights, Immigration, and Corrections	**Not yet engaged**	Opportunity to frame FGM/C as a human rights violation and align efforts with CEDAW recommendations.
NATIONAL INSTITUTIONS		
Indonesian Child Protection Commission (KPAI)	**Positively engaged**	Advocates for policy reforms and public education against FGM/C.
National Commission on Violence Against Women (Komnas Perempuan)	**Positively engaged**	Conducts research, public awareness, and policy advocacy on FGM/C.
National Human Rights Commission (Komnas HAM)	**Not yet engaged**	Potential to advocate FGM/C elimination as part of Indonesia's human rights obligations.

TABLE 3: KEY CIVIL SOCIETY ACTORS AND THEIR ENGAGEMENT

ORGANISATION	ENGAGEMENT STATUS	KEY OPPORTUNITIES
HEALTH SECTOR		
Indonesian Midwives Association (IBI)	**Positively engaged**	Issued a circular against FGM/C; training and education initiatives.
Indonesian Medical Association (IDI)	**Positively engaged**	Supports Roadmap 2020-2030; legal framework reinforcement.
Indonesian Society of Obstetricians (POGI)	**Not yet engaged**	Can integrate FGM/C as gender-based violence in ethical guidelines.
Indonesian Paediatrics Society (IDAI)	**Not yet engaged**	Potential to partner with Child Protection Task Force for education.
RELIGIOUS GROUPS		
Indonesian Ulema Council (MUI)	**Positively engaged**	Recent shift in stance; collaborating with Ministry of Health.
Nahdlatul Ulama (NU)	**Positively engaged**	Influence through Islamic boarding schools and Fatayat NU.
Muhammadiyah	**Positively engaged**	Issued *fatwa* against FGM/C; operates extensive health facilities.
CIVIL SOCIETY ORGANISATIONS		
Perkumpulan Keluarga Berencana Indonesia (PKBI)	**Positively engaged**	Advocacy, policy review, and public campaigns.
Yayasan Puan Amal Hayati	**Positively engaged**	Advocating for FGM/C integration into religious counselling.
Perkumpulan Rahima	**Positively engaged**	Female ulama networks promoting anti-FGM/C discourse.
Indonesian Women's Ulama Congress (KUPI)	**Positively engaged**	Issued 2022 fatwa against FGM/C. Digital platform for awareness.
Rumah Kita Bersama (Rumah Kitab)	**Positively engaged**	Research-based advocacy; Islamic perspective on FGM/C.
Yayasan Kesehatan Perempuan (YKP)	**Positively engaged**	Long-term advocacy and engagement with Ministry of Health.
Youth Coalition for Girls (YCG)	**Positively engaged**	Social media campaigns targeting youth awareness.
Jaringan Aksi Remaja	**Positively engaged**	Focus on gender equality and FGM/C elimination among adolescents.
CEDAW Working Group Indonesia (CWGI)	**Positively engaged**	Monitoring CEDAW compliance; potential to raise FGM/C in reports.
Kalyanamitra	**Positively engaged**	Research on medicalisation of FGM/C; collaboration with government.
COMMUNITY-BASED		
Paguyuban Perempuan Menoreh (GUYUB REMEN)	**Positively engaged**	Rural-level advocacy and village policy influence.

3·3
INTERNATIONAL AND REGIONAL RESPONSES TO FGM/C IN INDONESIA

In Indonesia, international investment in FGM/C prevention has been particularly impactful, with Australia's DFAT and the UN Population Fund (UNFPA) serving as key contributors. A notable example is the Towards Universal SRHR in the Indo-Pacific (TUSIP) programme—a $57 million initiative funded by DFAT. TUSIP aims to expand access to comprehensive sexual and reproductive health and rights (SRHR) services, information, and education across the Indo-Pacific region. This includes family planning, testing and treatment of sexually transmitted infections, and access to safe abortion services where legally permitted.

UNFPA has played a strategic role in advancing FGM/C prevention in Indonesia. It successfully advocated for the inclusion of an FGM indicator in the National Medium-Term Development Plan (2025–2029). It supported the integration of FGM/C into Government Regulation No. 28/2024 and the draft Ministerial Regulation on Reproductive Health. UNFPA also promoted national budget allocations for FGM/C prevention under the Ministry of Health. Its capacity-building efforts include strengthening teacher training for delivering comprehensive Adolescent Reproductive Health (ARH) education, covering FGM/C in both public and Islamic schools, supported by the development of culturally relevant curricula and modules. Additionally, UNFPA has developed a National Midwifery Continuing Professional Development (CPD) Framework, embedding FGM/C content to ensure midwives are equipped to address the issue. To address the social norms underpinning FGM/C, UNFPA has engaged with religious organisations such as *Nahdlatul Ulama* and *Muhammadiyah*, supporting literature reviews, assessments of *fatwa* implementation, and interventions aimed at shifting community norms.

To address the social norms underpinning FGM/C, UNFPA has **engaged with religious organisations** such as *Nahdlatul Ulama* and *Muhammadiyah*, supporting literature reviews, assessments of *fatwa* implementation, and **interventions aimed at shifting community norms**.

4. COUNTRY CASE STUDIES

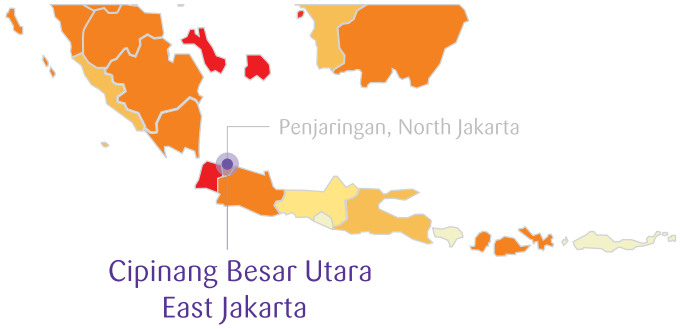
4.1 CASE STUDY: PENJARINGAN VILLAGE, NORTH JAKARTA, INDONESIA

CONTEXT: Penjaringan Urban Village is one of five *kelurahan* within the Penjaringan Sub-district, alongside Pluit, Pejagalan, Kapuk Muara, and Kamal Muara. As of 2024, the population stands at 115,070 residents, comprising 59,120 men and 55,950 women, with a population density of 29,131.65 people per square kilometre. North Jakarta, including Penjaringan, is characterised by its ethnic, religious, and cultural diversity. According to the 2010 population census, the area is predominantly inhabited by Javanese, Betawi, Batak, Chinese, and Sundanese communities, with smaller populations of Minangkabau, Bugis, and other ethnic groups. Religious affiliation is similarly varied. Data from the North Jakarta City Statistics Agency (2020) indicates that 84.36% of residents identify as Muslim, followed by Buddhists (7.90%), Christians (7.67% including 5.75% Protestant and 1.92% Catholic), Hindus (0.05%), and others (0.02%), including Confucianism and indigenous belief systems.

One focus group discussion with community women and one key informant interview with a *Puskesmas* midwife were conducted.

KEY FINDINGS FROM THE DISCUSSIONS:

- **Terminology:** Participants were more familiar with the terms “female circumcision” or *sunat perempuan* than with FGM/C.
- **Age of Procedure:** Female circumcision was typically performed between birth and three months of age.
- **Location and Providers:** Most procedures were carried out by midwives at maternity clinics. Only two participants reported using traditional birth attendants outside Jakarta.
- **Government vs Private Practice:** A *Puskesmas* (government) midwife confirmed that *Puskesmas* Penjaringan 2 has not provided female circumcision services since 2008, in line with the 2006 Ministry of Health regulation prohibiting medicalisation. Midwives at the *Puskesmas* educate patients about the prohibition. However, community women reported that private midwife clinics continue to offer the service, indicating a disconnect between policy and practice.
- **Regulatory Gaps:** There is concern that private clinics may not have received information about the 2006 regulation or the forthcoming 2025 regulation prohibiting female circumcision.
- **Medicalisation:** Some maternity clinics continue to offer bundled packages including childbirth, female circumcision, and ear piercing. In some cases, circumcision is performed at the mother’s request during labour.
- **Methods Used:** Techniques included gouging with a coin, pinching with tweezers, and piercing with a sewing needle. Most mothers did not witness the procedure due to emotional distress.
- **Perceived Impact:** Participants reported minimal physical effects, like crying and slight bleeding, and no perceived long-term health consequences.
- **Cultural Practices:** No special ceremonies were held for circumcised girls. Instead, a general thanksgiving event *(selapanan)* is held for all newborns at 35 days old.
- **Motivations:** Reasons cited included hygiene, religious obligation, and family tradition. None of the participants could cite specific religious texts supporting the practice.
- **Decision-Makers:** Mothers or the wife’s family typically made the decision. Mothers were identified as the most influential figures.
- **Social Consequences:** In urban areas, participants noted no formal sanctions for not circumcising girls. However, some feared gossip or moral judgement, with uncircumcised girls perceived as unclean or at risk of immoral behaviour.
- **Awareness of Regulation:** Community members were largely unaware of government regulations prohibiting female circumcision. *Puskesmas* midwives were aware of the 2006 regulation but not of more recent developments.



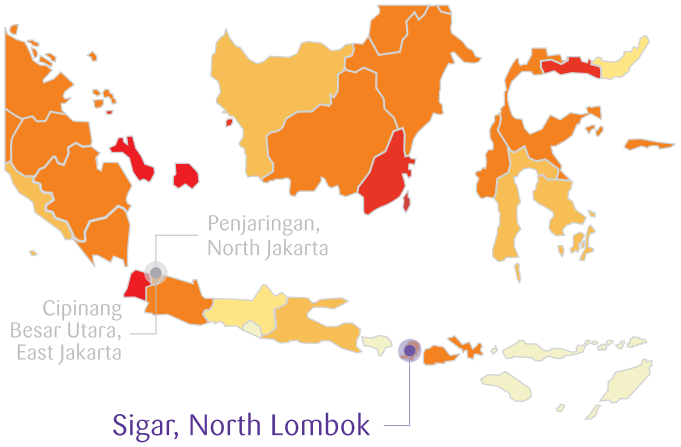
4.2 CASE STUDY: CIPINANG BESAR UTARA VILLAGE, EAST JAKARTA, INDONESIA

CONTEXT: Cipinang Besar Utara Urban Village (Kelurahan) is one of eight urban villages in the Jatinegara District. As of 2024, the population totalled 58,959 residents, 30,142 men and 28,817 women, resulting in a population density of 29,131.65 people per km^2. The religious composition of Cipinang Besar Utara is notably diverse. According to 2024 data from the Central Bureau of Statistics, majority of residents identify as Muslim (92.32%), followed by Protestant Christians (5.04%), Catholics (1.44%), Buddhists (1.17%), Hindus (0.03%), and others (0.01%), including adherents of Confucianism and indigenous belief systems.

One focus group discussion with community women and one key informant interview with a religious leader were conducted.

KEY FINDINGS FROM THE DISCUSSIONS:

- **Terminology:** Residents are more familiar with the term "female circumcision" or *sunat* perempuan.
- **Age of Procedure:** Typically performed between birth and two months of age.
- **Location and Providers:** Procedures are mainly carried out by midwives in maternity clinics, but also occur at Puskesmas, public clinics, and with traditional birth attendants.
- **Medicalisation:** Some maternity clinics and public health centres offer bundled packages including childbirth, female circumcision, and piercing.
- **Methods Used:** Techniques include prying the clitoris with a sewing needle, particularly for mothers giving birth. Most mothers do not witness the procedure due to emotional discomfort.
- **Perceived Impact:** Babies typically cry post-procedure, but participants reported no physical or psychological health issues.
- **Cultural Celebrations:** No specific celebration for female circumcision. General newborn ceremonies such as *selapanan* (held at 35 days) and *aqiqah* (on the 7th or 40th day) are observed. These involve shaving the baby's hair and distributing food to neighbours.
- **Religious Leader's View:** A local religious leader noted that female circumcision is rarely discussed publicly and is considered a private family matter, unlike male circumcision, which is publicly celebrated.
- **Motivations:** Reasons cited include hygiene, religious belief, tradition, and controlling female sexuality. While community women cited Islamic teachings, religious leaders clarified that female circumcision is *makruh* (discouraged) and not obligatory, especially if harmful. Many people continue the practice out of adherence to family tradition, without a detailed understanding of religious texts. Culturally, it is believed to reduce female sexual desire. A clear divergence emerged between community women and religious leaders. Women cited religious obligation as their primary reason, whereas religious leaders emphasised that the practice is not required in Islam and should be avoided if harmful.
- **Decision-Makers:** Mothers are the primary decision-makers, with influence also from grandmothers. Fathers typically defer to mothers for newborns.
- **Social Consequences:** Female circumcision is considered a private matter; girls who are not circumcised are not subject to gossip or sanctions in the community.
- **Awareness of Regulation:** Community members and religious leaders were unaware of government regulations prohibiting female circumcision. Midwives recommended targeted outreach to *Posyandu* cadres and *Jumantik*, who frequently interact with pregnant women. Religious leaders suggested using community religious forums (e.g. *Majelis Taklim, Majelis Subuh*) for awareness-raising.



4.3 CASE STUDY: SIGAR PENJALIN VILLAGE NORTH LOMBOK, INDONESIA

CONTEXT: Sigar Penjalin Village is one of seven villages in the Tanjung Sub-district of North Lombok Regency, West Nusa Tenggara Province, Indonesia. The Sasak ethnic group predominantly inhabits the village. While the exact population density per square kilometre is not specified, the village is part of a region with a high prevalence of female circumcision practices. The majority of the population in Sigar Penjalin is Muslim, reflecting the broader religious composition of West Nusa Tenggara.

One focus group discussion with community women and seven key informant interviews with two religious leaders, one CSO representative, one household wife, one traditional birth attendant, one retired teacher/community leader, and one health centre midwife were conducted

KEY FINDINGS FROM THE DISCUSSIONS:

- **Cultural Continuity and Practice:** Female circumcision remains prevalent in Sigar Penjalin Village, rooted in longstanding customs, traditions, and perceived religious obligations. Rituals such as tooth sharpening accompany the practice, which varies from region to region.
- **Age and Timing:** The procedure is commonly performed on girls aged 1 week to 2 years, with exceptions for adult women before marriage or upon conversion to Islam.
- **Motivations and Beliefs:** Drivers include purification, religious identity, social conformity, and perceived health benefits. Misconceptions persist, including beliefs about the invalidation of ablution. Some community members believe that if a girl who has been circumcised experiences regrowth, a second circumcision may be necessary. This belief is linked to notions of behavioural control and aesthetic outcomes, such as preventing disobedience and enhancing facial radiance.
- **Religious Interpretation:** Community members are divided on religious mandates. Religious leaders assert that female circumcision is not obligatory and lacks a clear scriptural basis.
- **Locations and Practitioners:** Circumcision is conducted at health centres, homes, or by traditional healers. Practitioners include midwives, health workers, and traditional birth attendants. Some health workers abstain due to regulatory restrictions. Household wives reported that female circumcision is typically performed by midwives at health centres, with costs ranging from Rp. 35,000 to Rp. 50,000. This affordability contributes to the continued accessibility and normalisation of the practice within the community.
- **Decision-Making Authority:** Parents and in-laws predominantly decide on circumcision, motivated by fear of social sanctions and adherence to tradition.
- **Procedural Methods:** Techniques range from cutting the clitoris with razors or knives to symbolic non-invasive practices. Cultural rituals often accompany the procedure.
- **Health and Social Impacts:** Girls may experience pain, bleeding, and fear. Rare medical complications are reported. Non-circumcised girls face ostracism, bullying, and stigma.
- **Awareness of Regulation:** Government prohibitions are known only to health workers and CSOs. The broader community remains uninformed.
- **Strategies for Change:** Effective prevention requires education, engagement with religious and traditional leaders, and policy advocacy. Resistance stems from entrenched beliefs and limited awareness.
- **National Efforts and Community Response:** Participants endorse national prevention initiatives. Symbolic practices persist, indicating that community perceptions remain unchanged. Migrants face barriers in influencing local norms.

4.4 CASE STUDY: KALIAWI VILLAGE, LAMPUNG, INDONESIA

CONTEXT: Kaliawi Village is one of seven villages in the Karang Pusat sub-district of Bandar Lampung City, covering an area of 56 hectares. The village has a population of 8,933 individuals, consisting of 4,407 men and 4,526 women. Bandar Lampung, including Kaliawi Village, is characterised by significant ethnic diversity. The population includes the indigenous Lampung tribes – *Pepadun* and *Saibatin*, as well as Javanese, Sundanese, *Minangkabau*, Balinese, Chinese, and Malay communities. The religious landscape is predominantly Muslim (93.55%), with minorities practising Protestantism (2.32%), Catholicism (1.62%), Hinduism (1.49%), Buddhism (0.32%), and Confucianism (0.01%). The city is home to a diverse mix of racial groups, including Malays, Chinese, Javanese, and Sundanese, reflecting its multicultural and multi-ethnic identity.

Focus group discussions were held in Kaliawi Village but also in the Metro district with 18 housewives, some of whom were still mothers and grandmothers, and 15 KIIs with four religious leaders, (two male, two female), four community leaders and women activists, two young people (university students), two academics (one male and one female), and three health workers.

KEY FINDINGS FROM THE DISCUSSIONS:

- **Terminology and Demographics:** In Kaliawi Village, the term 'circumcision' is commonly used for both males and females.
- **Age of Practice:** Female circumcision is typically performed between 40 days and 5 years of age.
- **Practitioners and Locations:** Procedures are conducted by midwives at maternity clinics or by traditional healers at home. While midwives at public health centres follow the prohibition, some private clinics and doctors continue the practice, often under pressure from the community or financial incentives.
- **Medicalisation and Symbolic Practice:** Some hospitals offer circumcision as part of delivery packages. Midwives may simulate the procedure without actual cutting. Reports include symbolic or minimal interventions to satisfy cultural expectations.
- **Methods Used:** Tools include small scissors, sharp objects, needles, and syringes. The clitoris (referred to as *'jaldah')* is the targeted area, with minor bleeding managed using antiseptics like betadine.
- **Immediate Impact:** Infants often cry due to pain and bleeding, with some discomfort lasting up to two days. Participants reported no long-term physical or psychological effects.
- **Cultural Celebrations:** Unlike male circumcision, female circumcision is not widely celebrated. Some ethnic groups mark the occasion with symbolic food offerings or small gatherings.
- **Motivations:** Justifications include religious obligation, tradition, hygiene, sexual control, and enhancing marital pleasure. The practice is often viewed as a continuation of ancestral customs.
- **Religious Perspectives:** Religious leaders were divided; some supported the practice, citing Islamic texts and tradition, while others opposed it on grounds of harm and lack of scriptural mandate. Exposure to CSO and government education influenced opposition.
- **Decision-Making Authority:** Mothers, grandmothers, and in-laws are primary decision-makers. Young women reported being circumcised at their mother's request, often alongside birth registration or ear piercing.
- **Social Pressure and Stigma:** Uncircumcised girls may face bullying, stigma, and assumptions of immorality. Feelings of guilt and religious inadequacy were reported by mothers whose daughters were not circumcised.
- **Awareness of Regulation:** Most participants were unaware of government prohibitions. Those informed expressed willingness to comply if religious guidance aligned with state policy.
- **Prevention Strategies:** Effective prevention requires religious education, community engagement, and dissemination of *fatwas* such as KUPI's prohibition. Involving religious institutions and trusted leaders is critical.
- **Contradictions and Emotional Conflict:** Some mothers expressed relief when midwives refused to perform circumcision, yet also felt guilt and fear of social judgement. Education on health risks and religious permissibility helped alleviate these concerns.

4.5 CROSS-CASE ANALYSIS

- **Prevalence and Typology:** Female circumcision remains prevalent in both urban and rural areas across Penjaringan (North Jakarta), Cipinang Besar Utara (East Jakarta), Sigar Penjalin (North Lombok), and Kaliawi (Lampung City). The practice includes WHO Type 1 (partial or total removal of the clitoris) and Type 4 (non-medical procedures such as piercing, scraping, and symbolic rituals).
- **Age of Practice:** The age at which female circumcision is performed varies by region: from birth to 3 months in Penjaringan, up to 2 months in Cipinang Besar Utara, from birth to 6 years (and occasionally adulthood) in Sigar Penjalin, and from 40 days to 5 years in Kaliawi.
- **Decision Makers:** The decision to circumcise is typically made by mothers, grandmothers, or in-laws, reflecting intergenerational transmission of the practice and the influence of familial hierarchy.
- **Community Perspectives on Change:** Community members expressed willingness to abandon the practice if it is proven harmful to health or not mandated by religion or custom. Awareness of government regulation was cited as a potential deterrent.
- **Key Drivers:** The practice is driven by beliefs in health and hygiene benefits, religious obligation, and adherence to ancestral traditions. Myths perpetuating the practice include fears of sin, impurity, invalid ablution, and social deviance among uncircumcised women.
- **Social Sanctions:** Uncircumcised women may face gossip, stigma, exclusion from religious activities, and barriers to marriage. These sanctions reinforce compliance with the practice.
- **Barriers to Change:** Key barriers include patriarchal norms, conservative religious interpretations, lack of gender and human rights education, insufficient dissemination of government regulations, and absence of enforcement mechanisms for symbolic or medicalised circumcision.
- **Awareness of National Regulation:** Grassroots communities, religious leaders, and traditional healers were largely unaware of the 2025 Ministry of Health regulation prohibiting female circumcision. Health workers at public facilities were more informed but lacked updated guidance.
- **Community Responses to 2025 Policy:** Community members, CSOs, and health workers responded positively to the regulation, indicating a readiness to comply if health risks are acknowledged. However, traditional birth attendants in Lombok continue to support the practice as a cultural legacy.
- **National level Advocacy Challenges:** Challenges include resistance from conservative religious groups, lack of public understanding of human rights violations, continued community demand, support on social media platforms, stigma against non-compliant health workers, and limited dissemination of regulatory frameworks.
- **Opportunities for Reform:** Opportunities include the 2025 Ministry of Health regulation, the 2020–2030 national roadmap for FGM/C prevention, supportive figures within religious institutions, existing advocacy networks, and the potential of social media for awareness-raising among youth.

5. LEARNINGS FROM OTHER REGIONS

Indonesia was compared with Egypt, Iraqi Kurdistan, Somalia/Somaliland, Ethiopia, and Kenya to uncover similarities and differences, while learning from best practices that could inform approaches in the Southeast Asia context. Complete country profiles are available on the Orchid Project website.

Indonesia and Egypt share significant similarities in their religious context regarding FGM/C. Both countries have large Muslim populations and rank among the top three global contributors to FGM/C cases. In both contexts, religious justifications for the practice are prominent, with FGM/C often viewed as a means of purification and control of female sexuality. The high rate of medicalisation in Egypt (78.4%) and growing trends within Iraqi Kurdistan and Somali communities present cautionary lessons for Indonesia. Egypt's experience demonstrates that promoting FGM/C as a medical procedure can legitimise rather than eliminate the practice. Indonesia, where midwives play a notable role (similar to Ethiopia), should address the risk of medicalisation early in its strategy development.

As Indonesia begins to develop legal prohibitions against FGM/C, it can learn from both the successes and failures of other countries. Egypt's experience highlights the dangers of policy oscillation and inconsistent messaging. Kenya and Ethiopia show that laws alone are insufficient without addressing underlying social norms. The recommendation to adapt Egypt's legal framework—criminalising all forms of FGM/C, clearly defining prohibited acts, and establishing severe sanctions—while incorporating Indonesia's foundational values, provides a balanced approach.

Indonesia's roadmap, which includes public education, data collection, policy advocacy, and organisational integration, aligns with successful multifaceted approaches seen in other countries. The **FGM-Free Village Project in Egypt** and Wadi's community engagement in Iraqi Kurdistan demonstrate the effectiveness of community-led initiatives.

Indonesia could particularly benefit from the **Generation Dialogues approach used in Egypt, Ethiopia, Somalia, and Sudan**,[95] which creates non-judgmental spaces for discussing decision-making dilemmas. While Indonesia shares many contextual similarities with countries like Egypt, it faces unique challenges in addressing FGM/C. Previous reports[96] suggest Indonesia leans toward **"preventive efforts over repressive measures"** compared to Egypt's "more stringent approach." The integration of Indonesia's foundational values (Pancasila and UUD 1945) into anti-FGM/C frameworks presents both a challenge and an opportunity for developing culturally appropriate interventions that maintain human rights principles.

By learning from the experiences of Egypt, Iraqi Kurdistan, Somalia/Somaliland, Ethiopia, and Kenya, Indonesia can develop a contextually appropriate and effective approach to eliminate FGM/C. To effectively address FGM/C, Indonesia should consider:

Evidence suggests that success will require:

1. **Engaging religious leaders** in meaningful dialogue without imposing zero-tolerance framing
2. **Developing clear legal definitions** and consistent enforcement mechanisms
3. **Addressing the risk of medicalisation** through healthcare provider training and ethical guidance
4. **Facilitating community-led initiatives** that emphasise awareness and sensitisation on FGM/C, while promoting inclusive and sustained dialogue among all stakeholders—especially within communities that may be resistant to change.
5. **Moving beyond health consequences** narratives to broader understandings of harm
6. **Maintaining consistent messaging** from authorities on FGM/C practice, such as national and regional governments, health authorities, law enforcement and judiciary, to build trust and credibility.

6. RECOMMENDATIONS

This report presents a set of recommendations that are informed by extensive consultation with local partners and grassroots organisations, and are shaped by the cultural, political, and operational realities of the country. The recommendations are tailored to reflect regional specificities.

The report examines the applicability of global approaches and learnings to the Southeast Asian context. In particular, the relevance of survivor-led strategies and the integration of FGM/C into medical curricula may not be suitable for the region. Many women in Southeast Asia do not identify as survivors, often because they do not recall undergoing the procedure or do not perceive it as harmful. Similarly, efforts to mainstream FGM/C education in health training institutions and to support model health facilities are unlikely to succeed without more substantial government commitment and more region-specific data on health impacts. The report encourages the use of locally grounded data and narratives, noting that approaches rooted in external contexts may not always resonate with local communities and could risk being perceived as less relevant.

RECOMMENDATIONS FOR INDONESIA

1. ESTABLISH RELIABLE, COMPREHENSIVE, CONSISTENT AND STANDARDISED DATA COLLECTION

- **Support the Ministry of Health (MoH) to reintegrate data on the prevalence of FGM/C into the periodic Indonesian Health Survey (SKI).** Collecting this data alongside other health indicators will provide critical evidence on the scope of the practice—particularly in light of the involvement of health professionals in performing FGM/C—and will strengthen the Ministry's capacity to enforce existing regulations and uphold medical ethics.
- **Advocate and explore avenues with The Central Statistics Agency (BPS) to integrate data** on FGM/C into Indonesia's Sustainable Development Goals (SDG) monitoring framework—specifically under targets related to gender equality, health, and the elimination of harmful practices (SDG 5.3).
- **Support the Ministry of Women's Empowerment and Child Protection (MOWECP) to integrate FGM/C prevention indicators** into the Desa Ramah Perempuan dan Peduli Anak (DRPPA) programme. These include monitoring the proportion of women who receive counselling on female genital cutting during immunization of a child or during an antenatal care visit.

2. STRENGTHEN NATIONAL LEGAL AND POLICY IMPLEMENTATION AND HEALTHCARE REGULATION ON FGM/C

- **Enforce the prohibition of FGM/C in line with the National Action Plan for the Prevention of FGM/C[97] (2020-2030)**, by issuing clear, binding guidelines with robust monitoring and accountable mechanisms, applicable to all healthcare settings, including private clinics, to curb the growing trend of medicalisation of FGM/C.
- **Integrate FGM/C awareness into routine maternal and child health services.** This includes training healthcare providers to address the issue sensitively during regular visits while incorporating culturally appropriate educational materials tailored to local languages and contexts into child health books, national marriage books, and resources distributed through *Posyandu* and community health centres.
- **Implement measures to ensure and meet the government's international commitments to safeguarding the rights and well-being of women and girls,** including but not limited to CEDAW and CRC recommendations.

3. PROMOTE RELIGIOUS RE-INTERPRETATION AND ENGAGEMENT

- **Facilitate structured engagement with religious authorities** at both national and local levels to build consensus to oppose the practice of FGM/C in Islam towards enforcing the prohibition of the practice as laid out in the National Action Plan (NAP) to prevent FGM/C.

- **Support the development and dissemination of contextually relevant religious education materials.** This new religious education material can be used as an effective communications strategy, which will aim to educate people on the lack of religious support for the practice and its possible harms. Indonesia Women's *Ulema* Congress (KUPI) has a significant opportunity to be involved in FGM/C advocacy, considering that KUPI has issued a *fatwa* that FGM/C without medical reasons, is *haram*. Still, members in strategic positions, such as the managing official of the Istiqlal Mosque, must be engaged with and supported to disseminate educational materials on FGM/C.

4. INVEST IN COMMUNITY EDUCATION AND BEHAVIOUR CHANGE

- **Implement targeted Community Behaviour Change strategies in partnership with organisations tailored to specific community contexts.** These should challenge entrenched social norms, dispel misconceptions, and promote positive narratives around bodily autonomy, health, and human rights through culturally sensitive messaging. Strategies could include integrating age-appropriate content on FGM/C into school curricula; developing youth-led advocacy programmes and peer education initiatives that leverage digital platforms, social media, and youth-friendly communication methods; and amplifying stories of resistance and change, such as young mothers choosing not to circumcise their daughters to inspire broader community reflection.

RECOMMENDATIONS FOR THE UK

The UK FCDO is encouraged to adopt a strategic, multi-level approach to support the elimination of Female Genital Cutting (FGM/C) in Indonesia, in alignment with national priorities and regional commitments.

1. SUPPORT THE OPERATIONALISATION OF THE 2025 REGULATION BANNING FGM/C IN INDONESIA

- **Advocate for the Enforcement of the 2025 regulation banning FGM/C**, in line with the National Action Plan for the Prevention of FGMC (2020-2030).
- **Provide funding support for the next round of the Survei Pengalaman Hidup Perempuan Nasional/ Violence Against Women Survey (SPHPN)**, which is facing budget constraints. Strengthening the analysis and use of regional data from SPHPN will be crucial to informing the implementation of Indonesia's 2020–2030 National Action Plan to Prevent FGM/C and ensuring that legal reforms are accompanied by evidence-based action.

2. SUPPORT INDONESIAN CIVIL SOCIETIES TO ADVANCE COMMUNITY-LEVEL AWARENESS AND BEHAVIOUR CHANGE

- **Strengthen partnerships with civil society organisations** that have strong local networks and understanding of the context to lead grassroots advocacy efforts on FGM/C, particularly in underserved and high-prevalence areas, particularly for the development and dissemination of culturally tailored Behaviour Change Communication (BCC) strategies that challenge harmful social and cultural norms and promote rights-based narratives.
- **Support members of the Asia Network to End FGM/C** in participating in national CEDAW reporting processes. This includes contributing to consultations and developing a shadow report that integrates FGM/C into CEDAW submissions.
- **Support knowledge generation and evidence-based advocacy** by working with regional feminist and human rights organisations working on research, advocacy, and grassroots mobilisation, such as Asia Network to End FGM/C.

3. SUPPORT UN AGENCIES' PROGRAMMES ADDRESSING FGM/C IN INDONESIA:

- **Building on existing support, continue strengthening UNFPA's efforts** to enhance midwifery education and professional development through the implementation of the National Midwifery Continuing Professional Development (CPD) Framework in Indonesia. This includes components focused on de-medicalising FGM/C and aligning midwifery training with International Confederation of Midwives (ICM) standards.
- **Promote the expansion of Adolescent Reproductive Health Education (ARH Education) in collaboration with UNFPA**, the Ministry of Education, and key religious organisations such as Nahdlatul *Ulama* (NU), Persatuan Islam (PERSIS) and *Muhammadiyah* in Indonesia.
- **Support Indonesia and UNFPA's forthcoming ethnographic study** exploring midwives' motivations for performing FGM/C, including thorough stakeholder engagement, technical input, or future implementation of its recommendations.

4. SUPPORT AND LEVERAGE HUMAN RIGHTS MECHANISMS THAT CALL FOR THE ELIMINATION OF FGM/C

- **Leverage Global Accountability Mechanisms** to advocate for the explicit inclusion of FGM/C under SDG 5 on gender equality, SDG 3 on Good Health and Well-being, and SDG 16 on Peace, Justice, and Strong Institutions.
- **Support Data Collection efforts** being carried out in the country, aligning with International Human Rights Standards.

Both Malaysia (CEDAW) and Indonesia (CRC) are scheduled for upcoming reviews, presenting **key opportunities to submit evidence, challenge harmful state narratives, and push for alignment of national laws and practices** with international human rights standards.

REGIONAL POLICY PRIORITIES FOR GOVERNMENTS, HUMAN RIGHTS AND DEVELOPMENT PARTNERS

- **Leverage the Beijing +30 and ICPD commitments**, which explicitly call for the prohibition and elimination of FGM/C, by reinforcing FGM/C as a violation of gender equality and SRHR, particularly in the areas of violence against women and girls (Critical Area D), women's health (Critical Area C), and the rights of the girl child (Critical Area L).
- **Support regional platforms and align stakeholders** to advance shared goals on gender equality and the elimination of harmful practices such as FGM/C. This includes supporting the 2025 regional convening organised by ARROW and UNFPA, supporting the DFAT–UNFPA Regional Accountability Framework Programme, and exploring collaboration with the Government of Australia through the Southeast Asia Gender-Based Violence Prevention Platform.
- **Leverage international human rights treaties to reinforce norms and standards that advocate an end to FGM/C**, particularly the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), and the Convention Against Torture (CAT). Both Malaysia (CEDAW) and Indonesia (CRC) are scheduled for upcoming reviews, presenting key opportunities to submit evidence, challenge harmful state narratives, and push for alignment of national laws and practices with international human rights standards. The next Universal Periodic Review (UPR) cycle also presents an opportunity to challenge Malaysia's stance on FGM/C as a cultural practice and advocate for policy alignment with human rights obligations.
- **Strengthen international and regional partnerships with agencies such as ASEAN, WHO, and UNESCO**, and engage actively to ensure that FGM/C is integrated into broader gender equality and child protection agendas. This includes supporting ASEAN's renewed 10-year Gender Mainstreaming Strategic Framework and advocating for the explicit inclusion of FGM/C as a priority issue within its implementation under the ASEAN Commission of Women and Children (ACWC).
- **Support regional medical and midwifery associations in developing and promoting professional guidelines** that explicitly oppose the medicalisation of FGM/C. These include The Midwives Alliance of Asia (MAA), Asia & Oceania Federation of Obstetrics & Gynaecology (AOFOG), and the Asian Oceanic Society of Paediatric and Adolescent Gynaecology (AOSPAG).

ANNEX A

As part of its commitment to eliminate harmful practices against women and girls, the Government of Indonesia, through the Ministry of Women's Empowerment and Child Protection (KemenPPPA), launched the National Action Plan (NAP) on the Prevention of Female Genital Mutilation/Cutting (FGM/C) for the period 2020–2030. This initiative, established in 2021, outlines a comprehensive, multi-sectoral strategy to prevent and eradicate FGM/C across the nation.

OBJECTIVES OF THE NATIONAL ACTION PLAN:[98]

1. Raise Public Awareness: Foster widespread understanding within communities that FGM/C poses serious health risks to women and girls, thereby encouraging voluntary abandonment of the practice.
2. Strengthen Legal Protection: Establish robust legal safeguards that explicitly prohibit FGM/C on women and girls of all ages.
3. Develop a National Data System: Implement a reliable data collection mechanism to monitor public awareness trends and inform evidence-based policy interventions.
4. Enhance Institutional Coordination: Build an integrated system for FGM/C prevention involving both state and non-state actors.

ROLES OF KEY MINISTRIES AND INSTITUTIONS:[99]

1. **Ministry of Women's Empowerment and Child** Protection (KemenPPPA)
   - Coordinates inter-ministerial and institutional efforts related to FGM/C prevention.

2. **Ministry of Health**
   - Conducts public education on the health risks of FGM/C through healthcare professionals.
   - Integrates FGM/C prevention into medical, health, and midwifery education curricula.
   - Develops and enforces policies prohibiting FGM/C by health workers and institutions.
   - Applies the prohibition across all age groups.

3. **Ministry of Religious Affairs**
   - Provides religious education on the harms of FGM/C through religious instructors.
   - Incorporates FGM/C prevention into religious education and premarital counselling modules.

4. **Ministry of Education, Culture, Research and Technology**
   - Promotes a culture of non-circumcision through the integration of FGM/C prevention into primary, secondary, and tertiary education curricula.

5. **Ministry of Home Affairs**
   - Prevents local governments from issuing policies that support or legitimise FGM/C.

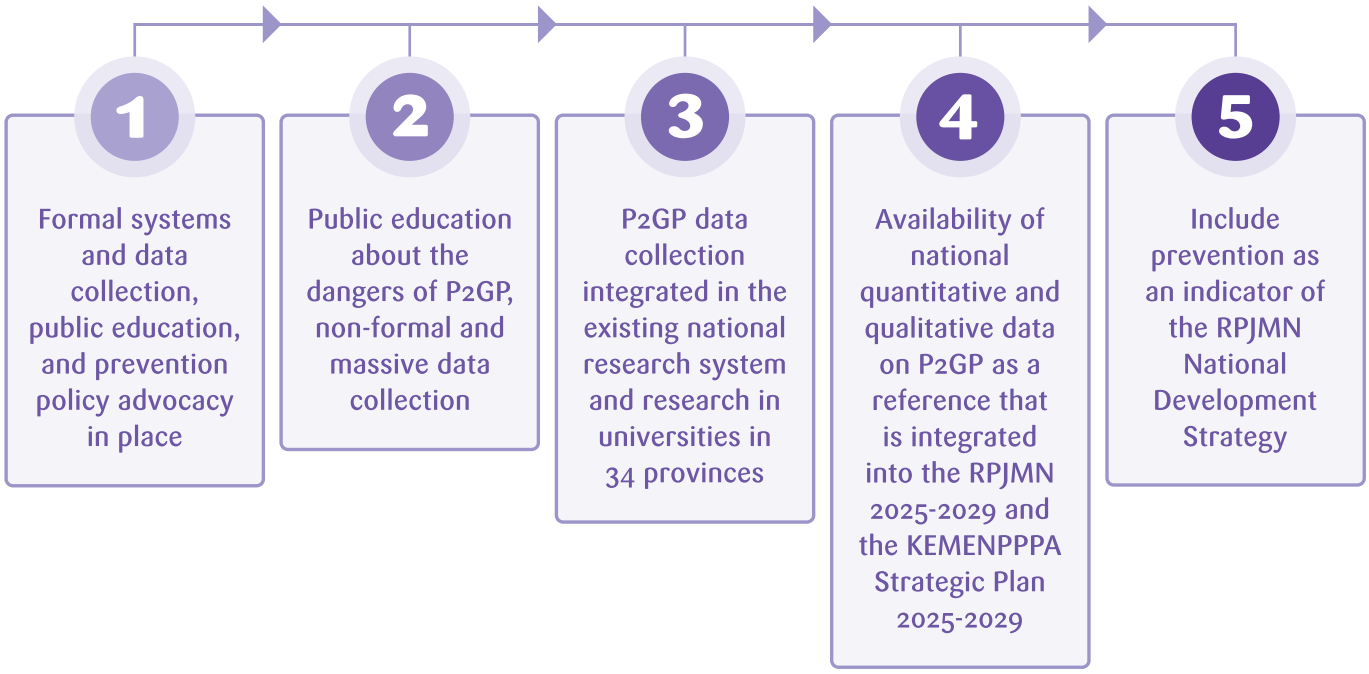
6. **National Development Planning Agency (BAPPENAS)**
   - Integrates FGM/C prevention into the National Medium-Term Development Plan (RPJM) and monitors its alignment with Sustainable Development Goals (SDGs).

7. **Statistics Indonesia (BPS)**
   - Includes FGM/C prevention as an indicator within Indonesia's SDG monitoring framework.

8. **National Human Rights Commission and Indonesian Child Protection Commission (KPAI)**
   - Collaborate with the National Commission on Violence Against Women to monitor the implementation of FGM/C prohibition policies.

The various stages of the Road Plan are as following:

FIGURE 11:
INDONESIA ROADMAP PHASE 1 (2020-2024)[100]



The 2020–2024 phase of Indonesia's National Action Plan[101] outlines a sequenced strategy to institutionalise prevention efforts and strengthen national accountability. The roadmap includes the following key steps:

1. **Establishment of Formal System:** Development and implementation of structured mechanisms for data collection, public education, and policy advocacy to support the prevention of FGM/C.

2. **Community Awareness and Informal Data Collection:** Promotion of public understanding regarding the health risks of FGM/C, while simultaneously gathering qualitative data through informal and community-based channels.

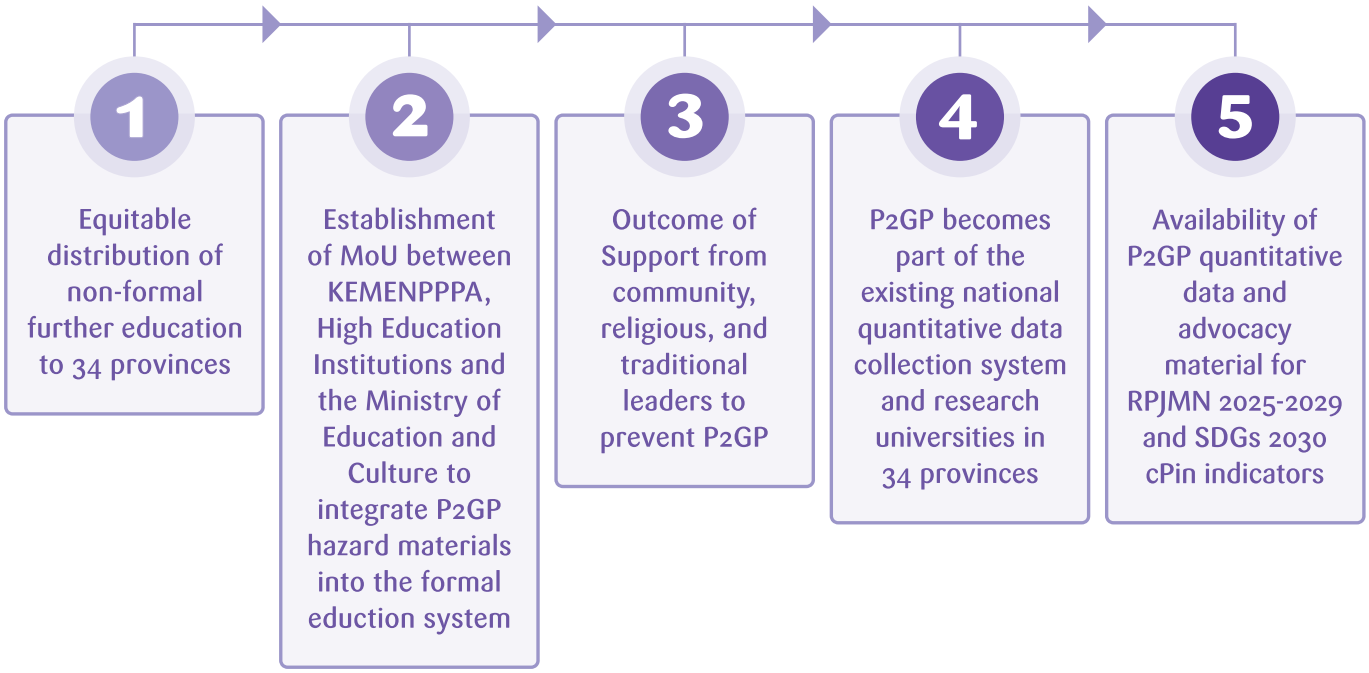
3. **Integration into National Research Frameworks:** Inclusion of FGM/C-related data collection within national research systems and academic studies across all 34 provinces, ensuring evidence-based policy development.

4. **Availability of National Quantitative Data:** Incorporation of FGM/C indicators into the National Medium-Term Development Plan (RPJMN 2025–2029) and the strategic plan of the Ministry of Women's Empowerment and Child Protection (KemenPPPA), to inform and guide national policy interventions.

5. **Recognition of FGM/C Prevention as a National Development Indicator:** Embedding FGM/C prevention within the RPJMN as a strategic development priority, thereby reinforcing its importance in national planning and resource allocation.

2025–2028 Roadmap for the Prevention of Female Genital Mutilation/Cutting (FGM/C):

FIGURE 12:
INDONESIA ROADMAP PHASE 2 (2025-2028)[102]



The second phase of **Indonesia's National Action Plan (2025–2028)** builds upon earlier efforts by advancing institutional integration, expanding educational outreach, and reinforcing data-driven advocacy. The roadmap outlines the following strategic priorities:

1. **Expansion of Educational Access:** Ensure equitable provision of non-formal education on FGM/C prevention across all 34 provinces, targeting underserved and marginalised communities.

2. **Integration into Formal Education Systems:** Establish Memorandums of Understanding (MoUs) between the Ministry of Women's Empowerment and Child Protection (KemenPPPA), Higher Education Institutions, and the Ministry of Education and Culture to embed FGM/C awareness and hazard prevention into formal curricula.

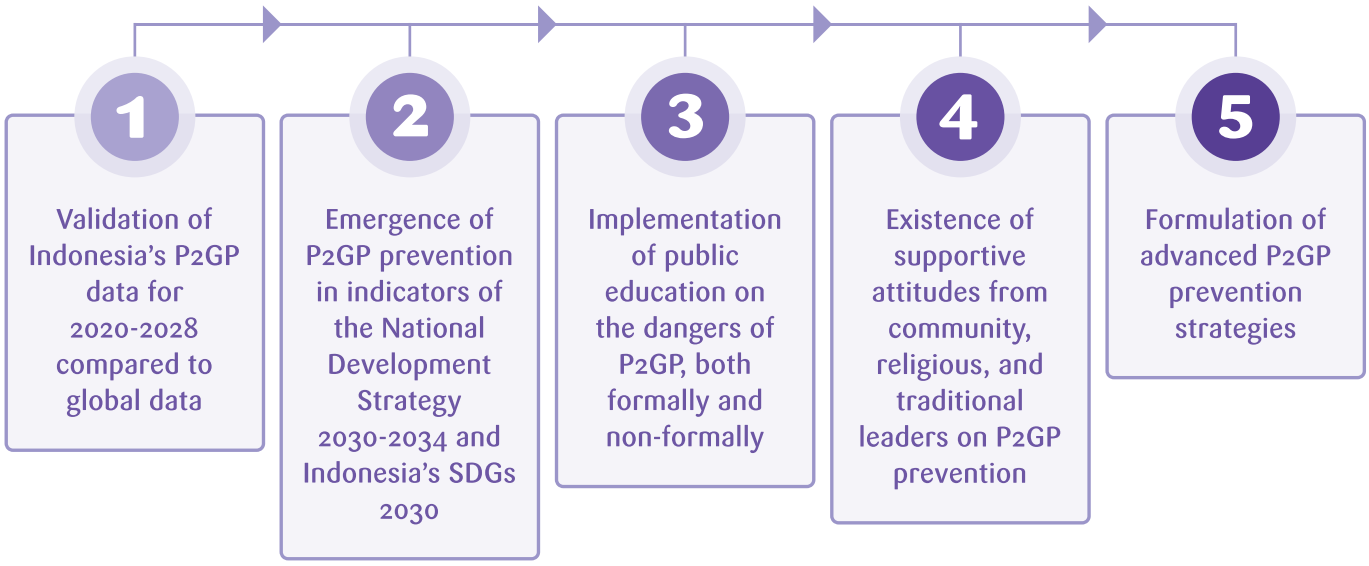
3. **Community Engagement and Advocacy:** Mobilise support from community leaders, religious authorities, and traditional figures to promote anti-FGM/C messaging and foster grassroots advocacy.

4. **Strengthening Research and Data Systems:** Institutionalise FGM/C data collection within national quantitative frameworks and academic research initiatives across all provinces, ensuring consistent and reliable evidence generation.

5. **Evidence-Based Policy and Development Planning:** Leverage both quantitative and qualitative data to inform the National Medium-Term Development Plan (RPJMN) and integrate FGM/C prevention as a recognised indicator within the 2030 Sustainable Development Goals (SDGs) framework.

2029–2033 Roadmap for the Prevention of Female Genital Mutilation/Cutting (FGM/C)

FIGURE 13:
INDONESIA ROADMAP PHASE 3 (2029-2030)



The final phase of **Indonesia's National Action Plan on the Prevention of FGM/C (2029–2033)** focuses on consolidating progress, validating national data, and advancing strategic interventions. The following initiatives form the core of this roadmap:

1. **Data Validation and Benchmarking:** Conduct comparative analysis between Indonesia's FGM/C data (2020–2028) and global statistics to assess progress, identify gaps, and inform future policy direction.

2. **Integration into National and Global Development Frameworks:** Embed FGM/C prevention as a formal indicator within the National Development Strategy (2030–2034) and Indonesia's Sustainable Development Goals (SDGs) framework for 2030.

3. **Comprehensive Public Education:** Continue formal and non-formal awareness campaigns to educate the public on the health risks and human rights implications of FGM/C, ensuring sustained behavioural change.

4. **Community-Based Advocacy:** Strengthen the role of community, religious, and traditional leaders in promoting anti-FGM/C messaging and supporting local prevention efforts.

5. **Development of Advanced Prevention Strategies:** Formulate and implement innovative, evidence-based approaches to further eliminate FGM/C, drawing on lessons learned and emerging best practices.

REFERENCES

1 UNICEF, *Female Genital Mutilation: A Global Concern* (New York: UNICEF, 2024).

2 The actual prevalence of FGM/C in Asia may be higher than current estimates, given likely underreporting and limited data from countries beyond Indonesia and Malaysia.

3 The 70 million estimate for Indonesia includes all age cohorts (from infants to older women), whereas 34.4 million women aged 15–49 are estimated to be affected, based on the 2020 census and national prevalence rate.

4 Government of Indonesia, *Government Regulation No. 28 of 2024, Articles 100–102, Deriving from Law No. 17 of 2023 on Health*. Ministry of Health (Indonesia), Regulation No. 2 of 2025, Deriving from Government Regulation No. 28 of 2024.

5 Calculated using the 2020 census and national prevalence rate.

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