# POLICY BRIEF

## ADDRESSING FEMALE GENITAL CUTTING (FGC) IN INDONESIA AND MALAYSIA:

Opportunities for Regional and Country-Level Action

arrow
asian-pacific resource & research centre for women

ORCHID PROJECT
WORKING TOGETHER TO END FEMALE GENITAL CUTTING

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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 policy brief draws from a recent study conducted by **Orchid Project** and **ARROW** titled "Female Genital Cutting[1] in Indonesia and Malaysia: Key trends, norms, drivers and forces for change". The study was undertaken with the support of the **South and Southeast Asia Research and Innovation Hub (SSEARIH) of the Foreign, Commonwealth & Development Office (FCDO)**, Government of the United Kingdom. The policy brief provides an overview of the prevalence of FGC in the two countries, the drivers behind the practice and recommendations for both, International and Regional Agencies, particularly the FCDO.

# KEY MESSAGES

- **Current estimates indicate that Asia accounts for at least 35% of the global FGC burden, affecting approximately 80 million women and girls**,[2] with the practice documented in India, Pakistan, Sri Lanka, Maldives, Vietnam, Cambodia, Thailand, Brunei, Singapore, Philippines, Indonesia and Malaysia.[3]

- Orchid Project (2025)[4] estimates that Indonesia and Malaysia together account for more than one-third of the regional burden of 80 million cases, with about 77.5 million women and girls of all ages affected (70 million in Indonesia and 7.5 million in Malaysia).[5, 6] The prevalence is particularly high among ethnic Malay communities, with rates exceeding 90%[7] in Malaysia. In Indonesia, certain regions such as Sulawesi report prevalence rates as high as 81.2%.[8] However, due to the lack of comprehensive data, the actual figures are likely even higher. Despite the scale of the issue, FGC remains significantly under-addressed within national policy frameworks and public health programmes.

- **Female family members play a key role in the perpetuation of FGC, which is most commonly performed within the first year after birth in both Indonesia and Malaysia.**

- **FGC in both Indonesia and Malaysia exists within a complex cultural framework where intergenerational practices, ancestral connections and life cycle rituals intersect.** The practice persists as families observe it for traditional values of honour, symbolism, and social status—often without questioning its origins or religious connections.

- **Legal protections against FGC remain inadequate.** Indonesia introduced a regulation in 2024[9] banning FGC, though an enforcement mechanism is yet to be implemented. Malaysia does not have any formal law or policy specifically recognising or addressing the practice. Nonetheless, the practice could potentially be prosecuted under general criminal laws and codes, depending on the circumstances, intent and degree of harm inflicted.

- A lack of data hinders understanding and effective evidence-based policy and action on the issue. Indonesia has had data on prevalence since 2013, and recently started reporting on prevalence through the national violence against women survey (SPHPN) in 2021 and 2024, whereas in Malaysia there are only small, localised studies available.

- **Female Genital Cutting (FGC) is highly medicalised in both Indonesia and Malaysia.** In Malaysia, up to 57% of procedures are carried out by healthcare professionals, while in Indonesia, nearly half of all procedures are performed within medical settings.[10] This medicalisation lends legitimacy to the practice and contributes to increased resistance to reform efforts.

- In line with the complexity of the issue, policy responses must be multi-sectoral, combining legal reform, healthcare regulation, religious engagement, and community-driven norm change, supported by adequate national budgets and political will in order to end the practice. The United Kingdom and other development partners can act as key catalysts, by supporting funding, research, facilitating policy dialogue between countries for best practice implementation, as well as centering and amplifying the voices of women's rights advocates in the region. UN agencies and development sector stakeholders should promote and enable global norm-setting standards especially in health and rights by leveraging WHO Technical Guidance and human rights treaty bodies.

# BACKGROUND

Female Genital Cutting (FGC)[11] is a practice internationally recognised as a grave violation of human rights, particularly the sexual and reproductive health and rights (SRHR) of girls and women. It impacts an estimated 230 million women and girls across 90 countries. While global attention has focused largely on Africa, estimates indicate that Asia accounts for at least 35% of the global FGC burden, affecting approximately 80 million women and girls across 12 countries. However, the actual prevalence of FGC in Asia may be higher than current estimates, given likely underreporting and limited data from countries beyond Indonesia and Malaysia which together account for over 90% of known FGC cases, commonly known as *'sunat'* or 'circumcision' across the region.

In Indonesia, national surveys show a declining trend in the prevalence of FGC among women aged 15–49 years, dropping from 50.5%[12] in 2021 to 46.3%[13] in 2024. However, there seems to be a resurgence—with increasingly more girls whose mothers have not undergone the practice being impacted. Malaysia, by contrast, lacks official government recognition of the practice and does not collect national survey data. However, a certain homogeneity in the findings of academic research suggests the prevalence of FGC to be about 93% of the female, ethnic Malay population (or more than 7.5 million girls and women).[14] Given the lack of comprehensive data, actual prevalence may vary.

**In both countries, the practice is commonly performed during infancy, with 70% of Indonesian girls undergoing the procedure before their first birthday.**[15] The form of FGC practised in both countries is predominantly Type I (partial or total removal of clitoris/prepuce), and Type IV (pricking, cutting, scraping, cauterising). In Indonesia, Type I accounts for 19%, and Type IV accounts for 18% of the caseload.[16] While in Malaysia, incidence of Type I is deemed to be increasing due to increased medicalisation. FGC 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. Documented complications of Type I, from other regions, 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, scarring, neuroma causing pain during intercourse, cysts that can become infected and sexual dysfunction. The short- and long-term effects of Type IV FGC in Asia are unreported and further research is required to unpack the harm caused by Type IV.

The sheer numbers of women and girls affected make FGC 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.

## RELIGION, MEDICINE AND LAWS: THE SYSTEMIC NORMALISATION OF FGC IN INDONESIA AND MALAYSIA

In the current context, FGC continues to be perpetuated due to cultural and religious beliefs; public support and demand; and harmful gender norms exacerbated by the absence of rights-affirming legal and policy frameworks and discourse.

### RELIGIOUS AND NORMATIVE JUSTIFICATIONS

**Cultural acceptance of FGC remains a major barrier to change**. In both Indonesia and Malaysia, gendered and patriarchal social norms dictate that FGC is perceived as a necessary 'rite of passage/ belonging', that it enhances health, fertility, or sexual satisfaction, and control of female sexuality sustain the practice. Approximately half of Indonesian women[17] and almost all Malaysian women continue to support FGC.[18]

**Religion also plays a central role in shaping perceptions and practices related to FGC in both countries.** The practice is widely perceived as a religious requirement, regardless of explicit religious mandate by texts or leaders. In Indonesia, while community members often view FGC as a religious requirement, religious leaders adopt more nuanced positions. The Indonesian Women Ulema Congress (KUPI) has issued a *fatwa* opposing FGC, while other religious bodies (such as the Majelis Ulama Indonesia (MUI) and Nahdlatul Ulama (NU)) take the stance that while it is not obligatory, it is recommended. On the other hand, Malaysia has a national *fatwa* (2009) issued by the Department of Islamic Development Malaysia (JAKIM), which declares FGC obligatory for Muslim women and girls. Only one state *fatwa* from Perlis, despite being legally non-binding, rules that FGC is not compulsory. **A broader trend toward religious conservatism amongst some segments in both countries further entrenches these beliefs, posing additional challenges to reform efforts.**

### FGC IN CLINICS: THE TREND OF MEDICALISATION

**Medicalisation of FGC presents a growing challenge in both countries.** In Indonesia, midwives perform nearly half of all procedures (as a part of standard maternity care packages), with private clinics being key enablers. In urban clinics, the practice is often framed as a "safe" medical procedure, reinforcing legitimacy and demand. Similarly, in Malaysia, 44.3% of FGC was performed by doctors with another 12.9% by nurses or midwives.[19] Over 85% of Muslim doctors are also noted to support FGC and two-thirds of them opine that FGC should be conducted by healthcare professionals.

Healthcare professionals in both countries disregard and/or trivialise the international health and rights-based discourse around FGC. The support among Muslim healthcare providers remains high, with some advocating for its inclusion in medical school curricula or routine neonatal packages to standardise the practice. Health workers cite safety, hygiene, parental demand, fear of social exclusion, accessibility, and alignment with community and religious values as reasons for continuing the practice.

### LEGAL AND POLICY GAPS

**Indonesia and Malaysia differ significantly in their legal and policy responses to FGC.**

Indonesia has taken formal steps to address the practice, including a government regulation enacted in 2024 banning FGC and a National Action Plan (2020-2030), outlining strategic actions toward its prevention. However, a narrow focus on the prevention as opposed to the elimination of FGC; lack of technical regulation specifying the enforcement mechanisms and legal consequences as well as poor outreach has resulted in limited awareness of the ban, thus reducing the effectiveness of the policy.

In contrast, Malaysia operates in a regulatory vacuum with no cohesive national policies and monitoring frameworks, specifically addressing FGC from either the Ministry of Health or the Department of Islamic Development (JAKIM). Under the penal code (Section 44), FGC is prosecutable as 'hurt' or 'grievous hurt' for causing harm. It can also be prohibited without exception under the Child Act, in line with Malaysia's obligations under the Convention on the Rights of the Child (CRC). However, the coexistence of common, Islamic, native and indigenous law, combined with longstanding sensitivities around acknowledging "female circumcision" as a harmful practice, further complicates policy development and enforcement. Efforts to frame FGC as a human rights or child protection issue have met with resistance or indifference from both political and religious authorities.

# STRATEGIC RECOMMENDATIONS FOR POLICY ACTION

While complex, pathways to change exist-both within the region and globally. Muslim majority countries in the region and globally have taken various positive steps towards addressing FGC. Although official data is lacking, the practice is believed to be uncommon in countries like Bangladesh. In contrast, the Maldives—where FGC is prevalent—has publicly stated that it is not a religious requirement and is actively working to end it. Across MENA and Africa, many countries have made significant strides in confronting FGC through a combination of legal reform, religious reinterpretation, and public health interventions. Egypt has enacted a ban on the medicalisation of FGC and imposed criminal penalties for violators, reinforced by both medical and human rights arguments. This policy is further strengthened by religious edicts from Al-Azhar University, which unequivocally condemn the practice as having no basis in Islam and affirm its harmful impact on women's health and bodily integrity. In Africa, the practice is not connected with religion, but culture, as it is prevalent across Muslim, Christian and indigenous religions. 22 out of the 28 countries in Africa that practice FGC have passed laws to end the practice. Southeast Asian governments and actors can draw on these precedents to craft culturally acceptable, technically sound, and politically feasible strategies for elimination.

## POLICY ACTION FOR GOVERNMENT AND NATIONAL ACTORS IN MALAYSIA AND INDONESIA

In the current context, FGC continues to be perpetuated due to cultural and religious beliefs; public support and demand; and harmful gender norms exacerbated by the absence of rights-affirming legal and policy frameworks and discourse.

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

**INDONESIA:**

- **Support The Ministry of Health (MoH) to reintegrate data** on the prevalence of FGC 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 FGC—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 FGC 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 FGC prevention indicators** into the Desa Ramah Perempuan dan Peduli Anak (DRPPA) programme. The programme aims to provide space for women to participate 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.

**MALAYSIA:**

- **Explore the possibility of integrating FGC indicators into upcoming national health surveys**—building on the precedent set by the inclusion of intimate partner violence (IPV) in the recent National Health and Morbidity Survey (NHMS), particularly within the mother and child health module. This could include supporting compulsory reporting through postnatal care services and/or exploring a national survey in collaboration with the Prime Minister's Office.

## 2. STRENGTHEN NATIONAL LEGAL AND POLICY IMPLEMENTATION AND HEALTHCARE REGULATION ON FGC

**INDONESIA:**

- **Enforce the prohibition of FGC** in line with the National Action Plan for the Prevention of FGM/C[20] (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 FGC.
- **Integrate FGC 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.

**MALAYSIA:**

- **Collaborate with the Ministry of Health to develop comprehensive guidance for healthcare professionals (including midwives)**, outlining the lack of health and medical benefits of FGC and how it is a non-scientific practice.
- **Integrating FGC awareness into healthcare services, including postpartum care education, by training healthcare providers and midwives** to address the issue sensitively during routine maternal and child health visits, creating opportunities for education and early intervention.

## 3. PROMOTE RELIGIOUS RE-INTERPRETATION AND ENGAGEMENT

**INDONESIA:**

- **Facilitate structured engagement with religious authorities** at both national and local levels to build consensus to oppose the practice of FGC in Islam, and towards enforcing prohibition of the practice as laid out in the National Action Plan (NAP) to prevent FGC.
- **Support the development and dissemination of contextually relevant religious education materials.** This new religious education material can be used as an effective communications strategy, that 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 FGC advocacy considering that KUPI has issued a fatwa that FGC that is dangerous without medical reasons is haram, but members in strategic positions, like the managing official of the Istiqlal Mosque, must be engaged with and supported to disseminate educational materials on FGC.

**MALAYSIA:**

- **Facilitate evidence-based dialogue with religious authorities to clarify theological positions mandating FGC**, and help distinguish cultural practices from religious obligations.
- **Engage respected religious leaders, including young religious leaders, in communications and other advocacy efforts to foster community acceptance** of change and reduce resistance by aligning messages with religious values

**4. INVEST IN COMMUNITY EDUCATION AND BEHAVIOUR CHANGE IN**

**INDONESIA AND MALAYSIA:**

- **Implement targeted Community Behaviour Change strategies tailored to specific community contexts in partnership with organisations.** 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 FGC 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.

## STRATEGIC ROLE FOR THE UK: SUPPORTING CHANGE

The UK FCDO is encouraged to adopt a strategic, multi-level approach to support the elimination of FGC in Indonesia and Malaysia, in alignment with national priorities and regional commitments.

**POLICY ADVOCACY TO ELIMINATE FGC**

**1. SUPPORT THE OPERATIONALISATION OF THE 2024 REGULATION BANNING FGC IN INDONESIA**

- **Advocate for the Enforcement of the 2024 regulation banning FGC**, 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)**, that is facing budget constraints. Strengthening the analysis and use of regional data from SPHPN will be critical to informing the implementation of Indonesia's 2020–2030 National Action Plan to Prevent FGC and ensuring that legal reforms are matched by evidence-based action

**2. SUPPORT INDONESIAN AND MALAYSIAN 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 FGC, particularly in underserved and high-prevalence areas. This includes supporting 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 FGC into CEDAW submissions. In Malaysia, it is important to provide support that constructively addresses the government's framing of FGC as "merely circumcision," and highlights its broader impacts on women and girls.
- **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 FGC.

**3. SUPPORT UN AGENCIES PROGRAMMES IN INDONESIA AND MALAYSIA:**

**INDONESIA**

- **Building on existing support, continue strengthening UNFPA's agencies 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 FGC 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 to develop public opinions and open dialogue amongst adolescents and young people against FGC.
- **Support Indonesia and UNFPA's forthcoming ethnographic study** exploring midwives' motivations for performing FGC, including through stakeholder engagement, technical input, or future implementation of its recommendations.

**MALAYSIA**

- **Strengthen multisectoral collaboration in both countries** through UNFPA's ongoing efforts. In Malaysia, actively engage with the newly established multi-sectoral steering committee on FGC convened by UNFPA Malaysia.

**4. SUPPORT AND LEVERAGE HUMAN RIGHTS MECHANISMS THAT CALL FOR THE ELIMINATION OF FGC**

- **Leverage global accountability mechanisms to advocate for SDG 5.3.** Utilise Malaysia's 2025 Voluntary National Review (VNR) at the High-Level Political Forum (HLPF) to advocate for the explicit inclusion of FGC under SDG 5 on gender equality, SGD 3 on Good Health and Well-being, and SDG 16 on Peace, Justice, and Strong Institutions.
- **Support human rights-based legislative change via Malaysia's Universal Periodic Review (UPR) follow-up.** Continue engagement with the Human Rights Commission of Malaysia (SUHAKAM) and the Children's Commissioner to provide technical assistance, particularly through child rights advisors, to strengthen child protection policies and frameworks.
- **Support data collection efforts** being carried out in both countries aligning 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 FGC, by reinforcing FGC 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), 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 FGC. 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 FGC, 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 is also an opportunity to challenge Malaysia's stance on FGC 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 FGC 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 FGC as a priority issue within its implementation under the women and children's Agenda (ACWC).
- **Support regional medical and midwifery associations** in developing and promoting professional guidelines that explicitly oppose the medicalisation of FGC. These include The Midwives Alliance of Asia (MAA), Asia & Oceania Federation of Obstetrics & Gynaecology (AOFOG), Asian Oceanic Society of Paediatric and Adolescent Gynaecology (AOSPAG).

# REFERENCES


1 A Note on Terminology: Globally, the term most often used to describe the practice is 'female genital mutilation/cutting'. 'Female genital mutilation', or 'FGM', is perceived to be a term imposed by the West and not reflective of cutting as practised in the region. The word 'mutilation' is deemed to be imprecise. Since the term 'cutting' appears to be the more widely understood term within South East Asian literature, with words like *sunat wanita* or 'cutting' already normalised, this Law Report uses the term 'female genital cutting' or 'FGC' to refer to the practice. 'The region' is used when referring to similarities in the practice across Indonesia, Malaysia, Singapore and Thailand.

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

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5 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.

6 Orchid Project. 2024. Malaysia Country Profile.

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8 SPHPN. 2021. Ministry of Women's Empowerment and Child Protection of The Republic of Indonesia. Violence Against Women Survey - 2021 [SPHPN 2021] [Internet]. 2021 [cited 2024 May 23]. Available from: https://www.kemenpppa.go.id/page/view/NTAzNA==.

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11 The World Health Organisation (WHO) defines FGC as all procedures involving the removal of the external female genitalia or other injury to the female genital organs for non-medical reasons,

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18 Orchid Project (2024) Country Profile: FGC in Malaysia, p.73-74.

19 Rashid A, Iguchi Y. Female genital cutting in Malaysia: a mixed methods study. BMJ Open 2019;9:e025078. doi:10.1136/bmjopen-2018-025078.

20 Here the term FGM/ C is used to reflect the official name as used in wofficial documents.


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Link to the Report and Policy Briefs:
**https://www.evidencefund.com/lib/PKRBZRVX**

**ARROW** is a regional non-profit women's NGO based in Kuala Lumpur, Malaysia, and has consultative status with the Economic and Social Council of the United Nations. Established in 1993, it envisions an equal, just, and equitable world, where every woman enjoys her full sexual and reproductive rights. ARROW promotes and defends women's rights and needs, particularly in the areas of health and sexuality, and to reaffirm their agency to claim these rights.


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