# FGC in Indonesia: Country Profile

## April 2026

# About Orchid Project

**Orchid Project** is a UK- and Kenya-based non-governmental organisation catalysing the global movement to end female genital cutting (*FGC*). Orchid Project's strategy for 2023 to 2028 focuses on three objectives:

1. To undertake research, generate evidence and curate knowledge to better equip those working to end FGM/C
2. To catalyse, support and strengthen regional networks to actively participate in the movement to end FGM/C
3. To influence global and regional policies, actions and funding to end FGM/C.

Orchid Project's aim to expedite the building of a knowledge base for researchers and activists is being fulfilled in the **FGM/C Research Initiative.**

# About the Asia Network to End FGM/C

In 2019, Asian Pacific Resource and Research Centre for Women (ARROW) collaborated with Orchid Project to co-develop the **Asia Network to End FGM/C**. The Network currently has 80 members across 13 countries in the Asia region. It gathers evidence and data on harmful practices, raises awareness and facilitates knowledge-sharing across the region, and advocates for laws, policies and programmes to encourage the abandonment of all forms of FGC.

***Authors:*** Anne Morin, Shannon Thomson, Ozan Yucel (ed.)
***Recommended citation:*** Orchid Project (2026) FGC in Indonesia: Country Profile. Available from: **https://www.fgmcri.org/country/indonesia/.**
***Cover image design:*** Herwin Bahar (**www.istockphoto.com/portfolio/Herwinbahar**)

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WORKING TOGETHER TO END
FEMALE GENITAL CUTTING

## Use of this Country Profile

The primary purpose of this Country Profile is to improve understanding of the issues relating to female genital cutting (FGC) in the wider framework of gender equality and social change within Indonesia. By collating the research to date, this Country Profile can act as a benchmark to reflect the current situation. It also offers analyses of the situation and assists all those committed to ending FGC to shape their own policies and practices and create conditions for positive, enduring change in communities that practise FGC. This report provides a sound information base that can help determine models of sustainable change, to shift attitudes and behaviours and bring about a world free of FGC.

## A note on data

In a 2020 study, seven researchers highlighted the scarcity of data on the prevalence of FGC in the Southeast Asia region and their absence in global reporting (1). Of the limited research on FGC in the region, most studies focus on specific populations and are not necessarily representative. Data collection may also be hampered where authorities deny or ignore the existence of FGC. Against this backdrop of scarce and uneven data, recent national surveys also differ in how missing data are handled, which affects prevalence estimates. Discrepancies in the handling of missing data in the 2013 Indonesian Basic Health Research (RISKESDAS) study led to differences in prevalence estimates, with the Ministry of Health reporting 51.2% (2) and UNICEF reporting 49% (3). The 2024 Status of Women in Indonesia National Survey (SNPHP 2024) compares results from 2024 with those from 2021, and the figures differ slightly from the 2021 survey (SNPHP 2021). These differences may be due to statistical adjustments and may not always represent trends (4, 5). The Indonesian government has issued an ambitious data strategy, including Demographic Health Survey (DHS) modules on women's life experiences every four years (6). More precise mapping at regional and district levels has yet to be published. Academic research undertaken by professionals from various disciplines forms the backbone of this Country Profile. We also reviewed reports and statements from government sources and non-governmental organisations (NGOs), postgraduate research, media materials, webinars and documentaries.

# List of Abbreviations

| | |
|---|---|
| ARROW | Asian-Pacific Resource and Research Centre for Women |
| CBO | community-based organisation |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| CRC | Convention on the Rights of the Child |
| CSO | civil-society organisation |
| FGC | female genital cutting |
| FGM | female genital mutilation |
| FGM/C | female genital mutilation/cutting |
| GP | general practitioner |
| IBI | Indonesian Midwives Association |
| IDI | Indonesia Medical Association |
| IDAI | Indonesian Pediatric Association (*Ikatan Dokter Anak Indonesia)* |
| ICPD | International Conference on Population and Development |
| KEMENDIKBUD | The Ministry of Education and Culture (*Kementerian Pendidikan dan Kebudayaan)* |
| KEMENKES | Ministry of Health (MoH) *Kementerian Kesehatan* |
| KOMNAS-PEREMPUAN | National Commission on Violence against Women (NCSPHPN) (*Komisi Nasional Anti Kekerasan terhadap Perempuan)* |
| KemenPPPA | Ministry of Women Empowerment and Child Protection (MoWECP) (*Kementerian Pemberdayaan Perempuan dan Perlindungan Anak)* |
| KUPI | Indonesian Women's Ulema Congress (*Kongres Ulama Perempuan Indonesia)* |
| MUI | Indonesian Council of Ulama (*Majelis Ulama Indonesia)* |
| NGO | non-governmental organisation |
| OHCHR | Office of the High Commissioner on Human Rights |
| PERDOSNI | Indonesian Neurological Association *(Perhimpunan Dokter Spesialis Neurologi Indonesia)* |
| POGI | Indonesian Association for Obstetrics and Gynaecology (*Perkumpulan Obstetri Dan Ginekologi Indonesia)* |
| RISKESDAS | Basic Health Research survey (*Riset Kesehatan Dasar)* |
| SPHPN | Violence Against Women Surveys, Indonesia |
| UN | United Nations |
| UNFPA | United Nations Population Fund |
| WHO | World Health Organization |

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# Foreword

For more than four decades Kalyanamitra has fought to advance gender equality and justice in Indonesia, with a strong focus on advancing the rights of women and girls. We envision the realisation of a gender-just society and state system through strengthening women's capabilities with the principles of care and solidarity. Kalyanamitra holds a strategic role in advocacy and campaign in addressing gender-based violence in Indonesia, including FGM/C. With our three core programs: community development, policy advocacy, and knowledge management, we work at all levels (grassroots, national, regional-global) to end FGM/C, particularly in awareness-raising, civil society engagement, and multi-stakeholder collaboration. To elevate our advocacy and campaign efforts, producing studies, both organizationally and collaboratively, is crucial to providing strong evidence-based advocacy, and this country profile is one such effort.

FGM/C in Indonesia remains a complex issue today as it intersects with gender and social norms, medical, cultural, as well as religious beliefs. The practice includes symbolic procedures and those that cause physical harm to the bodies of girls; 58 percent are symbolic practices. Although policies have been progressively developed to prevent this from a health standpoint, they remain insufficient to overcome the cultural systemic barriers that cause it to continue. The issue of FGM/C is deeply rooted in perspectives and cultural constraints that view women as objects to be controlled and deprived of rights over their own bodies and choices. Therefore, efforts to eradicate this practice must involve massive efforts to change perspectives and social norms that have been reinforced and legitimised by policy for centuries. Providing eye-opening data is one of the efforts to build awareness that to prevent and end FGM/C requires collaborative work from many parties.

This Country Profile generated by Orchid Project provides a comprehensive point of view on FGM/C in Indonesia. The data and analysis provided are valuable and useful for advocacy work, especially among civil society organizations that continue to tirelessly fight for the rights of women and girls to be free from all forms of discrimination, exploitation, and gender-based violence, including FGM/C. As for decision makers and other related stakeholders, this report will be beneficial to strengthen the effort both on awareness-raising and decision-making.

Finally, we would like to thank the Orchid Project and the Asia Network to End FGM/C for involving us in the process of developing this Country Profile. We hope that this collaborative work will continue in the future to ensure that women and girls are free from all forms of FGM/C.

**Ika Agustina**

Executive Director, Kalyanamitra

# Executive Summary

This Country Profile provides comprehensive information on the most recent trends and data on female genital cutting (FGC) in Indonesia.  It includes an analysis of the current socio-political situation, legal frameworks, and key programmes and makes recommendations on how to move toward eradicating the practice. Its purpose is to equip activists, practitioners, development partners, and research organisations with up-to-date information to inform decision-making on policy and practice in the Indonesian and Southeast Asian contexts.

With about 280 million people, Indonesia has the world's fourth-largest population, after China, India and the United States (7).

The practice of FGC in Southeast Asia falls under the World Health Organization's (WHO) classifications of 'Type I' and 'Type IV' (8) . The practice of FGC in Asia has never been linked, in the minds of most Asians, to the more severe genital cuts or infibulation of 'female genital mutilation' in Africa, and in many ways has been actively differentiated from the practice in Africa (1).

In Indonesia, the terms 'sunat perempuan' or 'khitan' (referring to female circumcision in Indonesian and Arabic) are commonly used. The phrase 'Pemotongan dan/atau Pelukaan Genitalia Perempuan (P2GP)'—which translates to cutting and/or injuring female genitalia—was officially adopted by Indonesian Ministries in 2018 (9). This term is intended to encompass all harmful practices in the country, aiming to advocate against them while respecting cultural traditions.

In Indonesia, 46.3% of women aged 15–49 years have undergone FGC (102). Indonesia ranks among the nations with the largest populations of women and girls impacted by FGC worldwide. Regional prevalence is very high (above the national average) in Sumatra (62.5%), Kalimantan (58.8%) and Sulawesi (70.5%) (102).  The lowest regional prevalence (below the national average) is found in Java and Bali (36.7%)(102). Prevalence decreased in both urban and rural areas between 2021 and 2024; however, the prevalence of FGC is higher in urban areas (48.0%) compared to rural areas (43.85) (4, 5). This is primarily due to increased access to medicalised FGC in urban areas, urban migration, and retention of cultural norms in urban areas.

A shift in statistical methods between the 2021 and the 2024 national surveys makes direct comparisons challenging. However, Type 1 and invasive Type 4 increased between 2021 and

2024, while the overall prevalence decreased. In 2024, 35.0% of women and girls had undergone symbolic procedures—an increase from 2017, when this type accounted for 6.9% (4,5).

In 2013, among girls aged 0–11 who had undergone FGC, 77.7% were cut before six months of age, the vast majority at around one month (2). In some communities FGC marks the end of the postpartum period, often 40 days after birth, although it can occur up to nine years of age depending on local practice. FGC is frequently proposed alongside ear piercing and a child's first haircut (10). Clinics in Indonesia and Singapore offer FGC with ear piercing (1), suggesting a link between younger ages at cutting and medicalised FGC (11). Indonesia is one of the few countries worldwide that practises symbolic FGC, which are non-invasive procedures that do not result in physical injury.

There are four types of FGC practitioners in Indonesia (5):

- Doctors
- Midwives / nurses / paramedics, sometimes called 'bidan'
- Traditional birth attendants (*TBAs*) called 'paraji' or 'dukun bayi'
- Female circumcision healers, called 'dukun sunat'/ traditional circumcisers, called 'tukang sunat tradisional'

Early studies indicate that medicalisation contributed to the spread of FGC in Indonesia (12). Clinics in cities offer childbirth services, vaccination, ear piercing and FGC as a single, routine package, sometimes without informing mothers. From the 1990s onwards, the Indonesian government promoted medical services by trained doctors and midwives to replace herbal remedies provided by traditional healers (10).

Proponents argued that medicalisation would reduce the risk of infection associated with traditional procedures. However, evidence suggests medicalisation may in fact be more harmful: midwives tend to use scissors and perform cutting, whereas traditional practitioners often use penknives for scraping or rubbing as symbolic acts (13).

The Government introduced a regulation in 2025 prohibiting the health sector from performing physically harmful forms of FGC. However, the implementation of FGC-related policies has been inconsistent (13). Government Regulation No. 28 of 2024, issued to implement Law No. 17 of 2023 on Health, sets out the legal objective of 'eliminating the practice of female circumcision' (14). Despite the regulation, 24.2% of FGC in Indonesia is performed by medical professionals (midwives, doctors, nurses) (5).

Traditionally, FGC in Indonesia formed part of a series of ceremonies and rituals, followed by a communal meal. Practices vary by village, province and ethnic group, and are closely linked to religious observance, cultural adherence, and gender norms.

Nearly 70% of Indonesian women have heard of FGC (13). Many mothers are either unaware of whether they themselves underwent circumcision or have no recollection of it. 22% of women lack detailed knowledge of the specific method used when their daughters are cut and many men are unaware of the practice entirely (15). Support for FGC declined between 2017 and 2021. In 2017, a large study found that parents almost universally agreed that FGC was a necessity (98%) and that it should continue (97.8%) (16). By 2021, nearly half of Indonesian women—both in urban and rural areas—still supported the practice, while 34.8% viewed it negatively and 15.8% were unsure (5).

In Indonesia, the primary reasons for FGC include religious beliefs, cultural and family customs, and perceived health benefits. In high-prevalence regions, 92% of parents view FGC as a religious obligation, 80% as a cultural tradition, and 72% as a family tradition (17). Among women and girls aged 15–49, 26.1% reported health as their primary reason for undergoing FGC (17). Islamic religious authorities often struggle to pinpoint the origins of female circumcision (FC) within Islamic law, as there are no explicit references in the Quran or hadiths. Their opinions and interpretations regarding the necessity of FGC vary considerably. Nevertheless, many people continue to believe that female circumcision is intrinsically linked to Islam, perpetuating it as a cultural tradition (15).

The complex interaction of tradition, religion and symbolic practices in Indonesia presents several challenges to elimination efforts.

- Insufficient enforcement mechanisms for policy directives enacted by the Government and the Ministry of Health
- Potential resistance to the 2025 regulation banning FGC in the health sector
- Strong links between FGC, identity and social belonging, which may lead to resistance against anti-FC norms
- Medicalisation of FGC and commercialisation of the practice
- Differences in religious interpretation of texts and theology and the influence of these differences on fatwas and individual practice
- Differences in understanding of harm, especially of symbolic or non-invasive forms of FGC

Indonesia stands at a critical juncture in the movement to end FGC. With 46.3% of women aged 15-49 having undergone FGC, the country represents one of the world's largest affected populations (102). The 2024 Government Regulation and 2025 Ministry of Health directive prohibiting harmful FGC practices mark historic legislative achievements—making Indonesia the first Asian country to ban the health sector from performing FGC. However, implementation

remains the central challenge. The practice persists through a complex interplay of tradition, religion, medicalisation, and symbolic procedures, with deep-rooted beliefs about purity, identity, and religious obligation driving continued demand. The convergence of religious organisations—Muhammadiyah, Nahdlatul Ulama, MUI, and KUPI—in condemning FGC in late 2024 represents unprecedented religious consensus that must be leveraged. Yet significant obstacles remain: inconsistent enforcement mechanisms, resistance in high-prevalence regions, ongoing medicalisation despite regulations, and debates surrounding symbolic procedures. The path forward requires sustained commitment across all sectors—government, civil society, religious institutions, healthcare systems, and international partners—to transform legislative progress into meaningful change that protects the rights, health, and dignity of Indonesian girls and women.

# General National Statistics

**Population** (7)

Indonesia has the world's fourth-largest population in the world — with about 280 million people.

Median age: 31.5 years (2024 est.)

**Human Development Index** (18)

Rank: 112 out of 193 in 2022

Score: 0.713 ('High')

**Health** (18)

Infant mortality rate: 18.9 deaths/1,000 live births (2024 est.) – world rank of 148

Maternal mortality rate: 173 deaths/100,000 live births (2020 est.) – world rank of 52

**Literacy rates** (18)

Adult: 96% (female – 94.6%; male – 97.4%) (2020 est.)

**Press Freedom** (19)

RWB World Press Freedom Index: 111 out of 180 countries

**Religion** (5)

The Indonesian government recognises six official religions: Islam (87.2%), Protestantism (6.9%), Catholicism (2.9%), Hinduism (1.7%), Buddhism (0.7%), and Confucianism (0.5%). In addition, many local religions and beliefs are not officially accounted for by the Indonesian government but are practiced by indigenous tribes (6).

**Language** (5)

Bahasa Indonesia—the official language and a modified form of Malay—is the primary lingua franca. Other widely used languages include English, Dutch and local dialects, the most widely spoken of which is Javanese. Approximately 1,158 local languages are spoken in daily conversation by around 79.5% of the population.

# Sustainable Development Goals

The **2030 Agenda for Sustainable Development** was adopted by all UN member states in 2015, built on the Millennium Development Goals. The 17 **Sustainable Development Goals** (SDGs) constitute a global initiative urging nations to collaborate in eradicating poverty, enhancing health outcomes, reducing inequality, and fostering economic growth, all while ensuring environmental sustainability (20).

The fifth SDG focuses specifically on gender equality, but several indicators throughout the SDGs also relate to gender. Equal Measures 2030 combines these indicators to form the **Gender Equality Index** (GEI), a broader measure of gender empowerment (21).

The GEI employs a 0–100 scoring system to evaluate countries, categorising them as 'Very Good' (90–100), 'Good' (80–89), 'Fair' (70–79), 'Poor' (60–69), or 'Very Poor' (59 and below).

*Indonesia ranks 66 out of 139 countries on the GEI (21).*

While much of the Asia–Pacific region falls within the 'Poor' category, almost at par with the global average, Indonesia, at 67.9, scores slightly higher than the regional average. The projection for 2030 places Indonesia in the 'Fair' category, with a score of 72.9. This suggests that conditions for women in Indonesia are improving.

| Region/ Country | Score 2022 | Forecast 2030 |
| --- | --- | --- |
| Global average | 65.7 ('Poor') | — |
| Asia and the Pacific | 65.5 ('Poor') | 69.4 ('Poor' approaching 'Fair') |
| Indonesia | 67.9 ('Poor') 14th out of 26 countries in the region | 72.5 ('Fair')<br>13th out of 26 countries in the region |

# SDG 5: Gender Equality

SDG 5 aims to 'achieve gender equality and empower all women and girls. Within SDG 5, Target 5.3 specifically seeks to "eliminate all harmful practices, such as child, early and forced marriage and female genital mutilation" (22).

Despite an observed improvement in Indonesia's SDG 5 score—from 52.3 in 2015 to 54.7 in 2022—the country remains below the regional average. Projections for 2030 indicate a slower rate of progress for Indonesia compared to the Asia-Pacific region, with a forecasted 'Very Poor' score of 55.9. It is important to note that these SDG forecasts, made in 2022, may not have accounted for the 2024 and 2025 regulations which now ban invasive FGC.

| Region/ Country | SDG 5 Gender Equality Score 2022 | Forecast 2030 |
|---|---|---|
| Global average | 66.7 ('Poor') | 71.9 ('Fair') |
| Asia and the Pacific | 61.5 ('Poor') | 64.1 ('Poor') |
| Indonesia | 54.7 ('Very Poor')<br>111$^{th}$ out of 139 countries | 55.9 ('Poor') 116$^{th}$ out of 139 countries |

The Indonesian Government and the Ministry of Women's Empowerment and Child Protection (*Kemen PPPA*) have committed to preventing female circumcision/FGC. In support of the SDGs, the Presidential Regulation Number 59 of 2017 specifically pledges to 'eliminate all dangerous practices, such as child marriage, early and forced marriage, and female circumcision', coordinating across all levels of government (23).

# Introduction

**FGC** is defined by the World Health Organization (WHO) as the 'partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons' (8). At least 230 million girls and women alive today have undergone FGC, with over 80 million living in Asia (24). While these figures offer global estimates, they specifically relate to 31 countries across three continents that evaluate and report on the practice at the national level, thereby enabling international comparisons. Nevertheless, it is recognised that FGC affects girls in over 90 countries, indicating that these figures likely underestimate the actual prevalence of the practice.

FGC occurs in Africa, the Middle East, and Asia, as well as within diaspora communities worldwide. An estimated 4.1 million girls per year are at risk of being cut (24). Although global efforts to encourage communities to abandon FGC are making strong progress, population growth means that the actual number of girls at risk of being cut continues to increase.

The WHO classifies 'FGM' into four types: (8)

| Type of Cutting | Description |
| --- | --- |
| Type I | Partial or total removal of the clitoral glans (the external and visible part of the clitoris, which is a sensitive part of the female genitals, with the function of providing sexual pleasure to the woman), and/or the prepuce/clitoral hood (the fold of skin surrounding the clitoral glans). When it is important to distinguish between the major variations of Type I FGM, the following subdivisions are used:<br>• Type Ia. Removal of the prepuce/clitoral hood only.<br>• Type Ib. Removal of the clitoral glans with the prepuce/clitoral hood. |
| Type II | Partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva). |
| Type III<br>Often referred to as 'infibulation' | Narrowing of the vaginal opening with the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora. The covering of the vaginal opening is done with or without removal of the clitoral prepuce/clitoral hood and glans. |
| Type IV | All other harmful procedures to the female genitalia for non-medical purposes; for example, pricking, piercing, incising, scraping and cauterization. |

In Southeast Asia, reported practices are predominantly WHO Types 1 and 4 (1). In Asian contexts, FGC is not linked to more severe genital cuts such as Type 2 and Type 3.

# Defining Terms

Globally, the term most often used to describe this practice is 'female genital mutilation/cutting'. However, in countries such as Indonesia and many countries across Southeast Asia, 'female genital mutilation', or 'FGM', is perceived to be a term imposed by the West and not culturally reflective of the practice in the region (1). In Southeast Asia, female genital cutting is most often referred to as 'female circumcision'. The following terms are also used locally to describe the practice (25).

- ***Sunat perempuan*** and ***sunat*** - most commonly used in Malaysia, Singapore, Indonesia, Brunei and southern Thailand.
- ***Khitan/berkhitan*** - an Arabic term used in Indonesia.
- ***Sunnah*** or ***sunnath*** (meaning 'recommended practice') - used in the Philippines, Sri Lanka, the Maldives and parts of India.
- ***Khatna*** or ***khafd*** - used by practising communities in India.
- ***Pag-Islam***, ***pag-sunnat*** or ***turi*** - used in pockets of practice in the Philippines.
- **'Pemotongan dan/atau Pelukaan Genitalia Perempuan (P2GP)** - translates as cutting and/or injuring female genitalia - officially adopted by Indonesian Ministries to encompass all harmful practices in Indonesia, with the aim of advocating against the practice while respecting the value of traditions. The term P2GP is intended to set clearer limits, differentiate the practice from an "act recommended in religion," and ensure that advocacy to end the practice is not seen as 'anti-sunnah'. P2GP is used to refer to all forms of practices harming girls without a medical reason, whether in the name of tradition or beliefs (9), and includes all forms of 'sunat perempuan', all forms of FGM/C, including procedures, which are 'symbolic' in nature.

Wording matters in Indonesia. Jambi City, Samarinda City and West Lombok Regency revoked and replaced regulations on FGC with new regulations that do not explicitly mention 'sunat perempuan' but instead refer to 'sirkumsisi', a term that includes male circumcision. This loophole allows health workers to claim health service fees for 'circumcision' procedures (9).

*Since the term 'cutting' appears to be the more widely understood term within Southeast Asian literature, and since Indonesia has integrated its own wording for FGM/C into its internal debate, this Country Profile uses both the term 'female genital cutting' or 'FGC' to refer to the practice, as well as its Indonesian counterpart, 'P2GP'.*

# History of FGC in Southeast Asia

FGC has been practised for more than 2,000 years (26). While FGC is practiced in certain communities under the belief that it is a religious obligation; research indicates that FGC predates both Islam and Christianity. The earliest known reports of FGC in Southeast Asia, dating from the late 17th century, align with Islamic scholars' descriptions of the practice at the time (26). Islam may have arrived in southeast Asia as early as the 7th century, as Muslim merchants from the Arabian Peninsula passed through on their way to China's ports (27). Nowadays, there are 280 million Southeast Asian Muslims – about 15% of the world's 1.9 billion Muslims (28). For more information on the history of FGC in Southeast Asia, please reference the Malaysia Country Profile at **www.fgmcri.org/malaysia**, pgs. 23-25 (25).

FGC has long been hidden in communities across Southeast Asia. In 1994, governments, including Indonesia, agreed to end harmful practices, such as FGC, as part of their commitments at the International Conference on Population and Development (ICPD), which became the global benchmark for placing women's sexual and reproductive health and rights within a human-rights framework (11).

Despite these 1994 commitments, the WHO noted a lack of documented evidence of the practice, despite several accounts of FGC in Indonesia (29). This lack of evidence, a widespread issue throughout the region, resulted in the omission of data from any Asian country in the 2008 WHO interagency statement (30).

Indonesia first appeared with official prevalence estimates in a UN global report in 2016 (31). That report estimated that around half of all Indonesian girls below the age of 12 were thought to have been cut. Indonesia's affected population, together with Egypt's and Ethiopia's, thus constitute about half of the more than 230 million women and girls who have undergone FGC. At the time of publishing this Country Profile (2025), only two Asian countries – Indonesia and the Maldives – have published nationally representative prevalence data.

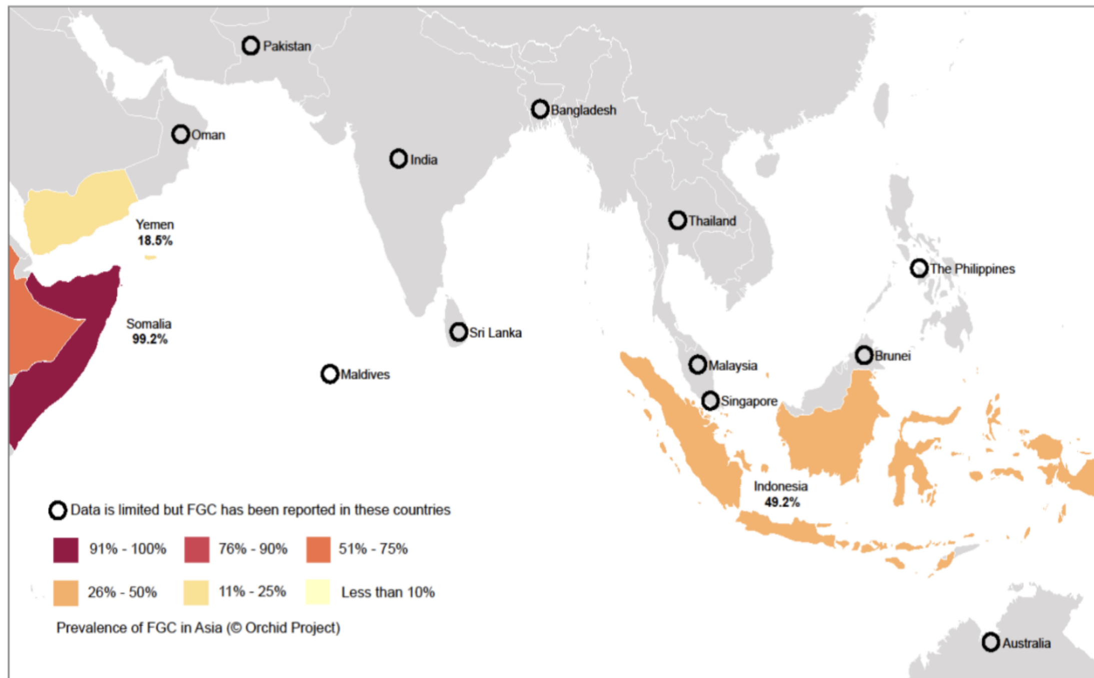


***Figure 3: Estimated prevalence of FGC in Asia (© Orchid Project)***

In 2012, the United Nations General Assembly unanimously passed a resolution framing FGC as a human-rights violation and a serious threat to the health of women and girls, including their psychological, sexual and reproductive health, and urged nations to ban the practice (32). That resolution was adopted by all UN member states and was reaffirmed by the assembly in 2014 (33).

Despite the lack of official acknowledgement, FGC is known to be practised in ten other countries across the region, including Brunei Darussalam, India, Malaysia, Pakistan, the Philippines, Singapore, Sri Lanka, Thailand, Cambodia and Vietnam. However, 'none of these are supported by the UNFPA-UNICEF Joint Programme on the Abandonment of FGM' (1). There has been extensive advocacy and prevention efforts in countries of high prevalence in Africa and among the African diaspora in Europe, but there is a 'paucity of discussion' (1) on genital cutting in the Asia-Pacific region.

*Indonesia is the only Southeast Asian country to have issued a regulation banning the health sector from performing FGC, and to have joined the Asian UNFPA-UNICEF Joint Programme on the Abandonment of FGM.*

# Ethnic Groups in Indonesia

As a multicultural state, Indonesia's cultural heritage encompasses approximately 1,340 ethnic groups. The largest ethnic groups are the Javanese (40.2%), Sundanese (15.5%), and Batak (3.58%) (7).

Indonesia is an archipelago of about 13,466 islands, only half of which are inhabited. Administratively as of 2021, Indonesia consists of 34 provinces, 514 districts/cities, 7071 sub-districts and 81,936 villages (5).

The island of Java is home to more than half of Indonesia's population (56.1%) and is among the most densely populated places on Earth. Sumatra comes second with nearly 22% of the population. Whilst the islands of Kalimantan and Sulawesi account respectively for 6.2 % and for 7.4% of the Indonesian population. Maluku and Papua account for 3.2% of the total (34).

Java and Sumatra, home to about 77.78% of Indonesia's population, represent the principal areas where this practice occurs, with the notable exception of East Java (35). In Sumatra, FGC is prevalent among several ethnic groups which include Alas, Gayo, North Aceh, Aceh Pesisir, Serawai of Bengkulu, Bangka Belitung, Melayu, Minang, Batak Mandailing, Bengkulu, Jambi, and Riau, as well as several ethnic groups in South Sumatra such as Lampung and Palembang (35).

In central Indonesia, FGC is most common among the Sasak and Bima but it is not practiced by the Sasak Bayan. In eastern Indonesia, FGC is prevalent on the islands of Ambon, Ternate, and Maluku, as well as some families in Lembata and Manggarai. In Papua, it is practiced by newcomers from Sulawesi, mainly in the coastal areas (35).

In Kalimantan, FGC is linked to newcomers from Java in regions such as Banjarmasin, Sambas, and Pontianak, but with a growing prevalence among local residents as a result of medicalisation. In Sulawesi, the practice is most common among the Gorontalo, the Mongondow in North Sulawesi, the Toro in Central Sulawesi, the Mandar, Makassar, and Bugis in South Sulawesi, the Bajo in Southeast Sulawesi, and the Muna in Southeast Sulawesi (35).’

***Figure 4: Ethnic groups in Indonesia (© Orchid Project)[1]***

# FGC and migration

More than 1.46 million Indonesian women lived outside of Indonesia in 2024 (36). Assuming all of these women were born in Indonesia and underwent FGC in infancy or early childhood before moving abroad — and applying the 2013 prevalence estimate of 49.2% (2)—Orchid Project estimates that approximately 720,000 Indonesian women residing outside Indonesia live with FGC.

The 2023 Migration statistics (37) show that 41,234 women have settled in Indonesia from Malaysia, 5,142 from Saudi Arabia, 1,150 from Singapore, and 1,164 from the Philippines—countries where FGC is practised or where cases have been reported.

It can be assumed that FGC has been practised on some of these women, either before moving to Indonesia, or after taking up residency. Anecdotal evidence has shown that some parents coming from high-prevalent countries take their daughters back home to undergo FGC, because traditional practitioners were not to be found and midwives knew about the 2014 Minister of Health regulation (16).

[1] Indicative map drawn from the data in Marcoes, Lies. 2023. ('One Decade of Indonesia's Efforts in Eradication of the Practice of FMG/C: The Experience of the UNFPA's Working Partners'. UNFPA Indonesia.https://indonesia.un.org/en/242657-one-decade-progress-eradicating-female-genital-mutilation-or-cutting-practice-indonesia) and the Wikipedia's map of Ethnic groups map in Indonesia, based on the 'Peta Suku Bagsa Di Indonesia (Ethnic Group Map) in the Ethnography Room of the National Museum of Indonesia, Jakarta. https://en.wikipedia.org/wiki/Ethnic_groups_in_Indonesia.

# Prevalence of FGC in Indonesia

*In Indonesia, 46.3% of women aged 15–49 years have undergone FGC (102). Prevalence is higher in urban areas (48.0%) compared to rural areas (43.8%) (4).*

Together, Indonesia, Egypt and Ethiopia account for roughly half of the estimated 230 million women and girls worldwide who have undergone the practice (31). Indonesia has the largest number of women and girls affected by FGC in the world.

The regional prevalence exceeds the national average in Sumatra (62.5%), Kalimantan (58.8%) and Sulawesi (70.5%). The lowest regional prevalence is in Java and Bali (6.7%) and in 'Other regions' (39.1%) (102).

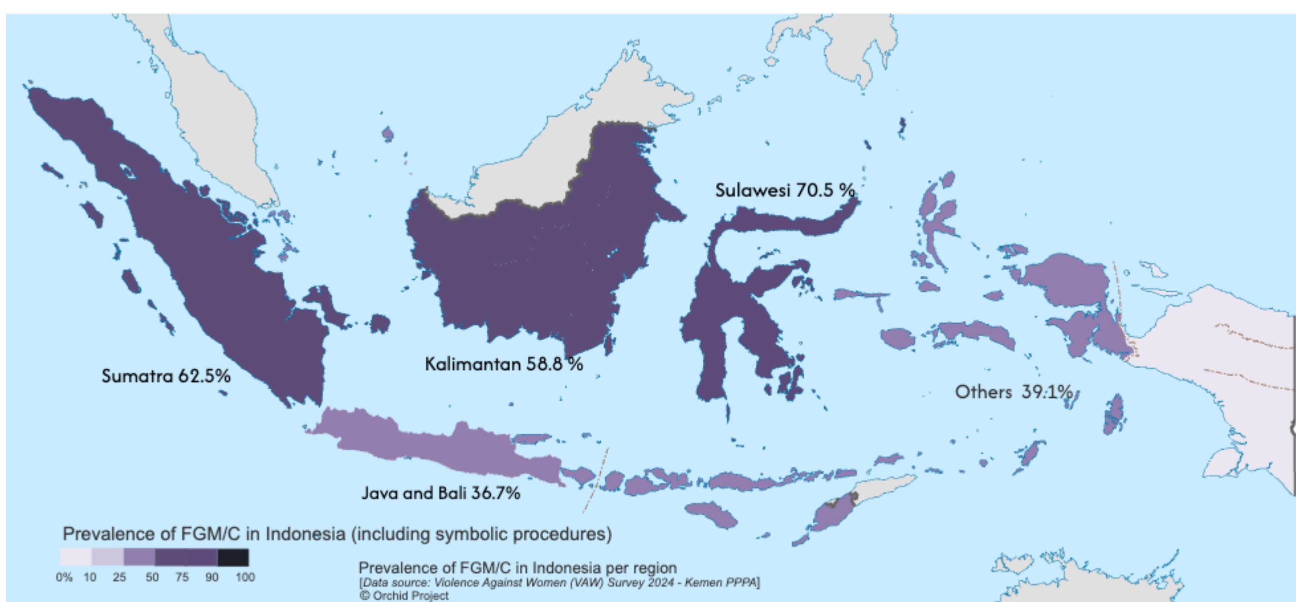


***Figure 5: National prevalence of FGC in Indonesia by major region, 2024 (102).***

The second Indonesian National Women's Life Experience Survey (SPHPN 2024) indicates an FGC prevalence of **46.3%** of women aged 15–49 in 2024 (102), whereas the first survey revealed a national prevalence of **50.8% in 2021** (5).

The 2013 Indonesian National Health Survey found that **one in two girls aged 11 years or younger (51.2%)** had undergone FGC (2). A 2003 targeted survey in eight different ethnic groups indicated a prevalence of 86% to 100% (38).

# FGC Prevalence by Age in Indonesia

When comparing prevalence by age cohorts, 53.3% of women aged 40–44 have undergone FGC compared to 45% of girls aged 15–19, hinting at a decrease in prevalence among the younger cohort (4).

In a separate child-based measure from the same survey, the share of daughters living with their mothers who have undergone FGC is 55% (4), which is not directly comparable to women's lifetime prevalence but may signal a new practice. More data are however needed.

35.4% of daughters affected by FGC have **uncircumcised** mothers, demonstrating that the practice has been **introduced in non-practising families** (5). Culture or tradition could be at play, extending within communities on a cultural basis, or reaching out to non-practising Muslim families. Midwives could also be an influential factor as they performed over half of the acts of FGC in 2021 (5).

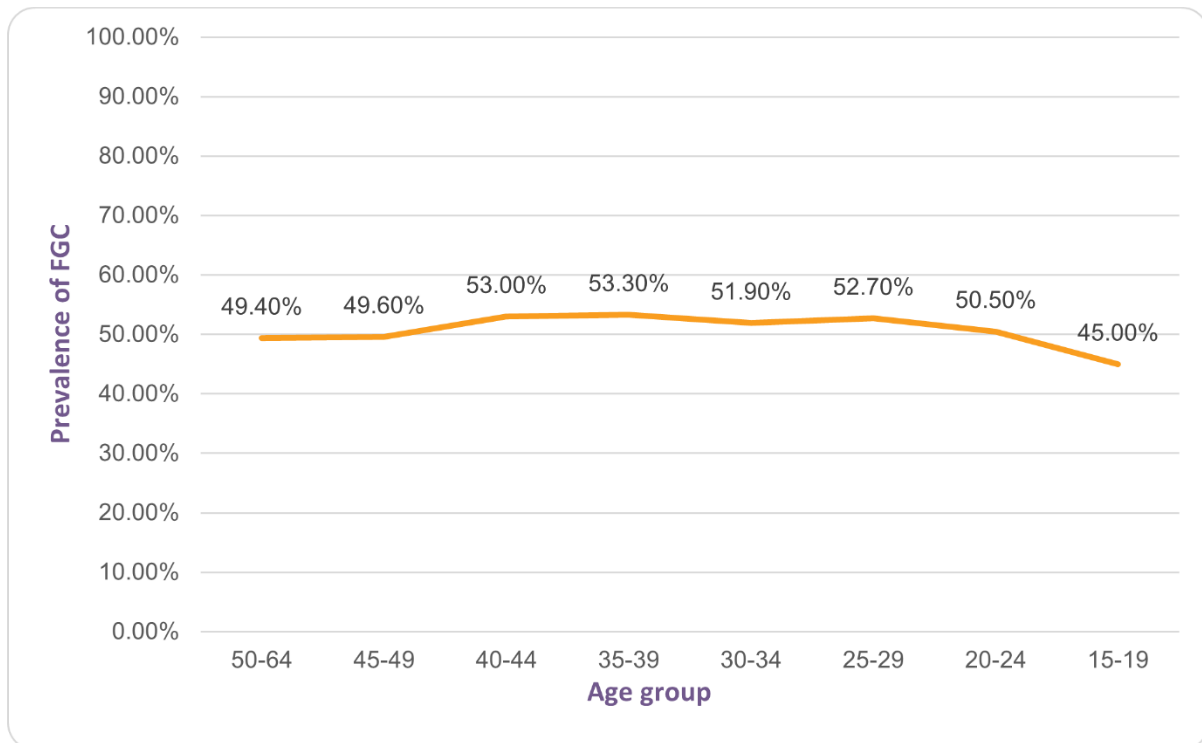


***Figure 6: FGC Prevalence by Age Cohort in Indonesia (5)***

## Prevalence in rural and urban areas

Prevalence has decreased in both urban and rural areas between 2024 and 2021. However, a slightly higher percentage of girls living in urban areas undergo FGC than those in rural areas. Between 2021 and 2024, the biggest decrease in prevalence occurred in rural areas (4,5) (see Figure 7).

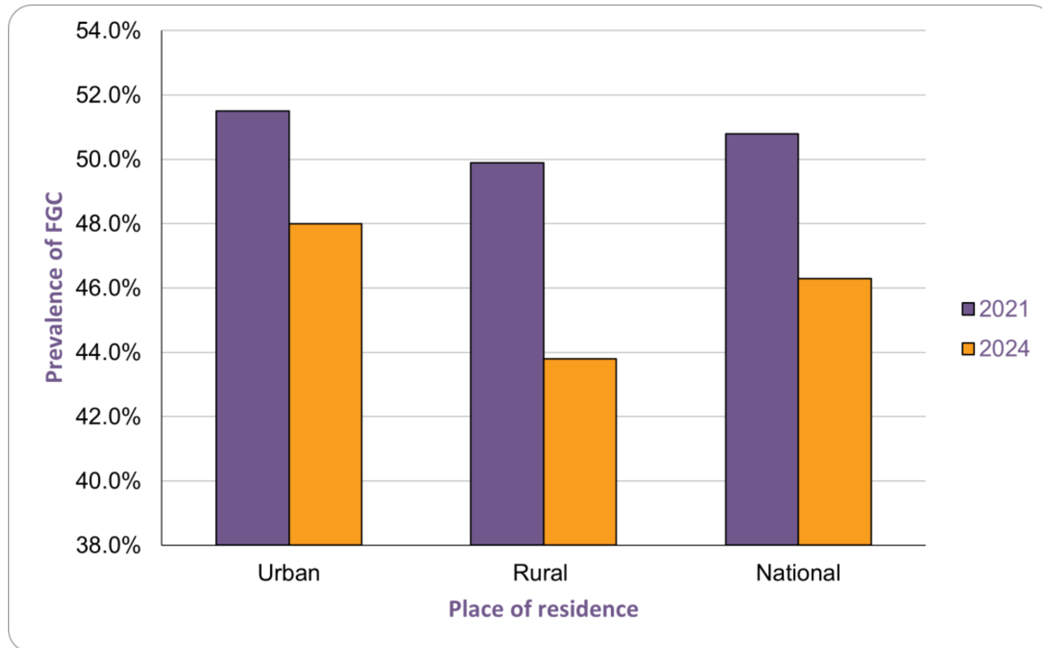


***Figure 7: FGC prevalence in Indonesia by area of residence (4, 5)***

Uncut mothers living in rural settings are more prone to cut their daughters (36.6%) than those living in urban settings (34.5%), despite the fact the former have heard less about the term FGC (65.5%) than those living in urban areas (71.7%) (5).

## FGC and education

Education level does not seem to affect the decision to perform FGC. While more women with a senior secondary education or higher have heard about FGC (74.1% compared to 66.5% for primary school education or lower), the prevalence across levels of education is consistent with the national prevalence level (5).

The impact of education in the FGC practice has evolved over time. In 2017, the majority of females affected by FGC lived in rural areas with a level of education below secondary schools (16). In 2013, daughters aged 0–11 in households where the head had no schooling or a higher-education diploma were less likely to have undergone FGC than those in households where the head had primary or secondary education (2).

# Types of Cutting

*Indonesia is among the few countries worldwide that practises symbolic FGC. These procedures involve non-invasive techniques that do not result in any physical injury (1).*

## Symbolic acts

Symbolic acts, those without any form of cut or physical injury, are practiced in Indonesia, particularly in Yogyakarta and some parts of Java. The technique symbolises purification from dirt. Cleaning the dirt humans are born with, in Javanese minds, allows them to escape the curse of Batara Kala, the god preying on human suffering, and to shield from bad luck (39).

A peeled turmeric root is placed over the girl's clitoris and cut, symbolically representing the genitalia; the root is then buried or thrown into the sea. Its yellow colour symbolises the yellow spirit cleansing genitalia from the dirt (10, 39). In Yogyakarta in 2002, half of the girls were undergoing symbolic procedures. Substitution in South Sulawesi sometimes takes the form of a rooster's comb being cut in lieu of genitalia and its blood smeared on the clitoris (39).

Indonesia separates invasive Type IV from symbolic procedures in its national surveys. A shift in statistical methods between the 2021 and the 2024 national surveys makes direct comparisons challenging. However, Type I and invasive Type IV have increased between 2021 and 2024, while the overall prevalence has gone down (4,5).

The 2024 Indonesian National Women's Life Experience survey shows that the following types of FGC practices are carried out (4):

- pricking, piercing, cutting, scraping clitoris until injured
- slightly cutting off the clitoris 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

The WHO classifications define FGM/C as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. Type IV involves all other harmful procedures to the female genitalia for non-medical purposes, for example pricking, piercing, incising, scraping and cauterisation (8).

The CEDAW Committee defines **harmful practices** as (40) practices that deny an individual's dignity and/or integrity, cause physical, psychological, economic or social harm and/or violence, and limit women's and girls' capacity to participate fully in society.

## Distribution of types

Within the 2024 SPHPN survey, approximately 23.6% of mothers did not know or did not disclose what type of FGC their girls underwent (102). The survey hypothesis is that the mother did not witness her daughter's circumcision. 41.4% of women and girls underwent forms of FGC that align with the WHO classifications (primarily Type 1 and Type 4) (102).

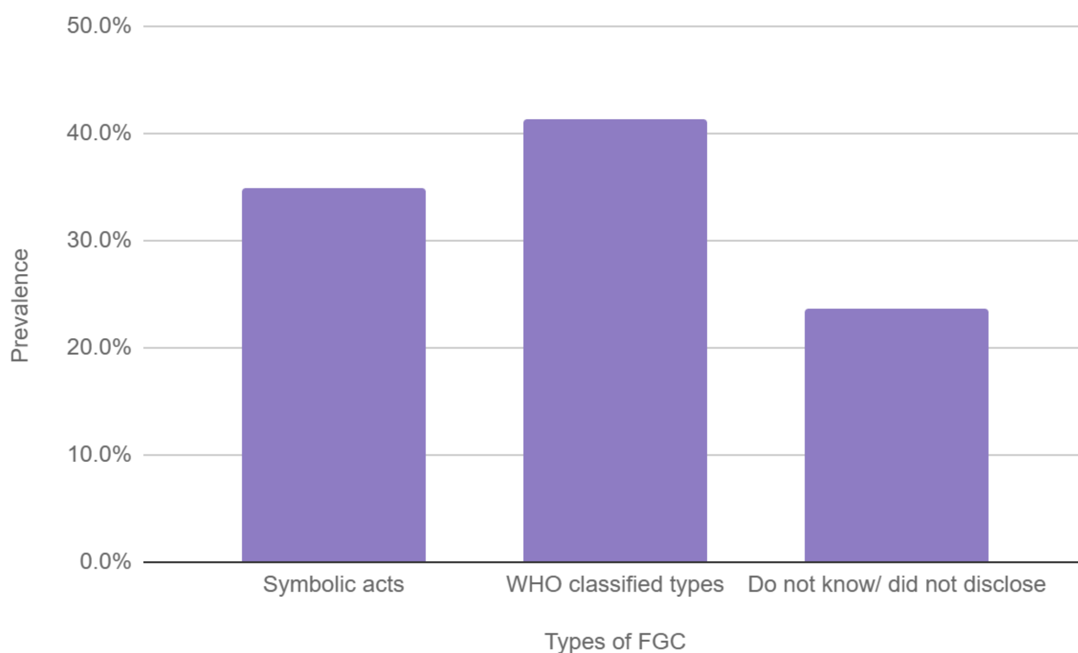


***Figure 8: Types of FGC in Indonesia, including symbolic procedures (102)***

*In 2024, 35.0% of women and girls had undergone symbolic (non-invasive) procedures, an increase from 2017, when the prevalence of this type was 6.9% (102).*

## Place of Residence

Symbolic procedures are more common in urban areas (41%) than in rural areas (34.4%). Conversely, physically invasive type 1 and type 4 procedures are more common in rural areas (43.3%) than in urban areas (35.3%) (5).

# Age of Cutting

In the 19th and 20th centuries, Southeast Asian girls were mostly circumcised between six and ten years of age, typically prior to making the formal declaration of the faith (shahada) and beginning to learn the Koran. In the early 20th century, areas known for their Islamic piety were already likely to circumcise girls in infancy, before the age of two (10).

In 2013, 77.7% of girls aged 0–11 years had undergone FGC before the age of 6 months, the majority at around one month of age (2). In 2021, among women aged 15–64, 68.5% underwent FGC within the first two months of life (5).

FGC may mark the end of the postpartum period, often observed 40 days after birth, although it can occur up to nine years of age depending on local practice. FGC is frequently proposed with the piercing of ears and the first cutting of hair (10). Clinics in Indonesia and Singapore offer FGC alongside ear piercing (1), which suggests a link between younger age at cutting and medicalised FGC (11).

FGC at younger ages is sometimes explained by parents' belief that babies feel less pain than older girls, who may be more aware or traumatised by the experience. The procedure may also coincide with 'Marhabah' and 'Akekah', religious ceremonies regarded as important life-cycle events for boys and girls (41).

## Place of Residence

While most girls undergo FGC before two months of age in both urban and rural settings, there are more girls being cut after the age of two years in rural areas (25.8%) than in urban areas (16.6%) (41).

# Practitioners of FGC

There are five types of FGC practitioners in Indonesia:

1. Doctors
2. Midwives / nurses / paramedics, sometimes called 'bidan'
3. Traditional birth attendants (*TBAs*) called 'paraji' or 'dukun bayi'
4. Female circumcision healers, called 'dukun sunat'
5. Traditional cutters called 'tukang sunat tradisional'

90% of procedures are performed by three main categories of practitioners: midwives/nurses/paramedics (45.8%); traditional birth attendants (27.7%); and female circumcision healers/ traditional cutters (16.5%). Doctors perform relatively few procedures (2.7%) (5).

## Midwives

The 2017 PSKK UGM survey revealed that midwives have a much better understanding of FGC than traditional practitioners, but that over a third still support the practice (16).

98.4% of midwives graduate from midwifery or nursing schools and engage in FGC primarily to attempt to reduce the risks that are perceived to be caused by traditional practitioners (16). Midwives experience pressure from parents to perform FGC and in some cases earn an income from providing it. However, many midwives express ethical concerns, worries about legal sanctions, and concerns for the health and well-being of women and girls. Midwives report awareness of the health consequences of FGC and cite reduced sexual desire, bleeding and potential death as consequences of the practice (16).

The types of cuts that midwives perform are similar to those of traditional practitioners. Cleaning without injury is nearly universal and scratching until bleeding is also common. 46.1% of midwives practice forms of FGC that involve injury or cutting. 36.7% of midwives believe that FGC is necessary for religious (35%) or connections to tradition, either societal (20%) or family (13.3%). 13.3% believe there are medical benefits (16).

### *Some midwives use symbolic acts to protect girls from invasive FGC*

> The midwife met me after her staff told her that someone wanted to meet. The midwife explained that female infant circumcision is no longer allowed. However, due to the high demand from families, the solution was to only perform a symbolic circumcision. Symbolic circumcision is not done by incising or cutting the vagina for fear of harming the baby. She explained that the labia majora, as it is medically called, is only wiped with sterile gauze and baby oil (42).

Many midwives are unwilling to carry out FGC because it is not taught in the midwifery curriculum. They clean the baby's genitalia without telling the parents that is all they have done. Symbolic gestures may accompany the cleaning, such as sticking scissors on the clitoris or pinching the clitoris with tweezers. Some midwives devise their own 'procedure' to avoid performing traditional female circumcision, which is considered harmful (43). Others compromise by 'piercing the genitalia' with tweezers and wrapping with gauze, using red products such as betadine to simulate a drop of blood (16).

Midwives who refuse to perform FGC may face social sanctions—such as stigmatisation and being labelled sinful—as well as shaming and parents may choose to seek a traditional practitioner (44).

Midwives who recognise the scientific evidence behind FGC regulations understand that they must follow existing rules (16). Not telling the truth to parents is seen as a necessary compromise, though they do not always consider how and why this may be problematic (45).

## Traditional birth attendants (paraji)

Traditional practitioners are predominantly Muslim; most have primary school education (76.9%) or no formal schooling (23.1%). They perform FGC in client's home (62.5%) or at the practitioner's home (25%). Most clean the clitoris and labia without injury (84.6%), some scratch the clitoris until bleeding (34.6%), and 11.5% cut the tip of the clitoris (46).

The procedure is learned from family members and is not taught formally. There is a universal belief among traditional practitioners that FGC is harmless and necessary, and that it confers benefits, including improving the appearance of the genitalia (60%) and reducing women's sexual desire (40%). As trusted community figures whose authority remains largely unquestioned, traditional practitioners occupy a pivotal role in the cultural perpetuation of FGC across generations (46).

The paraji, traditional birth attendants, hold knowledge passed down by the older generations. Paraji do not have formal medical training, unlike the professional midwives and nurses (47).

‘Traditional’, ‘indigenous’ and ‘modern’ health systems coexist when it comes to maternal and child health (MCH) in Indonesia. Traditional MCH systems are embodied by paraji (TBA), while the modern MCH system is represented by bidan (midwives). However, indigenous cultures are neither isolated nor immune to the influences of other cultures. Each ethnic group has its own local medical system, including ways of caring for women and babies (47). Generally, indigenous healers are respected for their expertise in traditional medicine, and even though they are seen as mediators between the spirit and human world. Paraji are also seen as mediators between the community, traditional belief systems and modern maternal and childcare (47).

The dukun, or shaman (48), have historically played an important role in Indonesian society, practising healing, sorcery or traditional ceremonies, and representing a connection with the esoteric world of spirits and mysticism. There are several kinds of dukun in Indonesia, and each community may call upon diverse skills. Economic instability, religious beliefs in the dominant communities or social conflict and violence have both in the past created suspicion about the dukun while paradoxically reinforcing belief in supernatural powers (23).

## The role of traditional cutters

In 2021, female circumcision healers and traditional cutters performed procedures on nearly 30% of girls, separate from traditional birth attendants (5). Although a like-for-like comparison is not possible, a juxtaposition of the data relative to the distribution of practitioners between the 2021 SPHPN (5) and the 2013 Indonesia Basic Health Survey (2) may indicate an emergence of circumcision practitioners, such as shamans.

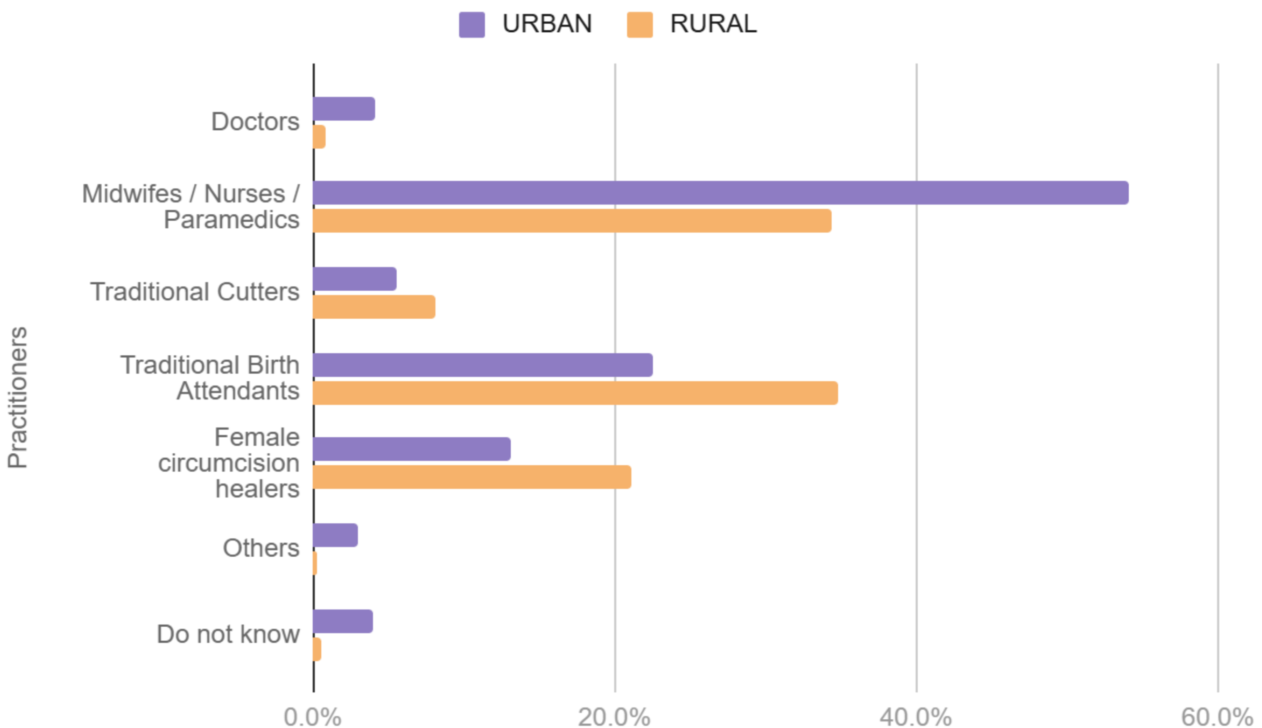


***Figure 9: FGC practitioners in urban and rural areas, 2021 (5)***

Traditional birth attendants are ageing and are likely to play a decreasing role in the future—even where midwives are prohibited from performing what is viewed as a customary practice, such as in Gorontalo (41).

While regional and localised research can help fine-tune this finding (49), further evidence-based data are needed to understand the roles, drivers and locations of the various traditional practitioners, as well as the trends of their respective practices.

# Medicalised FGC

Early studies show that medicalisation contributed to the spread of FGC in Indonesia (50). Clinics in cities offer child delivery, vaccination, ear piercing and FGC in one single package as a regular service, sometimes even without informing the mothers. The extent is such that ear piercing was on occasions called 'sunat'. The shift to a younger age may also be one of the results of the 2010 legislation and the promotion of 'delivery package' in medical facilities across Indonesia, offering vaccinations, medical check-ups and FGC (50). Medical professionals experience community pressure to provide medicalised FGC. 24.2% of FGC in Indonesia is performed by medical professionals (doctors, nurses, midwives) and 47.3% is performed by traditional birth attendants (5).

Procedures done by medical professionals are generally perceived as hygienic and safe (3). Campaigns against unsanitary conditions—particularly those associated with traditional practitioners—have driven practising parents towards healthcare providers in clinics (39).

*The main reason parents in Indonesia choose trained midwives to perform FGC is the falsely perceived medical safety of entrusting their child to a trained professional using sterile, standard-compliant equipment (16).*

Qualified midwives are widely accessible, with the Government aiming at having professional health personnel in every village. Finally, midwives provide maternity packages that include FGC (16).

The main reason for choosing traditional practitioners is the knowledge and respect of local tradition. Some parents refuse medical personnel on the grounds that the procedure might not be in line with tradition (46). Traditional healers are close to the society they serve, physically and psychologically. They provide services at the parent's home. They are often known and trusted and chosen also for close kinship and family advice. Finally, low costs, flexible tariffs according to the family fortune or in-kind payments also ensure traditional practitioners are still preferred in many places (6).

Parents may shun hospitals because medicalised settings do not provide religious satisfaction. Communities may feel particularly connected to traditions based on religious values and shamans do follow Islamic rituals which pledge the integration of the girl into the Islamic faith, unlike medical personnel or facilities. Religious satisfaction may prevent or dismiss even legitimate concerns about harm or risk of injury (51).

Parents may also believe traditional healers are more competent in FGC, and the trust may be greater. Some parents do not accept the Ministry of Health guidelines; some discover later than the medical midwives who circumcised their daughters only practiced a symbolic act, or only cleaned without either incision or excision, and demand a second circumcision from a shaman, with a cut (52).

Health personnel became involved in FGC because of the rapid development of modern medical science. Medicalisation goes on despite the ban or regulations. Midwives face a dilemma: they know FGC is not a medical procedure, brings no health benefit and can be harmful; yet they feel compelled to comply with demand for medicalised FGC (52).

Medicalisation in Indonesia perpetuates gender bias: the introduction of Western medicine has not changed people's mindset about female sexuality. Western medicine is seen as more hygienic, thus the turning to midwives for the practice. However, stereotypes on women and the fact that they are 'dirty' remain. At best, medicalisation reduces infection risk (52).

Medicalisation has impacted the practice of FGC, especially in terms of techniques, practitioners, tools and medication (39). From the 1990s onwards, the Indonesian government promoted medical services by trained doctors and midwives in an attempt to replace herbal medicine given by traditional healers (39). This shift was linked to the village midwife programme to reduce maternal and child mortality rates and to midwives' roles in the maternal, neonatal and child health programme; traditional birth attendants' functions were then limited to postpartum care and contraception counselling (15). The argument in favour of medicalisation focuses on preventing the risk of infection inherent to traditional procedures. It was, however, found that medicalisation may be on the contrary more harmful: midwives tend to use scissors instead of penknives and conduct real cutting. Traditional practitioners use penknives for scraping or rubbing in symbolic acts (53).

Arguments against medicalisation note greater harm when health workers perform the procedure, a finding supported by international studies reporting that cutting or deeper genital injury is more likely when performed by health workers using surgical devices (13).

According to a policy brief on medicalisation of FGC in South and Southeast Asia published by Equality Now, the Asia Network to end FGM/C, and Orchid Project,

> … perceived harm reduction, religion, and financial implications are reasons for medical practitioners to continue performing FGM/C. However, it has been internationally recognised that the medicalisation of the procedure does not eliminate the harm of FGM/C and has no sound scientific basis. Healthcare professionals are not taught how to perform FGM/C in medical schools, and they mostly learn how to perform it informally from senior doctors or traditional healers. There are serious risks associated with the medicalisation of FGM/C. Its performance by medical personnel may "wrongly legitimize the practice as medically sound or beneficial for girls and women's health. It can also further institutionalize the procedure as medical personnel often hold power, respect, and authority in society. (101).

### Community Health Centers *(Puskesmas* and *Puskesmas Pembantu*), and Integrated Health Centers (*Posyandu*).

As early as 2003, surveyed midwives indicated that they carried out more invasive FGC than traditional practitioners, in the forms of incision and excision (68-88% of the cases compared with 43-67% by traditional providers) (38).

In the PSKK-UGM 2017 survey, both traditional and health practitioners indicated that their acts of FGC included cleaning without injury, quasi universally (84.6% and 80% respectively) (16). However, more invasive procedures were also performed. Health practitioners self-reported carrying out more Type IV and Type I FGC than traditional practitioners (16). Parents reported that midwives performed Type I FGC nearly twice as much as traditional practitioners; at the same time, midwives were twice as likely to incise the clitoral region rather than cut off, and twice as likely to scratch or scrape the urethra (16).

### Place of residence

In urban environments, more than one in two girls undergo FGC at the hands of professional practitioners: 54.1% by midwives/nurses/paramedics and 4.1% by doctors (5).

Conversely, in rural areas, 64% of girls undergo FGC at the hands of traditional practitioners (5). The traditional birth assistants are nearly on par with the professional midwives and nurses, both groups of practitioners performing slightly above a third of FGC.

FGC in urban areas is mostly carried out in medical facilities run by doctors or paramedics (40.4%), rather than at traditional practice sites (18.4%) or at home (24.8%) (5). In rural areas, more girls underwent FGC at home (48.1%) than at traditional practice sites (22.2%) or in facilities run by doctors or paramedics (17.9%) (5).

### Training

Indonesian medical or midwifery curricula does not provide any official training, as FGC is not a medical act. In Indonesia, medical professionals learn the skills from peers with experience or senior colleagues (54).

United Nations Member States were urged by the General Assembly in 2020 to stop the medicalisation of FGC, 'which implies drawing up and disseminating guidance and legal provisions for medical personnel and traditional birth attendants so that they are able to respond to social pressures' and to provide 'an adequate response to the chronic mental, psychosocial and physical health problems [. . .] as these problems hinder progress in the field of health in general and in the protection of human rights, including the right to the enjoyment of the highest attainable standard of physical and mental health' (55).

## Continuation of FGC: ambiguous regulations, religious fatwas and professionalism

In Jakarta and surrounding areas, healthcare professionals exploit regulatory ambiguities to digitally promote female genital cutting (FGC). A medical circumcision centre's website stated: '*The Indonesian government permits female circumcision provided it does not involve complete cutting, merely incising or other symbolic acts that do not compromise women's health*.' (42).

FGC service providers in Indonesia legitimise their practices through a combination of Ministry of Health regulations and religious authority, specifically utilising the 2010 regulation (100) and 2014 Health and Sharia Advisory Council guidelines (100) as legal foundations for their operations since 2016. These providers distinguish their medical procedures from African practices by emphasising that they are conducted by qualified medical personnel in clinical settings, whilst Ministry of Health Regulation No. 6 of 2014 provides formal legitimation by stipulating the use of specified syringe sizes to prevent infection during procedures (23). However, this regulatory framework remains fundamentally problematic, as it lacks comprehensive procedural guidelines and FGC has never been integrated into formal midwifery or medical training curricula in Indonesia, creating a significant gap between regulatory permission and professional medical education.

The motivations for continuing to offer FGC services are parental demand, the professional sanctions in case of refusal, the professional hygiene and the obedience to the Minister of Health Regulation No. 16/2014 (23).

Most FGC service providers do not require consent from parents or guardians. One clinic does ask for parental approval when the child is a newborn. The procedures can be seen directly, which most parents do. Some parents do not witness their daughter's FGC because of angst about the procedure or postpartum conditions, because family members were present (often the grandmother); other parents were not allowed or not asked to see by the midwives.

# Laws related to FGC

Indonesia is a presidential representative democratic republic where the president is the head of both the state and government. It has a civil law system based on the Roman-Dutch model and influenced by customary law. In addition, Sharia law is practised in the northern province of Aceh (56).

Integrating human rights into the Constitution has fundamentally changed Indonesia's political system. Indonesia possesses three national human rights institutions: the National Human Rights Commission (Komnas HAM), Commission for the Protection of Children (KPAI) and the National Commission on Violence Against Women (Komnas Perempuan). Indonesia has ratified nine of the main human rights Conventions and Treaties, and participatory democracy, freedom of expression as well as increased women's participation were introduced through reforms (57).

No important reservation was made by Indonesia when agreeing to the gender equality CEDAW principles. The system of Indonesian law is grounded on common goals based on unity in diversity. Indonesia's constitution and laws are secular (58).

*Indonesia is the first Asian country to have adopted a regulation prohibiting the health sector to perform FGC. The 2024 Government regulation establishing the aim of eliminating FGC (14) was followed by a Regulation from the Ministry of Health in 2025 (59).*

These distinctions indicate a progression from the establishment of a broad legal prohibition to the development of more nuanced implementation guidelines that differentiate between harmful and symbolic practices, while extending protection across all age groups. The 2024 regulation is primarily concerned with establishing the legal framework and the objective of elimination (14). In contrast, the 2025 regulation offers more detailed implementation mechanisms, including specific provisions for 'communication, information, and education,' and mandates that the 'Central Government, Regional Governments, and community stakeholders shall conduct advocacy, socialisation, and community' initiatives (59).

It should be noted that Indonesian symbolic procedures (cutting a turmeric and scraping the clitoris without inflicting injury) are not sanctioned in the 2025 Regulation (59). Derivative regulations have not been drafted by the Ministry of Health at the time of publishing of this report.

The **Government Regulation No. 28 of 2024 (14)** on the Implementation of Law No. 17 of 2023 on Health establishes the legal aim of 'eliminating the practice of female circumcision'.

**The Law No. 17/2023, Article 46 paragraph (1) and (2)** state that 'Every infant and child has the right to be protected and free from all forms of discrimination and acts of violence that may interfere with the health of infants and children. The Central Government and Regional Governments are obliged to ensure the implementation of the protection of infants and children' (60).

**The 2025 Ministry of Health Regulation No. 2 of 2025, Article 6 (59) states that:**

(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.

(2) Promotive efforts as referred to in paragraph (1) are implemented through the provision of communication, information, and education, at least including:

a. the abolition of the practice of female circumcision.

(3) 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 mayora, hymen, and/or vagina, either partially or completely; and

b. other actions that cause damage to the clitoris, labia minora, labia mayora, hymen, and/or vagina, either partially or completely.

(4) 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.

(5) The Central Government, Regional Governments, and community stakeholders shall conduct advocacy, socialisation, and community.

# Federal Constitution of Indonesia and FGC

Indonesia's domestic legal system is based on a mix of civil law, customary law and sharia law, which apply to different types of citizens according to their race and religion (61).

The **Constitution of Indonesia (1945, 4th Amendment of 2002)** (62) does not explicitly refer to harmful practices or FGC. **Article 28B (2)** states that: 'Every child shall have the right to live, to grow and to develop, and shall have the right to protection from violence and discrimination'. The State is under obligation to protect, advance, uphold and fulfil human rights under **Article**

**28I (4); Article 28I (5)** places a duty on regulating and setting forth human rights in laws and regulations.

## International Treaties and Conventions

Indonesia is a party to international conferences and has signed several international human-rights conventions, which provide strong recommendations on the eradication of FGC, including the Convention on the Elimination of All Forms of Discrimination against Women (63).

**Article 5(a) of the CEDAW (42) recommends that state parties:**

> 'modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practices which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women [. . .].'

While not explicitly mentioned, FGC falls under such a cultural pattern and customary practice (63).

Efforts to eliminate FGC in Indonesia includes a change of regulation that prohibits all medical practitioners from conducting FGC procedures. Demand remains high, despite awareness programs among medical and health workers, parents, community and religious leaders.

The 2021 concluding observations on the eighth periodic report of Indonesia stressed that any form of FGC cannot be justified on religious grounds and constitutes a harmful practice. It further noted that 'exerting control over the bodies and sexuality of women and girls is in violation of the Convention' (64).

# Understanding and Attitudes

## FGC Rituals

Traditionally, FGC in Indonesia was part of a series of complex ceremonies and rituals, accompanied by a meal. Traditional healers or birth attendants were entrusted by the community and were seen as practicing a minor procedure using a sharp piece of bamboo, thorns, needles and small knives or razor blades. The procedure included a minor cut, prick, scratch, rubbing or stretching, to the clitoris, the hood or even the labia minora. A small drop of blood ensures the validity of the practice. A small piece of flesh 'no larger than a grain of rice' might be removed (10). FGC rituals in Indonesia vary from village to village, from one province to the next, and from one ethnic group to another; they are also closely linked to religious rituals.

Survey data indicate how common these practices are and who conducts them. **In Indonesia, 55.4% of households conduct traditional ceremonies and 62.5% of households conduct special religious ceremonies (16).**

Traditional ceremonies, during which FGC is carried out, are more prevalent in rural settings (62.8%) than in urban areas (39.1%) and are mostly conducted by traditional practitioners (71.3%) (16). Religious ceremonies are also more prevalent in rural settings (68.3%) than in urban areas (50.1%) and are also conducted by traditional practitioners (77.2%), although 57% also have professional midwives involved (16).

In both rural and urban areas, traditional outfits are worn, and the most common tradition is the Kenduri/ Selamatan communal feast. In rural areas, this is primarily conducted by traditional practitioners and in urban areas, this is conducted by medical midwives. In addition to the Kenduri/ Selamatan communal feast, in rural areas, the ritual is accompanied by showers with flowered water, lemon baths, and breaking of eggs.

**Region-specific** details on prevalence and practice of FGC can be found in the Indonesia regional reports, available here **www.fgmcri.org/indonesia**

## Knowledge of FGC in Indonesia

Approximately 70% of Indonesian women have heard of FGC.[2] Many mothers are either unaware of whether or not they have undergone FGC or have no recollection of the event. Additionally, most mothers do not have detailed knowledge of the type of FGC they experience or of the specific details of what was done when their daughters underwent FGC (4,5). Furthermore, the majority of men lack any awareness of the practice (15).

Parents and family members are the prime source of information regarding FGC. Community leaders or religious leaders are also regarded as knowledgeable sources, but close relatives are key to the cultural reproduction of FGC (16).

With population growth, more Indonesian women have heard of the practice than before, albeit more in urban areas than in rural ones. Recent communication efforts are bearing more fruit in urban zones, where awareness has risen slightly; by contrast, in rural areas, awareness has fallen (4,5).

## Support for FGC

Support for FGC has reduced between 2017 and 2021. In 2017, a large study found that parents almost universally agreed that FGC was a necessity (98%) and should continue (97.8%) (15). In 2021, nearly half of Indonesian women, in urban and rural areas alike, still supported FGC, but 34.8% had shifted to view the practice negatively and 15.8% were unsure (5).

In Indonesia, the primary decision-makers regarding FGC are women—mothers and grandmothers (15). 'Circumcised grandmothers tend to circumcise their daughters. A mother who was circumcised by the grandmothers will most likely circumcise her daughter', said a researcher of Center for Population and Policy Studies at Gajah Mada University in Yogyakarta (65).

Culturally, women have an important role in the family and community in preserving local customs and culture. Mothers act as educators in the family and are responsible for the values transmitted to children. When a family has not practiced FGC, they are reminded by other mothers from the neighbourhood (9).

Tradition is so strong that many fathers feel powerless to influence the decision, even when it goes against their convictions (16). Religious leaders also influence the decision (20%), while traditional leaders (1.8%) and other family members (6.3%) play a marginal role (2).

[2] 69.9% in the 2021 SPHPN survey and 68.5% in the 2024 SPHPN survey

In some cases, parents are not even consulted about the decision for a girl to undergo FGC and the decision is instead made by traditional birth attendants (TBAs) or midwives. Power relationships between the various actors were examined in a 2018 qualitative research study carried out in Java and in Madura, which found that: (66)

- The practice is anchored in traditional and religious elements that it is sometimes carried out without the request or consent of the girl's parents
- Those with knowledge and know-how are the practitioners, both traditional and medical. 'Circumcision is the shaman business'
- Parents may not know the precise details of circumcision and may be tricked by practitioners into believing that their daughters have undergone the practice, even though 'only' cotton wool and Betadine are applied
- Pressure from the family elders can create a sense of necessity and obligation among young parents
- FGC can be taught during Quran recitations. The practice continues because of community members' high trust in and reliance on their religious leaders

In the most densely populated areas of the country—Jakarta and surrounding cities—most services providing FGC do not require consent from parents or guardians (42).

## Driving factors behind the practice of FGC

In Indonesia, the primary reasons for FGC include religious beliefs, cultural and family customs, and perceived health benefits such as purity/ cleanliness.

In the most prevalent regions, 92% of parents view FGC as a religious obligation, 80% see it as a cultural tradition, and 72% believe it is a family tradition (13). 26.1% of women and girls aged 15–49 years reported health benefits as their primary motivation for undergoing FGC (13).

These beliefs differ between urban and rural areas. Religious motivations are more common in rural than urban areas, while health reasons are referred to more commonly in urban areas than rural (5).

Where families refuse to practice FGC, the primary reasons include a lack of social sanctions against non-practising families (5) or rejection of the idea of medical benefits associated with FGC, such as the believed positive impact on maturity, growth, fertility, or the control of lust (9). Trauma was mentioned by 7.1% of the respondents; Indonesia is the only country in Southeast Asia to cite such a psychological impact in surveys (5).

### Purity - Cleanliness

Circumcision originated from the word ‘khotana’, meaning ‘throwing away the bud’, in order to get rid of the ‘dirt’. Circumcision is seen as cleansing, which is essential for Muslim prayers as both men and women are barred from the mosque when considered polluted or unclean (68).

> “The various cutting practices in Indonesia all share the idea of purification, of purifying the body from dirt” (69).

> “Devotion, especially Islamic prayer, is obligatory, and the absolute requirement for this is to be clean. When the time of devotion is coming, a servant of God has to be clean. There is no dirt in or on his/her body. Because urine is considered as part of dirt, khitan is purposed to remove the rest of the urine, which sticks to the human body. By contrast, if one is not genitally cut, the purity of their body is questioned” (39).

Some Indonesian parents believe circumcision removes impurity for the rest of their children’s entire lives, and the ‘wudu’, ablution before acts of worship, would be ‘void’ if touched by an uncircumcised person. The drop of blood drawn out by traditional practitioners sometimes symbolises the purification that is needed (46).

Dirt/impurity is sometimes believed to bring bad fortune; FGC is believed to dry the vagina and prevent constant sogginess; filth 40 days after birth is believed to be black, like a black grain of rice or small kernel of corn in need of being pried out (46).

### Tradition

> ‘In our tradition, this is a complicated cultural act that would be almost impossible to simply eradicate. A woman as a mother, or a man as a father, inevitably feels guided by the culture to perform this ritual, no matter how simply. In the practice of circumcision in our culture, there are values of tradition, symbolism, honor, self-respect, manifestation of social caste status, and interpretations about ‘being a respectable woman’ (46).

Traditions around FGC in Indonesia are passed down from previous generations. In many cases, FGC is viewed as a necessity, and the practice is linked to belonging and acceptance for women within communities (16).

Tradition is anecdotally invoked for symbolic cutting: women in the family want to respect the local custom, ‘not resisting tradition but also not doing it by really circumcising’ (46).

The strength of tradition often outweighs the underlying health risks of the FGC practice. Awareness campaigns and information on the health and harm aspect of FGC are frequent in Indonesia, yet the demands of community and family traditions perpetuate the practice (9).

However, not all practices and values in Indonesia are either fully cultural or fully religious. The 2017 Center for Population and Policy Studies (PSKK UGM) study states: 'FGM/C practice that still exists in Indonesia cannot be separated from religion and tradition or culture' (16). Religion and culture are deeply intertwined in Indonesia and cannot be easily separated.

In a country so populated and hosting so many variations of the practice and its determinants, regional mapping of beliefs—and their respective strengths, including how they combine—would allow customised, efficient advocacy.

## Women's Life Cycles

> 'In our [Bugis and Makassar] culture, [FGC] is an important rite of passage in a woman's life cycle. Prohibiting it, even on religious grounds or using valid arguments, without understanding the rich and multi-layered cultural meaning within it, will not be able to eradicate it. Therefore, we need to face it by using a cultural strategy as well: how to alter the practice by not touching the girl's genitals, without interpretations that strengthen labeling and the stereotype that women are sex objects whose libido needs to be controlled' (46).

Religious and traditional rites are intertwined at key points in a woman's life cycle. Using the example of South Sulawesi farming communities, religious rites follow the life cycle: before birth, at birth, at circumcision, at marriage, and at death. Religious rites include elements of traditional beliefs, originating from ancestral traditions, and it may be extremely difficult to set them apart (70).

Anti-FGC Indonesian activists point to the loss of autonomy and the loss of freedom to determine the law for oneself when traditions and rites linked to women's life cycle and where FGC is included as a critical step (42).

## Women's Sexual Drives and Morality

> Women are '99% controlled by lust and 1% by reason'. Interview with Nurani Perempuan in Padang, 2013 (71).

Increasing the husband's sexual desire, reducing the wife's innate sexual drive, preventing girls from having multiple sex partners are mentioned as reasons for continuing the practice (12% and 20% respectively) (5). FGC is believed to control a woman's sexuality, to decrease her sexual libido, to preserve her virginity, to purify her, to make her a perfect Muslim woman, and to prevent promiscuity (71).

In traditional rural Acehnese villages, women are believed to

> ‘feel more stimulated during intercourse, feel longer pleasure, maintain their honour, and can last longer without intercourse. Female circumcision can weaken lust when a woman lives alone, beautify her appearance and her desire is more controllable. In addition, the scratched part of the female genitalia becomes open and makes women more controlled and calmer when having intercourse with their husbands’ (72).

However, the control or enhancement of sexuality, while mentioned in past literature, was mentioned by less than 5% of women in the SPHPN 2021 survey (5). This may show positive awareness from the Indonesian population compared with earlier research, when FGC was thought to regulate women’s lust, promote the stability of families and the moral order of society, or conversely, to enhance female arousal and increase love and feelings of honour by husbands towards their spouses(10).

Additionally, while marriage is not the main factor driving female circumcision practices in Indonesia, surveys show that 63% of young men favour circumcised partners, despite lacking awareness of any perceived benefits (73).

The younger generation may be more prone to believe that FGC is not obligatory in Islam, that there is no medical benefit, that there is no harm in not practising it, and some might even put forward the violation of human rights argument since FGC decreases sexual satisfaction and threatens health (71).

### Social Sanctions

Social sanctions are part of the reality for uncut women in Indonesia. Even though religious obligation, societal and family traditions, and medical reasons are the primary reasons for continuing FGC, social sanctions are cited by 33.8% of women living in rural areas and 18.0% of women living in urban areas (16).

*‘Social solidarity depends on shared uniformity’ (22).*

Social sanctions may include a lower status for the child compared with her peers, and moral condemnation of the parents by the community for not paying attention to the child’s religious development (74).

Midwives may also be sanctioned as well, placed in conflicting positions between regulations and societal demand, and labelled as irreligious or sinful among other social punishments (44).

### A Belief in Harmlessness

FGC in Indonesia is not always perceived as physically or psychologically harmful (68). For many parents, religious and cultural beliefs outweigh the perceived minor and short-term physical effects and psychological impacts are considered unimportant (75). In a small survey in Madura,

57% of respondents affirmed that, after circumcision, there were no complications; 24% thought they had become healthier and 12% believed they had better reproductive health (75).

Research on the health impact of FGC in Indonesia reveals bleeding, tetanus, bacterial infections, poor urine flow, open wounds, fever, and urinary tract infections (76). Some cases of sexual dysfunction following circumcision have also been documented in Gorontalo, Jambi, Riau and Banten (44). In West Java, a baby died after circumcision by a traditional healer; in 2014 in Banten (Java Island), a baby was in a critical condition due to continuous bleeding (52).

### Medical Benefits

Medical benefits are cited by about 50% of women and men for continuing the practice of FGC (16). FGC is believed to make daughters healthier, to increase fertility, to prevent gynaecological diseases, and to facilitate the birth of healthier children in future generations. In Bima, for example, FGC is believed to positively impact the maturity of the child, as well as her health and growth. In West Java, female circumcision is said to have the same medical benefits as male circumcision, namely 'saving women from diseases'; It has purported to prevent the labia from growing to large (73).

## Religious Belonging and FGC in Indonesia

87% of the Indonesian population are Muslim, accounting for approximately 242 million individuals, making it the largest Muslim population globally (77). 11% of the population (approximately 29 million people) identify as Christians, representing the largest religious minority in the country. The remaining Indonesians predominantly adhere to Hinduism, Buddhism, or Confucianism (77).

Both male and female genital cutting are recognised as part of Islamic teaching in Indonesia, and as a sign of devotion to Islam. Both are also practised by a minority of Catholics, Hindus and Buddhists in Java to preserve tradition (78).

FGC in Indonesia is based on 'religious orders and as a form of soul purification' (79). Purifying the body of dirt is also a shared idea among all FGC practices and rituals, as a prerequisite for Islamic prayer and for becoming a Muslim (39).

> 'FGC marks the entry of a woman into the faith, whether as an adult convert, or as a child born into the community' (10).

In Padang, girls go to traditional practitioners before the month of Ramadan, in order 'to be cleaned' before fasting (71). Traditional practitioners believe that an uncut Muslim would not be able to attend prayers in the mosque without proper ablution, marry or have children (71). Family

and religious leaders would always remind and indirectly persuade those who had not circumcised their daughters, as circumcision is often equated with Islamisation (80).

However, this has not always been the case and is not universal. Surveyed parents and religious leaders in 2003 were not aware of any connection between FGC and Islam and did not question the basis of the practice, simply passing it down from one generation to the next (38) .

According to the 2021 SPHPN survey results,

> 'around 4 out of 10 girls are likely to experience FGM/C in a way prohibited by WHO. This happens because half of the women respondents (mothers) still support circumcising their daughters for religious reasons. FGM/C is likely to persist due to a lack of understanding of the practice and because it is primarily concerned with customs passed down from generation to generation' (5).

An Islamic revival in the 1970s led to an expansion of the practice in Indonesia (10). Different religious Islamic beliefs, however, could contribute both to the disappearance of indigenous FGC practices and the resistance against more medicalised practices (39).

## Schools of Thought and FGC

There are four schools of thought in Sunni Islam: Hanafi, Hanbali, Maliki and Shafi'i. While the Shafi'i school of thought is predominant in Lower Egypt, East Africa and southern Arabia, it is particularly common in southern India, Southeast Asia and Sri Lanka – all places deeply connected through maritime routes across the Indian Ocean (10).

The four schools have different views on FGC (81):

- Hanafi do not consider FGC to be *sunnah* ('recommended')
- Hanbali have two opinions on FGC, *obligatory* and *honourable*
- Maliki consider FGC to be *sunnah*
- Shafi'i consider FGC to be *obligatory*

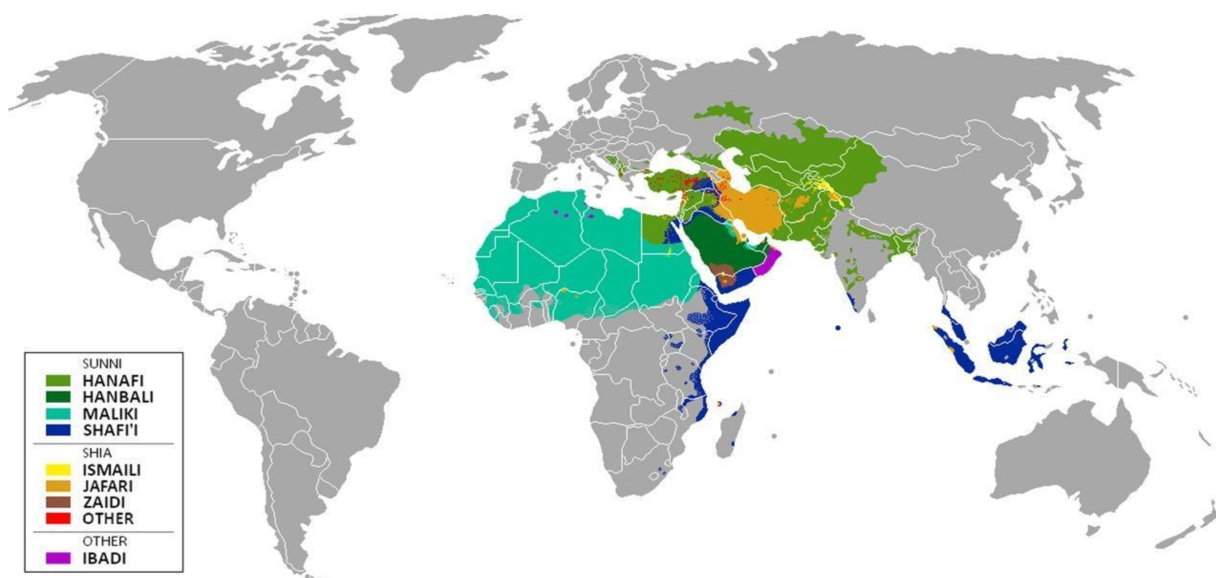


***Figure 10: World map of madhahib (schools of thought within fiqh, the Islamic jurisprudence) (32)***

Islamic Southeast Asia, including Indonesia, largely adhere to the Shafi'i school of thought, and many religious leaders have issued strong statements in support of FGC (1).

The Shafi'i position on FGC is most known by the formulation of the famous scholar Abu Zakariyya Yahya bin Sharaf al-Nawawī (631–676 AH/1233–1277 CE) in his work Tahāra (82):

> Circumcision is obligatory (wādjib) according to al-Shāfi'ī and many of the doctors, sunna according to Mālik and the majority of them. It is further, according to al-Shāfi'ī, equally obligatory for males and females. As regards males it is obligatory to cut off the whole skin which covers the glans, so that this later is fully denudated. As regards females, it is obligatory to cut off a small part of the skin in the highest part of the genitals (82).

Some religious scholars deny, however, that al-Nawawi is fully representative of the Shafi'i madhhab, since the school comprises different opinions (83).

> 'In Indonesia, Islam has many faces. It has always been diverse in terms of doctrine, understanding and interpreting the scriptures among the schools of thought, and has adapted to local cultures while inviting people to embrace faith. In Indonesia, Islam is syncretic' (84).

Religious scholars state that FGC is not a requirement in the Quran; rather, those who support the practice base their reasoning on the hadiths (82). The hadiths are statements or actions of the Prophet and his companions. The most frequently cited hadiths are the honourable deed hadith, the hadith on ghusl, the hadith on the 5 acts of Fitrah, the Hadith on the traditional midwife practising female circumcision, and the hadith on the Way of Abraham.

For more information on the interpretation of the hadiths, please refer to pages 87-88 of the Malaysia country profile available here:

**https://www.fgmcri.org/media/uploads/Country%20Research%20and%20Resources/Malaysia/malaysia_country_profile_v2_(june_2024).pdf**

# Knowledge of FGC Through a Religious Lens

Levels of knowledge of the religious jurisprudence at the foundation of beliefs on FGC seem inconsistent across Indonesia. Studies note some lack of knowledge, uncertainty and inaccurate beliefs regarding the religious law on FGC, particularly among mothers, midwives, teachers or staff in the public health offices. Myths about the source of symbolic practices stem from the same uncertainty (44).

Islamic religious authorities often struggle to pinpoint the origins of FGC within Islamic law, finding no clear references in the Quran or hadiths. Their opinions and interpretations regarding the necessity of FGC vary considerably. Nevertheless, many individuals remain convinced that FGC is intrinsically linked to Islam, perpetuating it as a cultural tradition (15).

Parents are the main source of information on FGC and on religion, nearly universally; family and neighbours (15.6%) are the next most common sources (16). Some children learn about religion in Islamic boarding schools (*pesantren*), Islamic primary school (*Madrasah Diniyah*) or Al-Quran learning centers.

# Challenges

## Demand for FGC and resistance to policies

The complex interaction of tradition, religion, and the use of symbolic practices in Indonesia creates a number of challenges in working towards elimination.

**Enforcement mechanisms for policy directives enacted by the government and the Ministry of Health are lacking.** Midwives and traditional birth attendants continue to practice despite the directives, and this contributes to continued parental demand for FGC services (67).

**The government's recent regulation banning FGC within the health sector (2025) may be resisted** in regions where FGC is prevalent such as Gorontalo, South Sulawesi, West Nusa Tenggara and Banten (46). In Jambi a 2020 local study found that nearly 80% of the respondents would potentially resist bans on FGC (85).

**Multifaceted identity and social belonging may result in resistance to anti-FGC norms** (86). In Gorontalo, the global anti-FGC norm was initially accepted and implemented through government policy, only to be subsequently rejected through local pressure for regulatory modification. The intervention of the Majelis Ulama Indonesia (MUI) supporting prominent Islamic organisations in their advocacy against policy change; the profound historical embedding of Islamic teachings in local identity and daily life; and the ethnic cultural and traditional identities of many Indonesians, may create challenges in shifting FGC norms (86).

## Medicalisation and urbanisation

Two interconnected developments have transformed FGC into a contemporary concern for Indonesian women: the paradoxical effects of medicalisation, which have fostered commercialised FGC practices, and the rise of Islamic fundamentalism since the late 1990s, which has reframed FGC as a religious obligation potentially leading to more severe procedures and increased institutional control over women's bodies. The convergence of these forces presents the most significant challenge, as religious justifications for FGC gain reinforcement from both medical legitimacy and commercial interests (39).

In Indonesia, FGC can be a lucrative practice (39). However, the cost of FGC varies widely and depends on who performs it. It is not always paid in cash; it may also be in kind, such as food. Payment for a circumciser's services may depend solely on the household's ability to pay. The cost of FGC services provided by both midwives and traditional circumcisers used to range from

approximately Rp10.000,00 to Rp30.000,00 (USD0.6–1.8[3]). With such affordable costs, it is unsurprising that the practice of FGC continues to this day. More recently, costs for FGC services range from Rp50.000,00 to above Rp200.000,00 (USD3–12, February 2025 exchange rate). Midwives do not charge for cleaning the vulva (symbolic FGC) (41).

**The cost of delivery packages** (ear piercing, vaccination and FGC) in professional medicalised environments averages Rp425,000.00 (USD26)[4], and ranges from Rp230.000,00 to Rp1.200.000,00 (USD 14–73) (16).

The cost for celebrations of FGC in some communities can reach Rp10.000.000, as in Banten for example (USD612) (16). FGC ceremonies in West Sulawesi, Gorontalo and West Nusa Tenggara are often accompanied by expensive rituals. In Gorontalo, for example, the expenditure for such ceremonies ranges from US763–84, which can be financially burdensome for many individuals (87). Whilst the scale of the FGC celebration is determined by each family's financial means, the expenditure on such events is intrinsically linked to the family's standing within the community. This connection inadvertently promotes the allocation of dedicated funds towards detrimental and superfluous practices that harm daughters (9).

In Jakarta and its surrounding areas, the cost of FGC services varies based on the reputation of the healthcare provider performing the procedure. The expense for parents for their daughters to undergo FGC differs according to the chosen facility or service location. Unlike in West Java, parental education in Jakarta does not influence attitudes and behaviours towards FGC practices. Researchers interviewed mothers employed in banks and other sectors, finding that well-educated women are prepared to pay substantial sums to doctors for their daughters' circumcision. Recognising the demand for FGC services, doctors market their offerings through social media platforms, with Klinik 123 openly advertising its services in numerous Indonesian cities (42).

## The taboo of sexuality

Indonesian cultural and religious norms have traditionally prohibited discourse regarding sexuality, deeming such discussions inappropriate in public, educational, and domestic contexts. Academic scholarship on this subject remains constrained, whilst regulatory frameworks, including sex education policies, are grounded in religious doctrine rather than empirical evidence. This cultural prohibition may impede essential dialogue concerning FGC, particularly among women who lack prior awareness of such procedures (88).

[3] February 2025 exchange rate
[4] As above

> 'For us, advocacy for eradication of FGM/C must be done concurrently with raising awareness about gender and sexuality, because that is where the roots actually lie. This is the basic material of the campaign and outreach for eradication of FGM/C that we are conducting in North Lombok.' Ririn Hajudiani, LPSDM, North Lombok, West Nusa Tenggara (46).

A lack of medical knowledge of female anatomy and a misunderstanding of what actually governs sexual drive have paradoxically led some researchers to wrongly credit MUI operating guidelines with enhancing female sexuality and cleanliness, in an attempt to convert non-practising communities to FGC (89).

## The importance of fatwa-issuing organisations

The post-1998 Asian financial crisis era gave rise to Islamic conservatism in some Indonesian provinces; in Madura, for example, uncircumcised Muslims were categorised as '*kafir*' (non-believers) (38).

Islamic education, particularly *pesantren* (traditional Islamic boarding schools), flourished under national political freedom and gained prominence alongside existing schools affiliated with Nahdatul Ulama and Muhammadiyah. The most significant *pesantren* development occurred in ultra-conservative Islamic institutions (90).

As the world's largest democratic Muslim nation, Indonesia is significantly influenced by fatwas, which play pivotal roles in both democratic construction and rising extremism. The methodology of fatwa production determines their (un)democratic content, with deliberative approaches generating democratic fatwas. In Indonesia, fatwa-issuing actors are as important as the content of the rulings (91).

Indonesian Muslims face conflicting recommendations between fatwas and institutions, particularly regarding human rights. They also encounter conflicting fatwas within faith-based organisations when central boards and regional branches implement divergent policies, creating confusion among members who are unaware of organisational regulations. Furthermore, imbalances of influence between religious organisations limit Indonesians' choices and reference points for healthy debate, reducing space for democratic expression of religious rights and pluralism, whilst a balanced and inclusive religious public space would allow organisations to enrich religious debates and reach broader society (91).

# Positions on FGC of religious organisations in Indonesia and fatwas

Indonesia is home to the largest Muslim population in the world, yet the legal and lawful foundation is national law. Fatwas have no legal basis but are used as religious references by the Muslim communities. Indonesian Muslims regularly solicit fatwas for guidance in worship and in worldly affairs from trusted religious organisations, such as **Muhammadiyah, Nahdlatul Ulama (NU) and the Indonesian Ulama Council (MUI)**. Different interpretations based on the same verses are proposed to their members and followers.

**Muhammadiyah** advise against FGC and link it to physical harm. Muhammadiyah base their position on their assessment that the hadiths used as the basis for FGC are weak; and because the Prophet himself never recommended it or had it done to his daughters. (102).

**NU and MUI** share the position that FGC cannot be prohibited, based on the hadith. However, both organisations state that avoidance of excess harm is required. **MUI** rely on the principle of *fitrah* (religious observance) (102) and **NU** base their position on the principles of *masyru* (prescribed by religion) and *sunnah/ mubah* (religious practice) (102).

In contrast, **KUPI** conclude that FGC is *haram* (forbidden). KUPI's position is based on protection of female anatomy and reproductive functions. KUPI believe that FGC violates *hifz-al*-nafs (protection of life) and posits that male circumcision is very different to that on women (102).

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

# Implementation challenges of legal bans

FGC regulations operate through a dual-level system: national oversight by the Ministry of Health, and regional implementation focused on healthcare access. Regional authorities determine service levies and reinvest tax revenue from government-managed health facilities into local development programmes.

Four lessons can be drawn from previous attempts to regulate FGC in Indonesia. The principal obstacles impeding effective FGC elimination efforts were: 1) Regional authorities demonstrated varying understandings of the 2014 Ministry of Health regulation; 2) The regulation's implementation proved ineffective at both district health office and regional government levels, with current outcomes remaining unclear; 3) Healthcare practitioners, particularly midwives who believe in FGC's benefits, frequently disregarded regulations, using medical justifications to

increase community demand; 4) Finally, inconsistent enforcement across provinces and districts undermined anti-FGC advocacy efforts by committed local authorities (44).

The 2019 Komnas Perempuan research identified national legislation as essential for addressing regional disparities. The 2024 health legislation prohibiting FGC procedures and the 2025 Ministry of Health regulation represent the second attempt in 18 years to establish effective legal frameworks. Researchers anticipate this legislation will resolve previous implementation failures and strengthen elimination campaigns (44).

# Symbolic procedures and harm

Indonesia recognises two types of procedures as 'symbolic' (4):

1. symbolically cutting turmeric
2. scraping the clitoris without inflicting significant harm (for example, rubbing, scrubbing, or cleaning without cutting)

These two procedures are considered non-invasive as they are designed to fulfil cultural and religious requirements without inflicting significant physical or physiological harm. In the early 2000s, the Indonesian Ulema Council agreed to the gradual phasing out of female circumcision, and supported ritualistic, non-invasive forms of the practice as a first step (95).

Symbolic procedures in Indonesia include symbolic gestures (for instance, touching the genitalia with a bamboo stick), use of substances (such as applying turmeric on the genitalia), ritual blessings (reciting prayers), and substitution with ritual gestures (replacing the physical procedures with cleaning with Betadine, to avoid physical and physiological harm).

In Indonesia, a debate exists regarding the potential of symbolic rituals to end FGC. This debate is considered controversial within the global positioning of zero tolerance to FGC. Within the debate in Indonesia, some parties believe that gradual prohibition of culturally ingrained practices can be achieved through a step-by-step approach. For instance, transitioning from physically harmful procedures involving clitoral cutting or damage to purely symbolic acts that do not cause bodily harm could be a viable strategy (9).

Others argue that even symbolic acts are a form of violence.

> 'Even symbolic (action) is violence, because this symbolic practice of circumcision departs from the same perspective: distrusting female sexuality.' (46).

There are concerns that symbolic procedures are linked to gender inequality, harm and a lack of necessity.

- **Reinforcement of harmful norms**: symbolic procedures perpetuate the idea that female bodies do not intrinsically conform to cultural or religious norms. Discriminatory beliefs include the notions that girls are inherently 'dirty' and promiscuous, despite evidence that sexual desire depends on physiological, psychological, emotional or cultural factors (96).
- **Potential for escalation**: the normalisation of physically harmless procedures leaves an open normative and cultural space for the continuation or resurgence of more invasive procedures, especially in circumstances where influencers demand a stricter cultural or religious adherence (97). In regions where symbolic practices are tolerated, evidence suggests that when societal conditions change—such as shifts in political or religious conservatism—more invasive forms of the practice can resurface.

Activists and government bodies in Indonesia have expressed several arguments against symbolic practices of FGC, even when non-invasive or largely ceremonial.

- **Violation of human rights**: Activists emphasise that FGM/C, regardless of its invasiveness, violates women's and girls' rights to bodily autonomy and freedom from violence. Symbolic acts, while non-physically invasive, are seen as a violation of these rights by perpetuating a broader framework of gender-based discrimination
- **Lack of religious mandate**: Many Islamic scholars and activists argue that FGM/C has no basis in religious texts and is instead a cultural practice that has been incorrectly associated with religious piety. Ending even symbolic forms helps dispel the misconception that the practice is a religious obligation
- **Global perspective and legal frameworks**: Local Indonesian groups advocate for the elimination of FGC, including symbolic practices, as part of Indonesia's commitment to international treaties like the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW). They argue that any tolerance for symbolic procedures undermines global eradication efforts. The linguistic and semantic ambiguities around FGM/C and female circumcision as well as the lack of legal prohibitions in many Asian countries exacerbate this risk, as symbolic practices are rarely scrutinised, allowing independent practitioners to operate unchecked.

# Responses to FGC in Indonesia

## The effectiveness of multifaceted approaches

Multifaceted approaches have proven their effectiveness in the eradication of FGC practice. All successful interventions have included **legal measures, education, community engagement and medical support (98)**.

- Community engagement: In order to shift perceptions and cultural beliefs, programmes focus on education and awareness. Kenya and Senegal have successfully engaged with local leaders and grassroots organisations.
- Strengthening legal frameworks: Laws in some countries have shown limited impact due to inconsistent enforcement, limited resources and cultural resistance. Comprehensive approaches should include training of law enforcement officers, healthcare providers and the judiciary, as well as protection and support for affected girls and women.
- Promoting collaboration between international organisations, governments and NGOs: This entails sharing best practices, resources and strategies, and by providing funding for local programmes, technical assistance and capacity building.
- Establishing effective monitoring and evaluation systems: Data-driven approaches may be used in tracking progress and identifying improvement opportunities.

## Roadmap for the prevention of FGC

The Ministry of Women's Empowerment and Child Protection, in collaboration with various stakeholders, has disseminated a roadmap and action plan for the prevention of P2GP with a target date of 2030. The various strategies include data collection, public education, policy advocacy, and coordination among stakeholders (6).

The strategy encompasses four principal components (6):

- cultivating comprehensive community awareness regarding the health risks associated with female genital cutting (FGC) to ensure informed decision-making that prevents its practice across all age groups
- establishing robust legal frameworks that provide stringent prohibitions and protective measures against FGC perpetration

- implementing systematic national data collection mechanisms to monitor evolving public awareness levels and inform evidence-based policy development
- creating cohesive organisational structures that facilitate integrated prevention efforts through coordinated collaboration between governmental institutions and community stakeholders

The National Commission on Violence Against Women (Komnas Perempuan) has called for revisions to Indonesia's 2020–2030 FGM/C prevention roadmap to include victim recovery provisions alongside existing prevention measures.

## United Nations Population Fund (UNFPA)

UNFPA's actions against FGM/C in Indonesia have achieved significant milestones across six principal areas (46).

1. **Strategic Foundation and Programme Development** established the intellectual framework through the landmark 2015 International Seminar and developed the Road Map for Prevention of FGM/C by 2030, which was disseminated to over 3,000 participants.
2. **Research and Evidence Generation** produced foundational studies on FGM/C medicalisation across 17 regencies and integrated FGM/C questions into the National Survey of Women's Life Experience, revealing that 55.2% of females aged 14–49 had undergone the practice.
3. **Religious and Cultural Transformation** facilitated the 2018 Bogor Statement clarifying religious perspectives on FGM/C and supported the Indonesian Congress of Women Ulama's landmark 2022 declaration that FGM/C is haram, whilst training 239 women ulama.
4. **Policy Development and Legislative Impact** contributed to the enactment of the 2019 Midwifery Law, which provides a framework for high-quality midwifery education.
5. **Healthcare System Transformation** reached nearly 8,000 healthcare professionals through training programmes and distributed 12,500 advocacy guides across 34 provinces and 449 cities and regencies.
6. **Multi-Sectoral Coordination and Community Implementation** demonstrated effective four-step engagement across government ministries, religious networks, healthcare associations, and community organisations, exemplified by the North Lombok pilot programme that trained 394 participants and resulted in village regulations protecting women from gender-based violence.

# Civil Society Organisations

### Kalyanamitra[5]

Kalyanamitra in Sanskrit means good friend (Kalyana/kalyani, meaning "good"; mitra means "friend"). Kalyanamitra is a feminist organization that was started to address gender inequality in the family, society, and the state in response to damage done to the women's movement by the New Order regime in Indonesia. Kalyanamitra was founded on March 28, 1985 in Jakarta by Ratna Saptari, Sita Aripurnami, Myra Diarsi, Debra H Yatim and Syarifah Sabaroeddin. The organisation gained NGO status as an independent women's organisation in 1985 and later updated in 2024.

Kalyanamitra's goal is to strengthen women's communities to become active social actors responding to gender inequality through community mentoring; to conduct studies and build evidence based on women's experience; and to actively advocate for gender equality through policy change and raising awareness on gender injustice.

### Perkumpulan Keluarga Berencana Indonesia (PKBI) Pusat[6]

Founded on December 23, 1957, PKBI is an organisation that posits that a responsible family can effectively address health and social issues, thereby enhancing welfare in Indonesia. This belief is based on attention to the future dimensions, health, welfare, and education for all family members. PKBI implements programmes, advocacy efforts, information dissemination, education, and services related to sexual and reproductive health in Indonesia. These initiatives include providing information and education for children, adolescents, and families; advocating for the eradication of sexual violence; addressing HIV and AIDS; offering family planning services; and advocating for health rights for all Indonesian citizens. PKBI operates 26 regional offices at the provincial level, over 100 branches at the district and municipality level, and 14 clinics throughout Indonesia. In 2025, PKBI will have programmes related to FGC, namely: 1. a campaign for the prevention and elimination of FGC through 25 social media channels; 2. a review of the Ministry of Health (MoH) 2018 guidelines for health workers on preventing FGC.

### Yayasan Puan Amal Hayati[7]

Puan Amal Hayati was established in 2002 by Mrs. Sinta Nuriyah Wahid, in collaboration with Muslim scholars, leaders of Islamic boarding schools, and social activists dedicated to women's empowerment. The term "Puan" is an abbreviation for "Pesantren Untuk Pemberdayaan Perempuan," while "Amal Hayati" translates to "hope of life." This organisation engages in Islamic studies that advocate for women's rights, facilitates interfaith dialogues involving leaders and

[5] https://kalyanamitra.or.id/
[6] https://pkbi.or.id/
[7] https://www.instagram.com/puan_amalhayati

communities of diverse faiths concerning issues of tolerance, pluralism, and peace in Indonesia, promotes gender equitable policies, and provides community education on tolerance and inclusion.

FGM/C is one of the key issues for this organisation. In 2025, Puan Amal Hayati is set to advocate to the Ministry of Religious Affairs for the integration of FGC topics into Islamic religious counselling and educational resources for future brides. Furthermore, Puan Amal Hayati aims to convene a national seminar on FGM/C in Indonesia and Malaysia, and to collaborate with Kalyanamitra in organising it.

### Perkumpulan Rahima[8]

Established in 2000, Rahima is dedicated to advocating for women's rights from an Islamic perspective. The organisation employs two primary programmatic approaches: 1. Education and information dissemination to foster gender awareness; and 2. Mentorship of female ulama networks through organisation and advocacy. Rahima's educational initiatives encompass the development of both female and male ulama, as well as training in madrasas for religious-education teachers, students, and religious figures. Information dissemination is facilitated through the publication of the Swara Rahima magazine, books, educational modules, the Al Arham bulletin, library services, and various social media platforms. The mentorship of female ulama networks is extended to approximately 1,000 alumni of Rahima's educational programmes, across eight provinces: West Java, Central Java, East Java, Yogyakarta Special Region (DIY), Banten, Special Capital Region of Jakarta (DKI Jakarta), Sumatra (Lampung and Aceh), and South Sulawesi. These alumni include leaders of Islamic boarding schools, leaders of religious study groups, Islamic religious teachers, Islamic religious lecturers, school principals, religious leaders, and instructors at the Office of Religious Affairs (KUA), as well as students.

Rahima collaborates with the Indonesian Women's Ulama Congress (KUPI). Rahima is also involved with Puan Amal Hayati in advocacy aimed at the Ministry of Religious Affairs. As a strategic partner of Kalyanamitra, Rahima has a network of female and male clerics who can advocate against FGC from a religious and gender perspective, as well as the dangers of FGM/C for women and girls. These clerics can disseminate information about FGM/C to their communities and networks in various regions.

### Kongres Ulama Perempuan Indonesia (KUPI)[9]

The Indonesian Women's Ulama Congress (KUPI) serves as a platform for female clerics from various nations to develop religious perspectives and fatwas concerning women's issues. KUPI

[8] https://swararahima.com/en/homepage/
[9] https://kupi.or.id/

has convened two congresses: KUPI I in Cirebon in 2017 and KUPI II in Semarang and Jepara in 2022. The four primary objectives of KUPI are as follows: acknowledging the existence and role of female ulama in both Islamic and Indonesian history; providing a forum for female ulama to exchange experiences related to women's empowerment and social justice; advancing knowledge regarding female ulama and their contributions to the progress of women and human civilization; and FGM/C in Indonesia and Malaysia | formulating fatwas and religious perspectives on contemporary issues from the standpoint of Islam. KUPI has issued a fatwa condemning FGC in 2022, coming from a women experience perspective.

Nur Rofiah, KUPI's founder, was appointed as the managing official of the Istiqlal Mosque (Academic Manager of the Istiqlal Mosque Ulama Cadre Education Program), a strategic position that enables the inclusion of FGM/C education materials. KUPI also has a digital encyclopaedia, Kupipedia, which contains information, documents and knowledge about KUPI that is continually updated as new data becomes available. All entries in Kupipedia are contributions from institutions and individuals who are members of the KUPI Network.

### Yayasan Rumah Kita Bersama (Rumah Kitab)[10]

Rumah KitaB was established in 2008 and became operational in 2010. It was founded by the late cleric and activist K.H. Affandi Mochtar, along with several activists from Islamic boarding schools. Initially, this institution functioned as a study centre that regularly conducted critical religious discussions. Over time, the institution developed programme strategies, including 1. Fostering critical thinking through the establishment of a resource centre aimed at generating critical perspectives on Indonesian Islam and social change that benefit marginalised groups; 2. Developing community-based Islamic boarding schools as platforms for learning and cultivating critical thinking about Islam for societal transformation; 3. Cultivating cadres of critical Islamic thinkers grounded in classical thought or educational texts (yellow books); 4. Engaging in public education and dissemination of Islamic thought, through campaigns that emphasise the perspectives of marginalised communities.

Rumah KitaB is rich in studies and writings on FGC from gender and Islamic perspectives, that can be used as an argumentative basis for policy advocacy and public-education materials.

### Yayasan Kesehatan Perempuan (YKP)[11]

Yayasan Kesehatan Perempuan (YKP) was established on 19 June, 2001, in Jakarta by activists concerned with the state of women's reproductive health in Indonesia. The organisation directly addresses various issues related to reproductive health and women's sexual rights, which are

[10] https://rumahkitab.com/
[11] https://ykp.or.id/

currently deemed controversial. YKP employs a systematic strategy aimed at fulfilling women's reproductive health and sexual rights, which remain overlooked, through the following approaches: 1. Advocacy: (a) legal protection for women to exercise their sexual and reproductive rights as integral components of human rights; and (b) access to quality, comprehensive, and affordable reproductive-health services for women in Indonesia and Malaysia, without discrimination. 2. Enhancement of critical awareness among individuals regarding reproductive and sexual rights, as well as gender justice, in an active and inclusive manner, enabling them to realise their reproductive and sexual health rights. 3. Strengthening and expanding collaborative efforts among various stakeholders to achieve equitable policies for the comprehensive fulfilment of sexual and reproductive health and rights (SRHR).

YKP was a leading advocate for the 2006 FGC ban. YKP was also involved in advocacy for the Regulation of the Minister of Health on female circumcision in 2010 and 2014, as well as Government Regulation (PP) Number 28 of 2024 concerning the implementation of Law Number 17 of 2024 concerning health.

### Youth Coalition for Girls (YCG)[12]

YCG was facilitated by Plan International Indonesia, a non-profit organisation focused on children's rights and gender equality. YCG is a continuation of the Youth Camp for Change programme held in 2016, which involved 30 Indonesian teenagers from various regions. Participants agreed to form the Youth Coalition for Girls, a discussion panel to fight for gender equality. YCG has evolved into an organisation with members aged 15–29 years from various genders. It aims to fight for the rights of girls and young women in Indonesia. YCG's activities include awareness-raising through social media, campaigns on Car Free Day, environmental surveys, participation in decision-making, and advocacy. YCG currently has branches in Kupang City and Jakarta Bogor Depok Tangerang Bekasi (Jabodetabek).

YCG is involved in networking work and advocacy against FGC through social media campaigns, aimed at youth communities. It can deliver a special approach that is creative, engaging, and youth-relevant approach to education and social media campaigns on FGC.

### Jaringan AKSI Remaja[13]

Jaringan AKSI (Jaringan AKSI Perempuan Remaja Sehat dan Berdaya) formed on 30 November, 2016 through an agreement among 32 civil society organisations, initiated with support from UNICEF, Population Council, and Flamingo. Jaringan AKSI is a participatory initiative formed on the awareness and concern of activists and organisations focused on protecting and empowering

[12] https://youthcoalition.blogspot.com/
[13] https://jaringanaksi.com/

children and adolescents, especially girls. It aims for individuals, organisations, and academics to collaborate in fighting for children's and adolescents' rights, to achieve gender equality and justice. Jaringan AKSI works thematically, based on needs and developments in issues related to gender equality, especially for adolescent girls in Indonesia—including: eliminating child marriage and sexual violence; eliminating FGC; prohibiting forced involvement in fundamentalist ideological activities, addressing conflict-related crimes against adolescents, protection the rights to education and to freedom of opinion and expression, as well as other relevant themes to improve adolescent girls' welfare.

Jaringan AKSI leverages its network to conduct education and public campaigns on FGM/C, notably on social media. The network focuses on gender equality issues for children and adolescents.

# Next Steps

## Conclusion

Indonesia stands at a critical juncture in the movement to end FGC. With 46.3% of women aged 15-49 having undergone FGC, the country represents one of the world's largest affected populations. Of the 46.3% of women who have undergone FGC, 41.4% underwent procedures consistent with WHO criteria and 35.0% underwent symbolic practices. 23.6% did not know what type of FGC they underwent or did not disclose the details (4).

The 2024 Government Regulation and 2025 Ministry of Health directive prohibiting harmful FGC practices mark historic legislative achievements—making Indonesia the first Asian country to ban the health sector from performing FGC. Yet significant obstacles remain: inconsistent enforcement mechanisms, resistance in high-prevalence regions, ongoing medicalisation despite regulations, and debates surrounding symbolic procedures. The path forward requires sustained commitment across all sectors—government, civil society, religious institutions, healthcare systems, and international partners—to transform legislative progress into meaningful change that protects the rights, health, and dignity of Indonesian girls and women.

## Call to Action

### Government of Indonesia

**Strengthen Implementation and Enforcement**

- Develop clear implementation guidelines and monitoring mechanisms for the 2025 Ministry of Health regulation across all 34 provinces
- Ensure that adequate budget allocation and reporting mechanisms are provided for implementation guidelines
- Establish accountability frameworks with sanctions for healthcare providers who continue to perform prohibited FGC procedures
- Allocate dedicated budget and resources for law and regulation enforcement, monitoring, and survivor support services
- Mandate comprehensive training for all healthcare professionals, law enforcement, judiciary, and local government officials on the 2025 regulation

### Enhance Data Collection and Research

- Conduct regional and district-level mapping of FGC prevalence, types, practitioners, and driving factors to inform targeted interventions
- Establish systematic data collection with traditional practitioners, including dukun sunat, to understand evolving practice trends
- Integrate FGC modules into regular national health surveys to track trends and evaluate policy effectiveness
- Support research on the effectiveness of different intervention approaches
- Include FGC data within measures related to the Gender Inequality Index (GII) to align FGC as an issue of gender inequality and assess its impact on human development achievements

### Expand the Prevention Roadmap

- Develop clear reporting and support pathways for survivors, ensuring local authorities are equipped to respond
- Create culturally sensitive, evidence-based educational materials for communities, families, and religious institutions
- Integrate FGC prevention into school curricula (both for students and teachers) (Ministry of Education)
- Integrate FGC prevention pre-marital counselling programmes (marriage officiants/ Pengulu, Ministry of Religious Affairs)
- Mandate Pendidikan dan Literasi Kesehatan Reproduksi untuk Remaja (Comprehensive Adolescent Reproductive Health Education and Literacy) under the supervision of the Ministry of Women's Empowerment and Child Protection (Kemen PPPA)

### Address Medicalisation

As 47.3% of FGC in Indonesia is performed by traditional birth attendants and 24.2% by medical personnel (midwives, nurses, doctors) (5), addressing medicalisation is a critical component of ending FGC.

- Remove FGC from all maternal and child health service packages offered by clinics and hospitals.
- Integrate FGC prevention into midwifery and medical school curricula, emphasising human rights, bodily autonomy, and evidence of harm
- Strengthen professional codes of conduct and ethical guidelines for healthcare associations (IBI, IDI, POGI) with clear sanctions for violations

- Provide capacity building for posyandu cadres in every village delivered by health providers/midwives (at sub-district level). The implementation of capacity building by health officials/midwives should be a measure of assessment of FGC policy monitoring.
- Provide training for midwives to utilise a “do no harm” approach, equipping them to maintain professional authority and community while also refusing to perform FGC. Many midwives include FGC in postnatal packages to maintain community loyalty and to respond to demand from mothers and mothers-in-law.

## Religious Institutions and Leaders

### Leverage Religious Authority

- Work toward religious consensus between Muhammadiyah, NU, MUI, and KUPI aligning theological positions toward abandonment of FGC
- Develop and distribute religious education materials clarifying that FGC has no basis in Islamic scripture and violates maslahah (well-being) principles
- Train imams, religious teachers, marriage officiants, and community leaders to address FGC in sermons, religious classes, and pre-marital counselling
- Pesantrens and madrasahs deliver adolescent reproductive health education using an empowering, gender-equitable interpretation of Islam. Reproductive health education in religious settings must actively dismantle patriarchal norms that position female bodies as objects of control.

### Support Women's Religious Leadership

- Amplify the voices of female ulama through KUPI and regional networks in religious discourse on FGC
- Integrate FGC education into Islamic boarding schools (pesantren), Madrasah Diniyah, and Quran learning centres
- Support the Istiqlal Mosque's inclusion of FGC education in its Ulama Cadre Education Programme
- Expand platforms like Kupipedia to make religious perspectives against FGC widely accessible

## Civil Society Organisations

### Strengthen Advocacy and Community Engagement

- Scale up community-based education programmes that address FGC alongside broader gender equality, sexual and reproductive health, and human rights
- Develop targeted interventions for high-prevalence regions (Sumatra, Kalimantan, Sulawesi) that respect local culture while challenging harmful norms

### Build Capacity and Coordination

- Strengthen collaboration among CSOs, religious organisations, healthcare associations, and government to ensure coordinated, multifaceted approaches, as well as knowledge exchange on effective interventions and best practices

## Healthcare Sector

### Transform Healthcare Practice

- Enforce professional ethical standards prohibiting FGC across all healthcare facilities and practitioners
- Provide comprehensive training on the 2025 regulation, recognising FGC as a harmful practice with no medical benefit
- Equip healthcare providers with skills to counsel families seeking FGC, offering evidence-based information on harm
- Develop protocols for reporting FGC cases and supporting survivors within healthcare settings

### Address Conflicting Pressures

- Create protected pathways for healthcare providers to refuse FGC without professional or social sanctions
- Establish peer support networks for healthcare providers committed to ending FGC
- Discontinue any training or knowledge-sharing on FGC procedures, even for symbolic forms

## International Partners and Donors

### Provide Strategic Support

- Fund comprehensive, long-term programmes addressing FGC through multifaceted approaches encompassing legal reform, education, community engagement, religious dialogue, and healthcare transformation
- Earmark funds for Comprehensive Adolescent Reproductive Health Education and Literacy (Pendidikan dan Literasi Kesehatan Reproduksi untuk Remaja).
- Provide targeted funding to accelerate the operationalization and capacity building of School-Based Violence Prevention and Response Teams (TPPK) in primary and secondary schools, and Sexual Violence Prevention and Response Task Forces (Satgas PPKS) in universities. Funding must ensure these teams have interactive, gender-responsive training modules to handle all forms of gender-based violence, including FGC.
- Prioritise funding for local CSOs and grassroots organisations with deep community connections and cultural knowledge

- Invest in research and evaluation to build the evidence base on effective interventions in the Southeast Asian context
- Fund research gaps identified in the National Women's Life Experience Survey on Violence Against Women 2024, which identified a lack of evidence-based studies documenting the short and long term harms of FGC in Indonesia
- Support longitudinal clinical studies to track consequences of FGC in Indonesia including infections, reproductive health consequences, and psychological impacts

**Facilitate Knowledge Exchange**

- Support South-South learning between Indonesia and other countries addressing FGC, particularly in Southeast Asia
- Promote regional collaboration through the Asia Network to End FGM/C to address cross-border challenges
- Amplify Indonesian voices in global FGC elimination efforts to ensure Asian contexts are adequately represented

**Maintain Long-Term Commitment**

- Recognise that norm change requires sustained engagement over decades, not short-term projects and that long-term financial commitments to support reproductive health and FGC elimination contribute directly to improving Indonesia's Gender Inequality Index (GII) and achieving national medium-term development plan (RPJMN), as well as contribute to global SDG target achievements
- Support institutional capacity building for government bodies, CSOs, and religious organisations
- Adopt Kemen PPPA's "pentahelix" collaborative ecosystem (involving government, academics, media, community, and business) to ensure financial efficiency, precise targeting, and high-impact social norm transformation. Prioritize funding for the expansion and capacity building of Local Service Units for Women and Children Protection (UPTD PPA), particularly in rural and remote areas where reporting remains critically low

**The elimination of FGC in Indonesia is achievable.** With unprecedented legislative progress, emerging religious consensus, dedicated civil society networks, and increasing awareness among younger generations, the foundation for change exists. What is required now is sustained political will, adequate resources, coordinated action across all sectors, and unwavering commitment to the rights and well-being of Indonesian girls and women. Every stakeholder has a role to play in ensuring that Indonesia's historic 2024-2025 regulations translate into lived reality—a future where no girl undergoes FGC, and all women and girls can exercise their fundamental rights to bodily autonomy, health, and dignity.

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