Policy Brief

Female Genital Mutilation/Cutting (FGM/C): Practices in Ten Indonesian Provinces[1]

A. SUMMARY

The World Health Organization (WHO)[2] estimates about 200 million women and girls around the world experienced FGM/C, which comprises all procedures that involve partial or total removal of the external female genitalia, or causes other injury to the female genital organs for non-medical reasons. This ranges from pricking or piercing the genital area to partial or full removal of the clitoris.

This policy brief outlines the primary findings of a research study on the practice of FGM/C, in 10 provinces in Indonesia with high prevalence rates and the attitudes and perceptions of the parents and health service providers involved in these practices.

The research helps to better understand the underlying drivers for FGM/C so that these practices can be eliminated. FGM/C should be viewed as a gender equality issue due to the negative short- and long-term health consequences experienced by women and girls who have undergone the practice. Eliminating FGM/C will contribute towards Indonesia's achievement of gender equality and women's empowerment, including as part of the Sustainable Development Goals (SDGs).

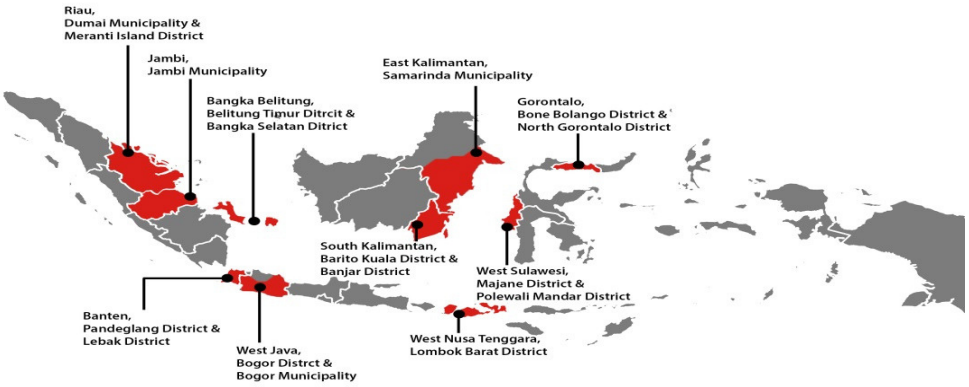
B. FGM/C IN INDONESIA

The 2013 National Basic Health Survey (Riskesdas) found that 51.2 % of girls age 0-11 in Indonesia had experienced FGM/C. The survey provided data on the prevalence of FGM/C by area (province/district), however did not include information on the types of FGM/C being practiced or its drivers[3].

Goals of study

This study aims to deepen our understanding of FGM/C in the 7 provinces with the highest prevalence of FGM/C in Indonesia (according to the 2013 Riskesdas), and in 3 provinces, also with higher than average prevalence rates, that have district level regulations requiring payment from health service providers for providing FGM/C. **The study does not provide a national picture of FGM/C across Indonesia, rather it generates data about FGM/C practices in the 10 selected provinces.**

Ten provinces that became areas of this current FGM/C research (PSKK UGM, Komnas Perempuan)



1 For study report please contact NCVAW (Komnas Perempuan) or CPPS GMU (PSKK UGM)
2 WHO. 2018. Female genital mutilation: Fact sheet. http://www.who.int/mediacentre/factsheets/fs241/en/, accessed January 18, 2018
3 Ministry of Health Republic of Indonesia, Health Research and Development Institution. 2013. National Basic Health Research (Riskesdas) 2013. Jakarta: Ministry of Health Republic of Indonesia.

Methodology of study

The research involved both quantitative and qualitative components to better understand why FGM/C is practised, and to determine strategies that can effectively discourage and ultimately prevent FGM/C. The Centre for Population and Policy Studies, Gadjah Mada University (PSKK UGM) undertook the quantitative part of the research while the qualitative component was conducted by the National Commission on Violence Against Women (Komnas Perempuan). The quantitative data was collected through interviews with 4,250 households (4,250 mothers and 2,782 fathers), 60 midwives and 26 traditional service providers and the qualitative study involved in-depth interviews and focus group discussions with 237 informants (230 females and 7 males) including mothers, midwives and Traditional Service Providers (TSPs), religious and community leaders, health district officers, district legal bureau staff and teachers. The study captured the perspectives of the parents of girls who had experienced FGM/C (the demand side) and midwives (health service providers), and Traditional Service Providers (TSPs) (including Traditional Birth Attendants (TBAs) and Traditional Circumcision Providers) who practised FGM/C (the supply side).

This included an assessment of the types of FGM/C being practised, according to the 2010 WHO classification[4]:

Type 1) Often referred to as clitoridectomy, this is the partial or total removal of the clitoris (a small, sensitive part of the female genitals) and/or the prepuce (the fold of skin surrounding the clitoris).

Type 2) Often referred to as excision, this is the partial or total removal of the clitoris and the labia minor (inner folds of the vulva), with or without excision of the labia major (outer folds of the vulva).

Type 3) Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal, formed by cutting and repositioning the labia minor and/or the labia majora (often through stitching), with or without excision of the clitoris.

Type 4) All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterizing the genital area.

Box 1: The History of FGM/C Policies in Indonesia

- 2006: Ministry of Health (MOH) issued Circular Letter no: HK .00.07.1.3.1047a to prohibit FGM/C being performed by Health Service Providers.
- 2008: Indonesian Ulema Council decrees a fatwa to not prohibit FGM/C. MUI considered FGM/C as: fitrah (virtue since birth), syiar Islam and makrumah (a noble deed).
- In 2010: Ministry of Health issued Ministerial Regulation number: 1636/ MENKES/ PER/XI/2010 about FGM/C. It does not authorize health service providers to perform FGM/C but states the FGM/C implementation must be conducted in safe and hygienic manner.
- 2014: MOH issued Decree no: 6/2014 to revoke the 2010 Decree. However the decree is still ambiguous as it provides at article 2 that the Advisory Council of Health and Islamic Teaching must publish guidelines on FGM/C to ensure the safety and health of girls and prevent female genital mutilation

Policy related to FGM/C

FGM/C as a harmful practice contravenes several existing Indonesian laws, notably: Law no. 7 1984 on the Verification of the Convention on the Elimination of all Forms of Discrimination Against Women; Law number 36/2009 on Health; Law number 23 2004 on the Abolition of Domestic Violence; and Law number 35 2014 on Child Protection. In addition, FGM/C practices violate medical ethics[5] (Uddin, 2010). Despite this legal basis, the application of policies on FGM/C is not consistent as shown in Box 1.

4 WHO, UNFPA, UNHCR, UNICEF, UNIFEM, UNAIDS, UNDP, FIGO, ICN, IOM, MWIA, WCPT, WMA, 2010. Global strategy to stop health-care providers from performing female genital mutilation. See also: WHO. 2018. Female genital mutilation: Fact sheet. http://www.who.int/mediacentre/factsheets/fs241/en/, accessed January 18, 2018; OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO, 2008. Eliminating Female genital mutilation; An interagency statement; United Nations Children's Fund (UNICEF). 2005. Changing a Harmful Social; WHO,"Female Genital Mutilation Programmes to Date – What works and what doesn't," Policy Brief WHO/RHR/11.36, http://apps.who.int/iris/bitstream/10665/75195/1/WHO_RHR_11.36_eng.pdf, accessed May 27, 2017.; WHO. 2000. A Handbook for Fronliner Worker.

5 Jurnalis Uddin et.al. 2010. Khitan Perempuan dari Sudut Pandang Sosial, Budaya, Kesehatan dan Agama.Jakarta: YARSI University and Central Board of Fatayat NU.

C. RESEARCH FINDINGS

Views of Parents

In all provinces studied, there was no significant difference between the perspectives of mothers and fathers. Both considered FGM/C to be a religious order (92%), a cultural tradition (80%), and a family tradition (72%).

Religious and cultural reasons largely underpinned an acceptance of FGM/C with perceptions that the practice was advantageous for sexual health, reproductive health, and girls' morality. In particular, some respondents revealed that they practiced FGM/C due to their belief that it is part of a woman's duty in becoming a whole Muslim (Kaffah). Most of the respondents also practised FGM/C according to inter- generational family traditions[6].

Box 2: Key Findings

1. FGM/C practices vary considerably from area to area in terms of linguistic terms used, associated stories/myths and ceremonial contexts. The types of FGM/C practised range from symbolic circumcision by cleansing the genital area to piercing, slicing, incising or cutting the upper part of clitoris or the area around clitoris.
2. FGM/C is practised because it is viewed as a religious requirement and inter-generational tradition. 61% of FGM/C occurs before the girl reaches 4 months in age and the other 36.1% occurs between the ages of 4 months and 3 years.
3. 61% of FGM/C occurs before the girl reaches 4 months in age and the other 36.1% occurs between the ages of 4 months and 3 years.
4. The medicalization of FGM/C is resulting in greater harm to girls due to the use of more invasive surgical techniques.
5. Midwives continue to perform FGM/C according to parents' demands and local community pressures.

Health Impacts

The views of parents – that FGM/C is advantageous to their daughters[7] – is directly contradicted by medical evidence, which shows the practice is harmful for both the mental and physical wellbeing of girls[8].

In particular, the types of FGM/C that cut through healthy tissue or body parts can lead to infection, damage to reproductive organs, a range of lifelong health disorders, and in some cases even death due to severe bleeding. This view on the harmful effects of FGM/C was shared by only a very small number of women respondents and health service providers (less than 3%)[9].

Health Service Providers

The study found that women respondents in rural areas were inclined to choose TSPs, whereas 60% of women respondents in urban areas chose midwives to perform FGM/C. The cost of FGM/C procedures was found to be low by local standards, costing on average between IDR50.000 - IDR100.000. In several regions, FGM/C was included in a 'birth package'[10]. However, with declining numbers of TSPs - as an ageing cohort that is not being replaced by the next generation – the use of Health Service Providers is likely to increase. This trend may see adverse consequences with evidence that increased medicalization of FGM/C can lead to greater harm.

FGM/C Medicalization

PSKK UGM (2017) found, in the 10 regions studied, FGM/C procedures most commonly involved WHO type 1 (clitoridectomy) and type 4, and in only 1.6% of cases was FGM/C undertaken in a purely symbolic – and less harmful – manner. Greater harm was found to result when health workers performed FGM/C, compared with TSPs. For example, most health workers performed FGM/C by rubbing until a wound appeared in the genital area (43% of 60 midwives respondents compared to 34% of 26 TSPs respondents) or by cutting the clitoris (23% of 60 midwives respondents compared to

6 Universitas Gadjah Mada, PSKK, 2017. (Draft) Study Report on the Female Genital Mutilation/Cutting in Indonesia, 2017; Komnas Perempuan. 2017. (Draft Study Report on the Female Genital Mutilation/Cutting in Indonesia; Uddin, 2010; Read also Budiharsana et al, 2003. Female Circumcision in Indonesia Extent, Implications and Possible Interventions to Uphold Women's Health Rights.

7 PSKK UGM, 2017; Komnas Perempuan, 2017.

8 Heidi Jones et.al, 1999. Female Genital Cutting Practices in Burkina Faso and Mali and Their Negative Health Outcomes, Stud Fam Plann 1999 Sep;30(3):219-30; Read also E. Banks et.al, 2006. Female Genital Mutilation and Obstetric Outcome – WHO collaborative prospective study in six Africa countries, Lancet 2006 Jun 3; 367(9525):1835-41; R. Elise B. Johansen, Bathija and Khanna, 2008; R. Elise B. Johansen, Heli Bathija and Jitendra Khanna: Work of the World Health Organization on Female Genital Mutilation: Ongoing Research and Policy Discussions. Finish Journal of Etnicity and Migration Vol.3 No.2/2008 p83-89; WHO, 2010.

9 Komnas Perempuan, 2017.

10 PSKK UGM, 2017.

11.5% 26 TSPs respondents)[11]. These results are supported by international studies which find that cutting or deeper genital mutilation with the removal of genital tissue was more likely when FGM/C was performed by health workers using surgical devices[12].

While a majority of midwives surveyed considered FGM/C to be unnecessary from a health perspective (64%) they continued to perform the practice due to demand, sometimes citing community pressure as a factor. The study also found there was confusion among some midwives about the legal/policy position on FGM/C with 35% believing there was no prohibition of the practice.

The importance of engaging religious leaders

The main reason behind parents' decision to perform FGM/C on their daughters was that the ritual is considered a religious order (92%). The experience of several countries in the Middle East and Africa (Egypt, Burkina Faso, Kenya, Liberia and Togo[13][14]) may be useful examples for the Indonesian Government to study. These countries were able to decrease rates of FGM/C following discussions with religious leaders on the long-term harmful effects of such practices. This highlights the importance of better educating religious leaders and broader society on the health impacts on women and girls, both immediately and later in life.

D. CONCLUSION

FGM/C continues to be practised across these 10 provinces due primarily to widespread beliefs that it is a religious requirement as well as an inter-generational tradition. Most commonly performed FGM/C types were types 1 and 4 (based on WHO definitions). Although there was a higher level of awareness from midwives on the possible harmful long-term health impacts of FGM/C, only a small number of respondents thought the practice should not be continued.

E. RECOMMENDATIONS

In order to advance its goal of gender equality in human and economic development, it is recommended that the Indonesian Government develop effective and integrated FGM/C prevention programs, and include FGM/C as an issue in its development planning. The abolition of FGM/C in Indonesia needs religious and cultural support, and the policy and legal framework should align with a broader human rights agenda.

This policy brief provides recommendations to all stakeholders for eliminating FGM/C:

RECOMMENDATION 1

To include the elimination of FGM/C in Indonesia's development planning, including in the Short-term and Mid-term National Development Plan (Rencana Pembangunan Jangka Pendek, dan Jangka Menengah Nasional/RPJMN), by collecting national-level data as part of, among other things, achieving the sustainable Development Goals in 2030.

This recommendation will be relevant for Coordinating Ministry for Human Development and Culture, Ministry of National Development Planning/National Development Planning Agency (Bappenas), Ministry of Women and Child Protection (MOWECP), Ministry of Religious Affair (MORA), Ministry of Health (MOH), BPS-Statistic Indonesia (BPS), National Commission on Violence Against Women (NCVAW/ Komnas Perempuan), and National Commission on Child Protection (KPAI).

11 PSKK UGM, 2017. Penelitian Kuantitatif tentang P2GP.

12 Ragab, Ahmed, 2017. Medicalization of FGM/C. Presented during High Level Meeting on Anti-Medicalization of FGM/C, Sharm El-Sheikh, Egypt, 25-26 September 2017. Also see: Pierre Foldes and Frederique Marz, 2015. The Medicalization of Female Genital Mutilation, May 2015, Forced Migration Review; Putranti, Basilica Dyah. 2008. To Islamize, Becoming a Real Woman or Commercialized Practices? Questioning Female Genital Cutting in Indonesia. Finnish Journal of Ethnicity and Migration Vol. 3, No. 2 / 2008; Budiharsana, et al, 2003. Female Circumcision in Indonesia; Extent, Implications and Possible Interventions to Uphold Women's Health Rights.

13 Female Genital Mutilation/Cutting: A Global Concern (link: https://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf) ; accessed January 18, 2018

14 Country Fact Sheet Ending Female Genital Mutilation (link: http://accaf.org/wp-content/uploads/2017/02/1387188563_Ending-Female-Genital-Mutilation.pdf) accessed January 18, 2018

RECOMMENDATION 2

To develop an effective multi-sectoral model or strategies to counter the narrative that FGM/C is in any way advantageous to women, with a view to adopting a zero tolerance approach to this practice across Indonesia, with a particular focus in areas with a high prevalence of FGM/C.

This recommendation will be relevant for MOWECP, MORA, MOH, Ministry of Social Affair (MOSA), Ministry of Communication and Information, Ministry of Education and Culture, Professional Institution (IBI/Midwives Association, IDI/Doctors Association, IDAI/Pediatrician Association and POGI/ Obstetrics and Gynecology Association), NGOs, Community Organization, Faith-based Organization, Private Sectors and media.

RECOMMENDATION 3

To engage with religious and cultural leaders through targeted advocacy and awareness-raising to better inform these influential figures and the wider community about the dangers of FGM/C for women and girls.

This recommendation will be relevant for MOWECP, MORA, MOH, MOSA, Ministry of Communication and Information, Professional Institution (IBI, IDI, IDAI and POGI), Faith-based Organization such as Nahdlatul Ulama (NU), Muhammadiyah, MUI, Dewan Masjid Indonesia (DMI), Indonesia Women Ulama Congress (KUPI) etc.

RECOMMENDATION 4

To strengthen policies and regulations by comprehensively revising policies and laws related to FGM/C. In particular, it is recommended that the Ministry of Health Regulation number 1636/ MENKES/ PER/XI/2010 be revised to prevent all forms of FGM/C and its legal status be elevated to become a Presidential Law.

This recommendation will be relevant for President Republic of Indonesia, Coordinating Ministry for Human Development and Culture, MOWECP, MOH, Ministry of Law and Human Rights, Ministry of State Secretariat.

RECOMMENDATION 5

To include material on both short and long term complications of FGM/C into the formal curriculum of Medical practitioners, Midwives, and Nurses.

This recommendation will be relevant for Ministry of Research, Technology, and Higher Education, MOH, MOWECP.

RECOMMENDATION 6

To better socialize the longer term health impacts of harmful practices including FGM/C as gender equality issue through different communication mechanisms.

This recommendation will be relevant for Ministry of Communication and Information, MOWECP, Mass Media, and Private Sectors.

RECOMMENDATION 7

To conduct further research on the broader impacts of FGM/C including health sector and economic impacts and in other majority Muslim areas where the practice was never, or is no longer, supported.

This recommendation will be relevant for Ministry of Technology, Research, and Higher Education, MOH, MOWECP.