FEMALE GENITAL MUTILATION/ CUTTING: AT THE INTERSECTION OF TRADITION AND MODERNITY

A MIXED-METHODS STUDY OF THE MEDICALIZATION OF FEMALE GENITAL MUTILATION/CUTTING (FGM/C) AT 17 DISTRICTS IN 10 PROVINCES - INDONESIA

QUALITATIVE RESEARCH BY: KOMISI NASIONAL ANTI KEKERASAN TERHADAP PEREMPUAN (KOMNAS PEREMPUAN)

WITH

QUANTITATIVE RESEARCH BY: THE CENTER FOR POPULATION AND POLICY STUDIES (PSKK) AT THE UNIVERSITY OF GAJAH MADA

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Female Genital Mutilation/ Cutting: At the Intersection of Tradition and Modernity

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EXECUTIVE SUMMARY

Female genital mutilation/cutting (FGM/C) refers to any procedure that involves the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons (WHO, 2008). A national study has found that this violation of the right to live free of violence affects 51% of girls under the age of eleven (Riskesdas, 2013). Removing or damaging healthy, viable genital tissue has no proven medical benefits; on the contrary, it is a painful and traumatic procedure that interferes with the natural functioning of the body.[1] FGM/C is linked to short, mid-term and long-term health consequences, such as infections, haemorrhaging, depression, birth complications and infertility (WHO, 2008).

This report presents and analyses data from a mixed-methods research project organised in 2017 by UNFPA with funding support from the Australian Department of Foreign Affairs and Trade (DFAT). The study contracted two agencies to investigate attitudes and behaviors of FGM/C clients and service-providers in ten Indonesian provinces (17 districts). The National Commission on Violence Against Women (NCVAW) conducted the qualitative component of the study while the Center for Population and Policy Study at Gadjah Mada University (PSKK UGM) conducted the quantitative study.

The Study use data from the national study known as 'Basic Health Research' (Riskesdas, 2013) to more closely examine beliefs and behaviors that directly or indirectly perpetuate FGM/C in areas identified as either having high FGM/C prevalence or local regulations that support FGM/C within their health service tariff system. The aim of the study was to create an evidence-base for policy advocacy with key government stakeholders. Previous studies and anecdotal evidence points to a shift from FGM/C being performed by traditional service providers to bio medically trained midwives. This is concerning because the medicalization of FGM/C, a trend in many world areas, does not lead to safer procedures and merely encourages the practice. By examining the trend to medicalization from the view of service providers and the parents who patronise them, the project generated data that guided relevant policy advice and recommendations.

[1] This contrasts with male circumcision, which has been found to provide some protection from certain infections, such as urinary tract infections and human immunodeficiency virus (Berg, Denison and Fretheim 2010, p. 16.

Compared to African countries, where efforts to eradicate FGM/C began in the 1980s, the Indonesian Ministry of Health began to formally address the problem in 2006. As a gender violence and reproductive health violation, the Government has recognised FGM/C as an obstruction to national growth and social wellbeing. Yet efforts to address the practice have been hampered by inconsistent legislation and a lack of supportive behavior change programs. The project has been successful in creating high quality data and engaging government stakeholders in guiding a firm policy and regulatory framework for leveraging social dynamics to discontinue the practice.

The Study

The study was aimed at determining prevalence and what really happen though field observation, thus the findings cannot be generalised to other areas in the nation. The Study use data from the national study known as 'Basic Health Research' (Riskesdas, 2013) to more closely examine beliefs and behaviors that directly or indirectly perpetuate FGM/C in areas identified as either having high FGM/C prevalence or local regulations that support FGM/C within their health service tariff system. Researchers were particularly interested in the trend to medicalization - the progressive shift from FGM/C being performed by TSPs to medical service providers.

The scope of the study and the domains it investigates is impressive. In all, the quantitative study used survey questionaries to explore the views of 4250 households (4250 mothers and 2782 fathers) and 86 FGM/C operators (60 midwives, 26 traditional service providers). The qualitative study conducted group and in-depth interviews with 237 informants (230 females and 7 males). This included mothers, midwives and Traditional Service Providers (TSPs), a category that includes *dukun bayi* (Traditional Birth Attendants) and *dukun sunat* (Traditional Circumcision Providers). The qualitative study also interviewed religious and community leaders, health district officers, district legal bureau staff and teachers.

Through surveys developed by experts in consultative processes, the interviewers explored the following questions:

- What are the types of health workers providing FGM/C services?
- What are types of FGM/C practiced and how do they fit within the World Health Organisation's classification of FGM/C?
- Why do parents choose FGM/C; what influences this choice as well as the choice of service-provider?
- What are the motives that guide the decision to subject a girl to FGM/C?
- Do some parents question the value of this tradition?
- Do service providers share their clients' beliefs that FGM/C is an important tradition that benefits girls?
- Are health workers aware of the human rights and legislative dimensions of the practice?
- Is FGM considered a religious or a traditional practice?

Main research findings

The study found that FGM/C in Indonesia is a diverse practice that ranges from washing or otherwise symbolically purifying the genitals area to pricking, scratching or cutting off part of the clitoris and/or clitoral hood. Contrary to popular beliefs that FGM/C is largely symbolic in Indonesia, almost all recorded cases involved subcutaneous trauma to the clitoris, the prepuce and other areas of the vulva. Ritual cleansing and other symbolic forms were found in 1.2% of cases, and at least 60% of FGM/C involved cutting into or cutting off genital tissue as reported by parent's respondents. The study did not fit the remaining cases in the WHO typology (28% of parents reported types that cut part of the clitoris and prepuce and 6% were said that FGM/C involves scratching or scraping part of the urethra) (PSKK UGM, 2017). Only small number of TSP (7.7%) reported performing symbolic form of FGM/C by ritual cleansing using turmeric without causing any harm. No midwives performed the symbolic type of FGM/C. Midwives and TSPs reported 23.3 to 43.3 % and 11.5 to 34.6 % performing type 4 FGM/C, respectively.

The study found that many recognised FGM/C practices were painful and resulted in haemorrhage and infection which are dangerous. Half of all cuttings took place before the first four months of life and a further 24% of girls were cut before they were three years old. Qualitative data points to the trend of FGM/C being performed at a younger age, which is creating a generation of girls who do not remember or cannot monitor the physical harm done. Subjecting babies and toddlers to the procedure is partly an outcome of the medicalization, since FGM/C is a service bundled in 'birth packets'.

Among practising communities, FGM/C was found to be a social norm supported by the belief that FGM/C helps a women become fully Islamic (*Komnas Perempuan*, 2017; Uddin, 2010; Budiharsana et al, 2003). Religious understandings are entwined in other beliefs, namely that FGM/C is a customary practice performed from generation to generation and that it decreases sexual desire, improves reproductive health, and improves marital harmony (PSKK UGM, 2017; *Komnas Perempuan*, 2017; Uddin, 2010).

Appearances of FGM/C as a timeless tradition and religious rule concealed private oppositions to the practice by midwives and, to a lesser extent, parents. Though almost all parents believed FGM/C was beneficial and necessary, 66% of midwives did not perceive FGM/C as worthwhile and 55% were aware of Ministry of Health prohibitions against the operation (PSKK UGM 2017). These statistics encourage future work that supports midwives awareness and communication skills to refuse FGM/C clients. This is especially important in light of the finding that TSPs are an ageing cohort, moving to retirement and not being replaced.

Key recommendations

The following seven strategies are recommended for future work to monitor and eradicate FGM/C in Indonesia:

1. Develop data to chart the prevalence of FGM/C in Indonesia; for SDG indicators, including at the subnational level. For purposes of monitoring and evaluation, and securing long-term national government commitment, FGM/C must be integrated into demographic meta-data sets.
2. Create and develop multi-sectoral projects in high prevalence areas, with the possibility of developing prototypes that can be scaled-up; A focused and multi-sectoral approach that works comprehensively and intensively with different government agencies, religious leaders and CSOs to abandon the practices of FGM/C.
3. Educate doctors, midwives and health service providers on FGM/C; To address the supply side of FGM/C, the following activities are recommended: initiate dialogue with the Ministry of Health and the Ministry of Higher Education to mainstream FGM/C prevention into reproductive health services and education as well as professional development workshops with midwives who work in community health services, hospitals and other health care centers.
4. Policy Reform – strengthen regulative frameworks; FGM/C policy needs to be developed for consistency and comprehensiveness. This requires revising existing legislation and other measures, integrating policy on FGM/C into the Sexual Violence Bill.
5. Engage women, men and youth in preventative programs through local NGOs and schools; Above all, it is important to target women – as the clients of FGM/C services – and youth – as the future clients. Community-focused programmes can best be achieved by working with government, CSOs, and NGOS working on issues with youth, gender violence, and reproductive health.
6. Work with religious leaders; Working with faith based organizations and individual prominent religious scholars are needed because as authoritative figures on Muslim laws, religious leaders have the potential to sway the beliefs of FGM/C clients practicing communities.
7. 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.

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CEDAW	:	Convention of the Elimination of All Forms of Discrimination against Woman
FGM/C	:	Female Genital Mutilation/Cutting
ICPD	:	International Conference on Population and Development
MoH	:	The Ministry of Health
MOWE CP	:	The Ministry of Women's Empowerment and Child Protection
MSP	:	Medical Service Providers
MUI	:	The Indonesian Council of Ulema (Islamic Scholars)
NCVAW	:	National Commission on Violence Against Women
NU	:	*Nahdlatul Ulama*
P2GP	:	*Pemotongan/Perlukaan Genitalia Perempuan*- FGM/C
PBUH	:	Peace Be Upon Him
PSKK UGM	:	The Center for Population and Policy Study at Gadjah Mada University
Riskesdas	:	*Riset Kesehatan Dasar* (Basic Health Research)
SDGs	:	Sustainable Development Goals
SRHR	:	Sexual and Reproductive Health and Rights
TSPs	:	Traditional Service Providers
TBA	:	Traditional Birth Attendants
TCA	:	Traditional Circumcision Providers

CHAPTER 1: INTRODUCTION AND METHODOLOGY

Female genital mutilation/cutting (FGM/C) is a traditional practice concentrated in 29 countries in Africa and the Middle East but is also found in some Asian countries including India, Pakistan and Indonesia. Worldwide, two hundred million women and girls are estimated to have been subject to the procedure with another 15 million being at risk of having it done to them before 2020 (UNICEF, 2016). As a medical act with no health benefits, FGM/C is regarded by the international community as a threat to reproductive health, a form of gendered violence and a breach of several other human rights (Johansen et al, 2008).

Within the broader framework of the National Action Plan for the Elimination of Violence Against Women, in 2006 the Ministry of Health (MoH) issued a circular letter prohibiting medical personnel from performing the procedure. This promising moment, and its subsequent developments, can be summarised as follows:

- 2006: The Ministry of Health issued a Circular Letter (No. HK.00.07.1.3.1047) to prohibit the medicalization of FGM/C by health workers. This letter was revoked in 2008 after opposition from the MUI (*Majelis Ulama Indonesia*, the Indonesian Council of Islamic Scholars) who issued a fatwa (no. 9A) against the circular letter.

- 2010: The Ministry of Health issued Ministerial Regulation number: 1636/ MENKES/ PER/XI/2010 about FGM/C. It explicitly does not offer authorization to health service provider for performing FGM/C. It ensures the FGM/C implementation is conducted in safe and hygiene manner. This decree accommodated the MUI fatwa.

- 2014: The Ministry of Health issued a Health Decree (No. 6/2014) that had a specific clause revoking the 2010 decree (article 1) based on the lack of health benefits and the harmful risk of medicalization (Berita Negara Republik Indonesia, 2014 No. 185). For many, the 2014 MoH regulation did not provide a clear stance on whether Indonesia bans or allows medical FGM/C[2]and was seen by many to legitimize medicalization (Marcoes & Rohmaniya 2015).

[2] Article two stated, "The Advisory Council of Health and Islamic Teaching shall be mandated to publish guidelines for the female circumcision that ensure the safety and health of girls and prevent female genital mutilation".

The effort to ban FGM/C in 2006 received support from NGOs that worked in women's health issues as well as the Ministry of Women's Empowerment. It did not, however, receive support from the Ministry of Religion and the MUI (Indonesian Council of Ulema). This national non-state organization that serves as an umbrella for religious scholars, organizations and leaders declared a fatwa based on arguments that FGM/C was *fitrah (*virtue since birth*), syiar Islam* and *makrumah* (a noble deed)[3]*.* To be clear, the fatwa was not pro-FGM/C, rather it opposed the government ban on FGM/C as an act against Islamic law.

The most recent legislation has renewed the Government of Indonesia (GoI) position on FGM/C as an obstacle to the advancement of gender equality, sexual and reproductive health, and other outcomes in the national interest. The post 2014 zero-tolerance stance was in part prompted by the national ratification of the UN Sustainable Development Goals, which include number five on Gender Equality and Empowerment. This SDGs makes clear that improving women's health and empowerment is essential for the sustainable human and economic development of nations and depends on the abolishing traditional harm practices such as FGM/C.

Symbolic or Real Cutting?

In contrast to Africa and Middle East, where FGM/C was addressed in the 1980s and 1990s, Indonesia began working on FGM/C in the late 2000s. Felliard and Marcoes (1998) suggest that the reason FGM/C has received little attention in Indonesia, compared to Africa, is that popular beliefs are that it is mostly symbolic or simply a matter of a small prick or cutting the nick of the clitoris or other parts of the vulva. This popular belief, which is still common in Indonesia today, is challenged by empirical studies that found most FGM/C in Indonesia corresponds to WHO types 1 and 4 (Budiharsana et al, 2003; Uddin 2010; Badan Litbang Kesehatan, 2013; Habsjah, 2013). For instance Uddin (2010) estimates that: across Indonesia, 44% of FGM/C practices in the limited range of hospitals and clinics they looked at practise FGM/C type 1, while the remaining 56% practised FGM/C type 4 (Please see Table 3 Types of FGM/C based on WHO classification).

It is the case that infibulation, an extremely violent form of FGM/C found in parts of Africa, and not the norm in Indonesia. It does not follow that FGM/C in Indonesia is not violent is not worthy of attention. Millions of Indonesian girls in Indonesia have suffered, or are at risk of cliterodectomy or other extremely painful types of subcutaneous damage to their genital tissue. From a human rights perspective, violence committed against even one girl is one too many.

[3] The Fatwa Commission of The Indonesia Ulema Council . 2009. The Fatwa Ruling of the Indonesia Council No 9A 2008 on The Law on The Prohibition of Female Circumcision. Jakarta: The Indonesia Ulema Council

The Study

This study, organized by the UNFPA with funding support from Australian DFAT, builds on past research by exploring cultural expressions and types of FGM/C in practicing communities. It departs from prior research by investigating patterned behaviors and socio-cultural reasons that perpetuate the cycle of supply and demand for FGM/C. Some questions explored include:

- Who are the FGM/C clients? What are their background characteristics? Where do they go to for FGM/C services? Why do they choose particular service providers?
- Who are the FGM/C operators? Where do the different service providers perform FGM/C? How does each type of health service provider perform FGM/C?
- What is the technical procedure followed for different service providers? How do they learn how to perform FGM, are there any guidelines? What type of FGM/C do the different service provides perform?
- What are attitudes and knowledge of the health service providers (doctors, midwives and nurse) towards FGM/C? Are they awareness of FGM/C regulations? Do they know the health and psychological implications of FGM/C?
- What is the rationale and motivation for providing FGM/C services? What fee structure do providers use, how much does FGM/C costs and is money an incentive for service providers?
- Are providers billing costs to public schemes? Is there any social pressure to health service providers/users from the community to perform FGM/C?
- What are the rationale and motivation for the community to get FGM/C service from a health provider? What are the knowledge and attitudes of the community towards legislative policy and human rights aspects of FGM/C? What are the cultural and religious perceptions of FGM/C?

Goals of the Study

The goal of the current study is to support the Government of Indonesia create relevant policy changes to support the reduction and elimination of FGM/C. To reach this target, the study aimed to zoom in on findings from the national study known as 'Basic Health Research' (Riskesdas, 2013) to better understand the views and experiences of FGM/C from the perspective of clients, service-providers and other stakeholders, including medical workers, health administrators, and community and religious leaders.

The focus on actors that supply *and* demand FGM/C is important because solutions to promote its eradication need to tackle both sides of the reproductive cycle. In addition to developing policy dialogue and advocacy, this study will serve as the basis for refining questions for demographic monitoring of FGM/C prevalence, future study and developing community-focused awareness programs. Addressing both supply and demand for FGM/C requires approaches that are ground-up and top-down and specific to the regions studies. After all, this is not a prevalence study and so, does not form evidence for nation-wide models to address FGM/C in Indonesia as a whole.

Study objectives:

1. To describe the distribution of FGM/C cases by type of health service providers and by place such as hospitals, clinics and other public health service facilities.
2. To explain the various characteristics of health service providers (doctors, nurse, midwives) performing this procedure.
3. To determine the variation of FGM/C (FGM/C type) by type of operator and medical procedures and also to identify the health consequences.
4. To assess attitudes and perceptions of providers towards the practice.
5. To understand context, rationale/motivation (such as: financial incentive, social pressure, cultural or religious conviction etc.) for health providers to decide whether or not to perform FGM/C.
6. To assess the knowledge, attitude and practice of medicalization of FGM/C among the community, including legislative policy and human rights aspects
7. To provide support to the Government of Indonesia (GoI) to implement policies to promote the abandonment FGM/C through appropriate regulation/legislation, based on current valid evidence.

Methodology

The research design was descriptive, cross-sectional and applied both qualitative and quantitative approaches. As a mixed methods study, the two teams worked together to harmonise sequential data collection and analysis. The study utilized semi-structured questionnaires, in-depth interviews and group discussions. The quantitative study by PSKK UGM used a multi-stage area sampling process and in particular, relied on purposive, PPS and snowball sampling techniques. Data was generated through survey questionnaires and in all interviewed 4250 households (4250 mothers and 2782 fathers) and 86 FGM/C service providers.

The qualitative study by *Komnas Perempuan* (National Commission on Violence Against Women) relied on observations and interviews (in-depth and women's narrative) with 237 informants. Group discussions were held with 277 participants, the majority were selected from samples created by the quantitative study. As well as interviewing parents and service-providers *Komnas Perempuan* extended their interviews to understand the views of teachers, health officials, and community and religious leaders.

Both research teams did the following:

- Conducted a literature review on FGM/C in Indonesia in relation to demography, culture and policy dynamics
- Designed and conducted research about the attitudes, choices, motives and preferences of FGM/C procedures in ten provinces
- Analyze the data using a human rights and policy frameworks.

The overlap between sampled communities and meta-thematic categories lent itself to a form of triangulation known as convergent design. Convergent design allows for the comparison and contrast of data that is collected at roughly the same time and using parallel constructs. It encourages the analyses of each data set separately, followed by a comparison of the data for consistencies, incongruities and differences.

Compared to a single method approach, creating two data sets took more effort in terms of doing the research and coordinating research teams. In light of the advantages, including the ability to "validate one form of data with the other form, to transform the data for comparison, or to address different types of questions (Creswell & Clark, 2007: 118) it was worth the additional resources. As well as producing data that can be internally validated through triangulation, involving both qualitative and quantitative approaches encouraged greater inter-disciplinary and multi-stakeholder engagements.

Selecting study locations

The PSKK UGM research team used the technique of 'multistage sampling' - a process whereby samples with good representative value are sequentially refined. In this case, the quantitative research team selected for provinces, then districts, sub-districts, villages and households through the following process.

Table 1: FGM/C Prevalence Across Regions (Riskesdas, 2013)

No	Province	Consideration	No	District	Consideration	
		High Prevalence of FGM/C at Provincial Level			High Prevalence of FGM/C at District Level	Local Regulation
1.	Gorontalo	83,7	1.	Bone Bolango District	93,1	
			2.	Gorontalo Utara District	86,9	
2.	Bangka Belitung	83,2	3.	Belitung Timur District	93.1	
			4.	Bangka Selatan District	90,6	
3.	Banten	79,2	5.	Pandeglang District	90,7	
			6.	Lebak District	87,6	
4.	Riau	74,4	7.	Dumai City	85,8	
			8.	Meranti Islands District	83,5	
5.	South Kalimantan	78,7	9.	Barito Kuala District	85,7	

No	Province	Consideration	No	District	Consideration	
		High Prevalence of FGM/C at Provincial Level			High Prevalence of FGM/C at District Level	Local Regulation
			10.	Banjar District	84,6	
6.	West Java	73,4	11.	Bogor District	93,6	
			12.	Bogor City	92,8	
7.	West Sulawesi	72,1	13.	Majene District	92,5	
			14.	Polewali Mandar District	90,7	
8.	East Kalimantan	60,4	15.	Samarinda City	80,5	Local regulation on FGM/S is available
9.	Jambi	69,7	16.	Jambi City	74,6	Local regulation on FGM/S is available
10.	West Nusa Tenggara	68,7	17.	West Lombook	58,1	Local regulation on FGM/S is available

The first step was to choose ten provinces with 17 selected districts:

(i) Seven of the provinces (with fourteen selected districts) were chosen based on Badan Litbang Kesehatan, 2013 findings that they had the highest FGM/C prevalence in Indonesia (Gorontalo, Bangka Belitung, Banten, Riau, South Kalimantan, West Java, West Sulawesi);
(ii) Three provinces (with 3 districts) were included because of legislative framework that supports the medicalization of FGM/C (East Kalimantan, Jambi and West Nusa Tenggara). In particular, these districts had issued a *perda* (local regulations) that includes FGM/C as a part of health services and so generating a levy payable to the district government.

After selecting the districts to study, the PSKK UGM team located for subdistricts and villages using Probability Proportional to Size (PPS). PPS samples were drawn from a finite population of units and the probability of selecting a particular unit was adjusted to take into account the relative proportion of its size. This is the benefit of PPS: that it creates sampling sizes that maximise proportionally to the actual size of the sample within the overall population.

To determine the size measures for each unit, PSKK UGM researchers relied on population data about the sub-districts and villages (with detailed information on the number of girls 0-14 years)

from the district level BPS (Board of Central Statistics) offices. This sampling frame selected for five sub-districts (*kecamatan*) and then five villages/neighbourhoods (*desa/kelurahan*), is illustrated in Annex 1 and 2.

To select the households the quantitative team relied on local channels such as heads of the villages, religious leaders, midwives and TSP to gather information for generating a list of households. The key criterion for selecting households was having at least one girl between the age of 0-11 who had experienced FGM/C. Once a list had been created, the qualitative team randomly selected ten households from the five villages across urban and rural populations to survey. In all, they interviewed 50 households from each sub-district for surveying and interviewing.

The qualitative study used the samples generated by the PSKK UGM team to the village level. Researchers then located interview subjects through word of mouth. This technique, known as snowball sampling, is a locally sensitive approach to gain access to informants because it relies on personal recommendations; from people already interviewed and also known to the researchers. Given that FGM/C is a sensitive topic, snowball sampling maximized trustful and respectful relations between the interviewer and interviewees.

Table 2: Respondents per Household (PSKK UGM, 2017)

Study Area (PSKK UGM) Province	Household Respondent		
	Wife	Husband	Female HH Member age 0-11 who experience FGM/C
Bangka Belitung	500	387	594
Banten	500	353	604
Gorontalo	500	366	621
Jambi	250	76	316
West Java	500	170	628
South Kalimantan	500	366	586
East Kalimantan	250	131	301
West Nusa Tenggara	250	183	304
Riau	500	391	623
West Sulawesi	500	359	674
Total	**4.250**	**2.782**	**5.251**

Interviewees

The qualitative study interviewed 230 women and 7 men including:

- 70 mothers. Only 2.8% of urban and 0.05% of rural women had NOT chosen FGM/C for their daughters
- 44 midwives
- 41 TSPs (traditional service providers)

- 40 religious and community leaders
- 11 Teachers and heads of schools
- 24 district health officers

The qualitative team also held seventeen group discussions with 277 midwives and other health service providers.

Data collection

The research teams conducted a desk study that reviewed the policy, legislative, normative dimensions of FGM/C in Indonesia and in a global context. *PSKK UGM and Komnas Perempuan* created the most comprehensive review of the history of FGM/C in Indonesia and overseas, national policy frameworks, traditional and religious interpretations, national social movements against FGM/C and policy histories in other countries of relevance to Indonesia. They relied on documents and literatures from Government, UN agencies, research institutes, NGOs, CSOs and academic journals. This literature review guided the formulation of the questions in surveys, group discussions and open-ended interviews.

Instruments

The research team at PSKK UGM and *Komnas Perempuan* developed the research instruments for this study in tandem with a consultative group consisting of government bodies (Bappenas, MOWE CP, MoH, National Statistic Office/BPS), UNFPA, academics, experts (on womens' rights, childrens' rights, a psychologist, religious leaders, SRHR experts). These instruments were formulated from the literature; through collaborative workshops with the consultative team and in the activities associated with the 'training of trainers' (ToT); and in field trials. Overall, refining the tools for interviewing and surveying focused on more sensitive ways of framing questions to elicit honest responses on sensitive topics.

Quantitative - The PSKK UGM team relied on three structured interview schedules: one for wives, one for husbands and another for health workers.

Qualitative - *Komnas Perempuan* researchers relied on methods including:

- *Interviews* – The researchers used open-ended questions for the purpose of eliciting in-depth information on experiences and feelings about FGM/C among key persons (formal and informal community leaders; health service providers and beneficiaries (including mother or family members). These interviews were designed to be sensitive to the pace and comfort of the interviewee with discussing a sensitive topic.
- *Group Discussions* – A total of 17 group discussions were held, each with between 15 to 20 participants who shared a common or professional identity. Two of the group discussions were held in each district within seven of the provinces. Other group discussions were conducted in each of the three remaining provinces. Moderators were trained in semi-structured questioning which allowed for conversation threads to emerge and be explored with support and guidance.

- *Women's narrative studies* (Oral Herstory Methods) - This feminist method was used when an opportunity arose to speak to a particularly vocal woman about FGM/C. By narrating her story, which usually involved questioning, doubt and even a struggle of conscience, women's narrative methods traced decision-making processes. Including this method of extended biographical narrative opened space for the sharing of experience that was non-conventional and so, interesting to record as a micro-resistance to the status quo.

Analysis of data

In seven provinces the quantitative field teams consisted of one supervisor, four enumerators, and one data editor (Riau, West Sulawesi, Gorontalo, Banten, West Java, South Kalimantan, Bangka Belitung). In three locations (Jambi, East Kalimantan and West Nusa Tenggara) the teams had a supervisor, two enumerators and a data editor.

The supervisor created the household samples, gained local permission to do research, coordinated and managed the progress of interviewers and checked the quality of at least ten percent of questionnaire data. The data editor reviewed the data collected by the interviewers for accuracy, consistency and completeness. In the process of making corrections and confirming the quality of data, they sometimes requested the interviewers re-interviewing or otherwise re-visiting a particular household.

After checking for quality, the data editor entered the data results into software program. Data managers at the PIP (*Pusat Informasi Penelitian*, Research Information Center) subjected this data to another round of checks and edits with the use of CS-Pro, a statistical data processing package. Programmers were contracted to manage and organize the final round of data entry and generate a descriptive statistical analysis. Though computer-programs were used for data entry, data cleaning and data analysis, the final analysis was conducted manually.

The qualitative research team transcribed the interviews and coded the content through the a priori categories of the matrix developed in the literature review. These categories included knowledge and attitudes: FGM/C practices, understanding of FGM/C policies and efforts made by respondents in the abandonment of FGM categories. In particular they relied on feminist, socio-cultural and human rights concepts in the analysis of interview materials. The final stage of analysis, both in the qualitative and quantitative study, developed conclusions and recommendations for future advocacy work to end FGM/C.

Quality Assurance of the Study

Quality assurance measures were taken (Annex 5) and observed throughout the research steps.

Ethical Considerations:

PSKK UGM's Ethical Committee gave ethics clearance for the research and interviews were trained in research ethics and special techniques for investigating a sensitive issue. Prior to

being interviewed respondents were briefed on the confidentiality of their answers and ability to terminate the interview at any time.

Limitations of the Study

- The quantitative study has a Sampling Error (SE) of 5% with Level of Confidence Interval 95%.
- The sensitivity of the focal concern likely influenced respondent disclosure.
- The sample selection was based on the number of FGM/C cases from Badan Litbang Kesehatan (2013). By choosing these districts, cultural and religious variables, known to have a strong relationship with the practice of FGM/C, were not considered. This quantitative sampling limitation was addressed by including questions to explore these variables in the qualitative component of the study.
- Memory lapse – for some women (mothers/ grandmothers) were reflecting on their experience years in the past (more than 5 years' timeframe) - and social pressure also influenced the reliability of data..
- Language barriers – most TSP didn't speak Bahasa Indonesian so the research team had to rely on local translators.
- Difficulty of accessing TSPs – TSPs often lived in remote areas. When the team arrived, they frequently found that the TSPs were not at home or in the place they worked because they were making a house call to attend to a client's reproductive needs.
- A priori bias - Questionnaire formats exclude the possibility of gathering insights about domains of experience not represented within the discursive parameters of the questions. This limit was mitigated to some extent by the open-ended interviewing methods of *Komnas Perempuan*. Notwithstanding the benefits of relying on mixed-methods, the qualitative approach also generated data from and analysed it within a pre-determined matrix developed in the desk review phase. This risked the same outcome, namely the editing of data to fit within a pre-determined schema.
- Composition of interview groups – In light of the cultural value of harmony between spouses, the high suasion between responses of husbands and wife is possibility due to being interviewed together. Future research should innovate in order to glean the views of men, this would involve not interviewing men within marital pairings.

<u>Some measures to control and overcome the above challenges included:</u>

- Enumerators were local females trained in building trust with interviewees and framing questions in order to conduct research on sensitive issues.
- To avoid outliers and distortion, this study examined extreme responses on a case by case basis to evaluate whether to separate them from the aggregate analysis or include it. If separated, questions were raised about the use of this data and how it should be presented.

Organization of the report

In analysing the studies, the author was struck by the high quality of the data and how the qualitative complemented the quantitative. In particular the voices and experiences of participants enhanced and deepened patterns and trends emergent from the quantitative data. The findings of the study are presented in chapters three, four and five. Chapter three provides information on the demographic characteristics of the selected households as well as some general features of FGM/C practice, including the ceremonial contexts, costs, types of FGM/C and the age of girls when they are subject to the procedure. Chapter four presents the findings of FGM/C from the view of parents and chapter five offers data on the perspectives of health service providers. Chapter six contains an analysis of the key findings and chapter seven, recommendations for a multi-sectoral engagement at national and sub-national levels to end FGM/C in Indonesia. But first, chapter two, which provides information of the socio-historical context for understanding the themes and questions of the study.

CHAPTER 2: FGM/C IN INDONESIA: A LITERATURE REVIEW

This chapter provides background material for the study's interest in the process of medicalization and other factors perpetuating the cycle of FGM/C supply and demand. In particular, it offers information about FGM/C terminology, history, socio-cultural features of the practice and contemporary landscape of medicalization. The last section describes the human rights framework that guides the analysis and recommendations for multi-sectoral advocacy work.

Terminology

Across Indonesia, there are many local words to describe what the international community calls FGM/C. In Bahasa Indonesia, the lingua franca of the nation, the practice is referred to as *sunat perempuan* or *khitan perempuan* (female circumcision). This study relied on the WHO (2008) classification (see table three) and definition of 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".

During a series of workshops with key stakeholders at the Ministry of Women's Empowerment and Child Protection, consensus was reached that, in Indonesia, FGM/C should be referred to as P2GP (*Pemotongan/Perlukaan Genitalia Perempuan;* cutting/wounding women's genitals). Within international parlance, cutting external female genital tissues has been described in a variety of terms: "female circumcision", "female genital mutilation", "female genital cutting" and "female genital mutilation/cutting". This report adopts this official UNFPA terminology, referring to cutting as "female genital mutilation/cutting" (FGM/C).

Table 3: Types of FGM/C (WHO,2010)

FGM/C Type	
Type I	Partial or total removal of the clitoris and/or the prepuce (clitoridectomy). When it is important to distinguish between the major variations of Type I mutilation, the following subdivisions are proposed: • **Type Ia**, removal of the clitoral hood or prepuce only;

FGM/C Type	
	• **Type Ib**, removal of the clitoris with the prepuce.
Type II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). When it is important to distinguish between the major variations that have been documented, the following subdivisions are proposed: • **Type IIa**, removal of the labia minora only; • **Type IIb**, partial or total removal of the clitoris and the labia minora; • **Type IIc**, partial or total removal of the clitoris, the labia minora and the labia majora.
Type III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). When it is important to distinguish between variations in infibulations, the following subdivisions are proposed: • **Type IIIa**, removal and apposition of the labia minora; • **Type IIIb**, removal and apposition of the labia majora.
Type IV	All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization.

A Brief History of FGM/C

Communities who today make up the nation of Indonesia have practiced FGM/C for centuries. The types, tools used, meanings and expression of the tradition are as diverse as the cultures of the archipelagic nation. No evidence exists for when or where FGM/C was first practiced in Indonesia but the oldest recorded information can be found in the writings of Nicolas Gervaise, a Frenchman who tutored two Makassar princes in the 17th century (in Feillard & Marcoes, 1998). After a long description of male circumcision ceremonies, Gervaise writes that the Makassarese are the only people in this part of the world that circumcise girls. Gervaise speculates that this secret ritual was based in the Islamic belief in this area that salvation is possible for women who should be allowed to save their souls through circumcision (Ibid).

In retrospect, the French tutor under-estimated how widespread FGM/C was among Muslims in the area that would become Indonesia. His opinion that the practice was related to Islam is consistent with the existent misconception that FGM/C is considered a demand of the Islamic Law, required by the Prophet (PBUH). Though found exclusively among Muslim communities, genital cutting is not determined by religion. Its lack of Islamic sanctioning is revealed by the varied prevalence of FGM/C across Muslim communities, both within Indonesia and internationally (UNFPA, 2015).

Some argue that FGM/C was practised before the arrival of Islam (Feillard & Marcoes, 1998). It may be, as Kaptein (1995) argues for male circumcision, that incising female genitals dates from pre-Islamic times but was progressively replaced by what is locally known today as “female

circumcision" (*sunat perempuan*). Reframing cutting practices as circumcision, according to this idea, was encouraged after a number of Meccan muftis issued several *fatwa* at the end of the 19th century that discouraged the old custom of incision (ibid).

The historical encompassment of incision as circumcision highlights that meanings and values of FGM/C alter in response to local engagements with new socio-cultural influences. It is more productive and empirically valid to not search for traditional or religious causes but rather to recognise FGM/C as a social norm. FGM/C constitutes a norm because it is socially upheld expectation motivated by the desire to avoid sanctioning and be social accepted within the Muslim community.

FGM/C Today

Population data to determine whether FGM/C is increasing or decreasing does not yet exist in Indonesia. What is known is that as a practice continuous with the past FGM/C, remains an accepted tradition. The 51% national prevalence rate (Riskesdas, 2013) is not distributed evenly but concentrated in certain regions. Gorontalo has the highest prevalence (84%) and East Nusa Tenggara/NTT the lowest (3%) (ibid). Historical shifts can be teased out by comparing and contrasting contemporary research with data from colonial reports. Using a comprehensive report by Dutch historian B.J.O. Schrieke (1922, quoted from Feillard & Marcoes, 1998) as a baseline, threads of continuity and change will be briefly mapped. Schrieke's (ibid) work is the obvious candidate for this task since it relied on 56 fieldwork reports from across the archipelago that described circumcision customs.

The contemporary spectrum of operational modes does not differ dramatically from that described in Dutch ethnographies. Now, as for then, FGM/C was at times shrouded in secrecy and in other cases, accompanied by small or large ceremonies (Schrieke, 1922, quoted from Feillard & Marcoes, 1998; Feillard & Marcoes, 1998; Budiharsana et al, 2003). The degree of pressure and trauma to the genital tissue ranged, as it does now, from washing or otherwise symbolically purifying the genitals region to rubbing, pricking, scratching, slicing or cutting off part of the clitoris and/or prepuce is also found in contemporary studies (ibid). In the colonial literature, almost all cases mention a small piece of the upper part of the clitoris (the size is rarely described) being removed (Schrieke, 1922, quoted from Feillard & Marcoes, 1998). This description bears a striking resemblance to the way FGM cuttings are described today (Feillard & Marcoes, 1998; Budiharsana et al, 2003).

Other aspects of FGM/C have proven historically robust. Girls are subject to the practice in childhood; after the time of male circumcision; FGM/C is still largely an all-female affair[4]; and even though biomedically-trained health workers are a new kind of FGM/C service-provider, many today use the services of the local *dukun* or traditional practitioner (Schrieke, 1922, quoted from Feillard & Marcoes, 1998; Feillard & Marcoes, 1998; Budiharsana et al, 2003). In the past, tweezers, needles, knives, razors, and coins were used to perform FGM/C. Today these

[4] The exception being Ngawi (Madiun-East Java), where the father and grandfather could be present.

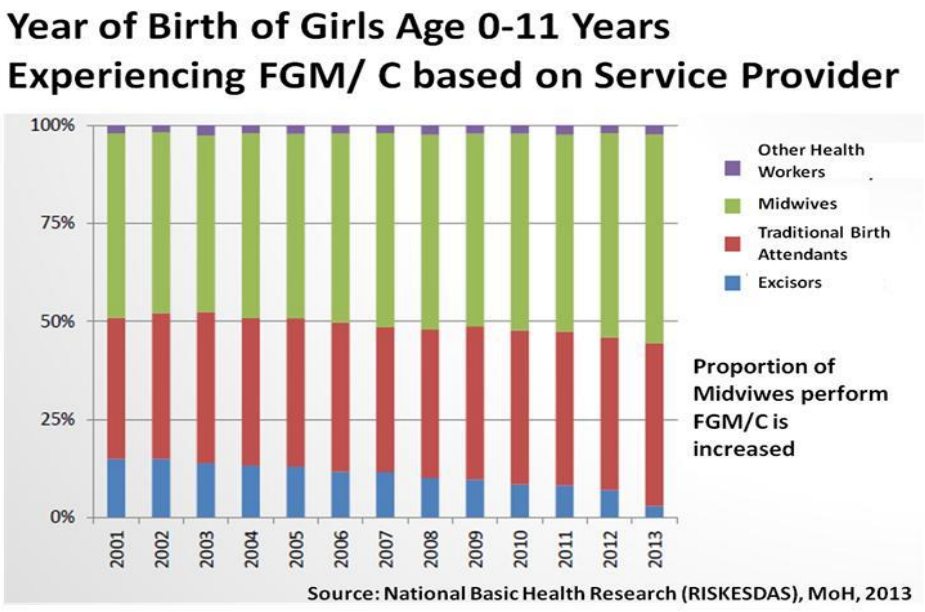
tools, more often in the form of metallic commodities than items handmade from bamboo or other natural materials, are still found. In recent decades, surgical scissors have appeared as a new tool to perform FGM/C.

The introduction of surgical scissors indexes the shift to FGM/C being performed in hospitals, community health centers and private practices. TSPs (traditional service providers) are still popular in FGM/C communities but so too, with the exception of Gorontalo, are midwives. As well as medicalization, another dramatic shift is a decrease in the average age of the operation. 97% of the 51% that Badan Litbang Kesehatan (2013) found to have undergone FGM/C were below five years of age and 83% were babies (under eleven months). These figures stand in stark contrast to colonial reports that found female genital cutting was commonly performed on girls when they were older, and up to 15 years of age (Schrieke,1922, quoted from Feillard & Marcoes, 1998).

Medicalization and Harm

In a study of eight Indonesian provinces by the Population Council, 68% of 2,215 cases of FGM/C were performed by TSPs and 32% by medical personnel (Budiharsana et al., 2003). Their conclusion, that medicalization is a growing trend, was supported by Badan Litbang Kesehatan (2013) data which aggregated client patronage of TSPs and Midwives over a thirteen-year period (see Figure 1).

Figure 1: Distribution of Health-Service Providers Performing FGM/C between 2001-2013



Medicalization can be traced to the 1990s, when the government supported midwives to replace *dukun bayi* (traditional birth attendants) as the key providers of reproductive health services (Putranti, 2008). Hospitals and communities began to offer FGM/C as part of a *paket persalinan* (birth packet): a one-off charge that covers a range of medical and traditional services including pre-natal check ups, birth support and delivery, and post-natal ear piercing (*tindik*), vaccination, and circumcision (*sunat, khitan*). By changing the cultural context of the procedure,

medicalization has made FGM/C a commercialised practice associated with modern medicine (Putranti, 2008).

Some argue that the medicalization of FGM/C is the safer of two options for it is performed under sterile conditions and often with the use of painkillers (Shell-Duncan, 2001). Though presented as a harm-reduction strategy, there is no evidence to support the notion that medicalization reduces obstetric or other long-term complications of FGM/C (Berg et al, 2010). Since 1982 the WHO has declared the performance of FGM/C by "any health officials in any setting including hospitals or other health establishments" as a breach of human rights. This statement has since been echoed in the condemnation of FGM/C by many medical authorities, boards and organisations[5] (Shell-Duncan, 2001: p. 1014).

There are multiple reasons for their opposition. From the view of the profession, cutting healthy genital tissue violates the principle "do no harm", a code upon which medical ethics is based. Performing FGM/C in a clinical context also misuses the status of biomedicine to legitimise gendered violence (Shell Duncan, 2001). From a medical perspective, FGM/C causes permanent, irreparable changes in the external female genitalia. The clitoris - the organ most likely damaged in Indonesian FGM practices – is anatomically equivalent to parts of the male penis and with the same embryologic origin (Berg et al, 2010).

As with other vascular tissues of the female external genitalia, the clitoris and the prepuce engorge to serve an important physiological function in the cycle of sexual response and fertility (Berg et al, 2010).[6] Cutting off this tissue, which has a rich supply of nerve-endings, has been found to cause short, medium and long-term health consequences to the victim. In a systematic review of 17 primary studies of this topic, Berg et al. (2010, p. 20) found a clear association between type 1 FGM/C and health complications including pain, bleeding, shock, difficulty in passing urine and faeces, and infections. Given that WHO type I FGM/C is common in Indonesia (Budiharsana et al, 2003; Uddin 2010; Badan Litbang Kesehatan, 2013; Habsjah 2013), these problems can be extrapolated as risks for FGM/C victims in Indonesia.

Some researchers claim FGM/C to be a "psychological trauma according to DSM- IV and a potential cause of post-traumatic stress disorder" (Behrendt & Moritz, 2005: 1001). While reports on women's pain from the procedure and suffering from ongoing emotional disturbances are abundant, subjecting this topic to statistical analysis is difficult because of the many confounding variables (Berg et al. 2010). Qualitative studies that investigate psychosocial impacts have found the FGM/C victims experience difficulties including a loss of trust within the mother-daughter relationship (Al-krenawi et al, 1999); chronic anxiety and depression about their cut status (Toubia, 1994) and anxiety, bad memories and stress (Vloeberghs et al., 2010).

[5] For example, the International Federation of Gynaecology and Obstetrics passed a resolution in 1994 urging doctors to refuse FGM/C. Their call has been echoed by many other organisations including the American Medical Association, the UN International Children's Emergency Fund, the World Medical Association and Ministries of Health from many African Nations (Shell-Duncan 2001)

[6] In contrast to male circumcision, where the foreskin is cut off from the tip of the penis without damaging the organ itself, the degree of cutting and harm in FGM/C is anatomically much more extensive. FGM/C effects "sexual functioning by ablating some or all of the genital organs, or their innervation as well as damage neural innervation" (.. 2010, p. 19). Excising genital parts, coupled with damaged nerve-endings and the development of scar tissue and adhesions around the excised parts, reduces a women's capacity for physical and sexual integrity (Berg et al, 2010).

There is another, lesser researched, reason medicalization is not a lesser degree of harm. The Population Council (Budiharsana et al., 2003) study found that midwives cut deeper, and cut more genital flesh off girls than TSPs. This might be partly due to the use of surgical scissors rather than the razors, pins and penknives of the TSP though more research is needed. The findings of the Population Council research echo other observations that FGM/C procedures are more invasive in clinical settings (Putrianti 2008; Ragab, 2017, Foldes & Marz, 2015).

The Human Rights Perspective

In 2008, the World Health Assembly passed a resolution (WHA 61.16) on the elimination of FGM/C, emphasizing the need for concerted action to address the issue in all sectors, including health, education, finance, justice, and women's affairs (WHO, 2008). As well as inflicting needless pain on the girl child, the United Nations maintains that FGM/C is deeply rooted in gender-based discrimination and harmful gender stereotypes about the role of women and girls in society (General Assembly of Human Rights Council, 2015). This claim is grounded in the empirical evidence that "many contextual factors stemming from gender inequality have been documented to perpetuate FGM" (Khosla et al, 2017, p. 60).[7] In addition, motivations for FGM/C "include concerns about girls' marriageability and social acceptance, and the fear of a loss of protection by other women and the community at large if a girl does not undergo FGM" (ibid). Female genital mutilation is linked to other harmful practices, such as child and forced marriage, marital rape and intimate partner violence (General Assembly of Human Rights Council, 2015).

There have been two United Nations General Assembly resolutions on FGM (resolution 67/146, reaffirmed in 2014 by resolution 69/150). In 2014, FGM/C was identified as a priority issue in a seminal report of the Open Working Group on Sustainable Development Goals. Specifically it was identified as a specific harmful practice to be targeted within national development goals for 2106-2030. FGM/C violates many conventions and resolutions that been ratified by the Government of Indonesia (GoI). Like other member states, The GoI has committed to the Convention of the Elimination of All Forms of Discrimination against Woman (CEDAW); the Convention against Torture and other Cruel, Inhumane or degrading treatment or punishment (in the 1994 ICPD's program of Action, 4.22) and; the Convention on the Rights of the Child (article 24.3). The latter convention declares, "State Parties shall take all effective and appropriate measures with the aim of abolishing traditional habits that harm the health of the child".

[7] Khosla et al (2017, p. 60) cites research that identifies these contextual factors as "highly unequal societies in which gender prescriptions demand girls' virginity prior to marriage...women's chastity and monogamy in marriage...sexual availability of females to their male partners, and the production of legitimate male heirs to further their husband's patrilineage'.

CHAPTER 3: DATA ABOUT THE RESPONDENTS AND GENERAL FEATURES OF FGM/C

Characteristics of the Sampled Households

The study interviewed mothers and fathers from 4.250 households in 17 districts. The interviewees came from 20 ethnic groups and lived in both rural and urban regions. The majority of households had a low level of education, with 44% of the population having a below primary school education and 15% having graduated from high school.

Table 4: The Education Level of the (Female) Household Respondents (PSKK UGM, 2017)

Level of Education	Urban		Rural		Urban+Rural	
	Number (N)	Percent (%)	Number (N)	Percent (%)	Number (N)	Percent (%)
No/never been to school	9	0.7	71	2.4	80	1.9
No/have not graduated from primary school	34	2.6	225	7.7	259	6.1
Primary school (SD/MI)	315	24.1	1,208	41.1	1523	35.8
Junior High School (SMP/MTs)	244	18.6	691	23.5	935	22.0
High School (SMA/MA)	495	37.8	576	19.6	1071	25.2
Diploma (D1/D2/D3)	42	3.2	47	1.6	89	2.1
Bachelor (D4/S1)	68	5.2	123	4.2	191	4.5
Master/Doctoral Degree (S2/S3)	2	0.2	0	0.0	2	0.0
Total	**1,309**	**100.0**	**2,941**	**100.0**	**4250**	**100.0**

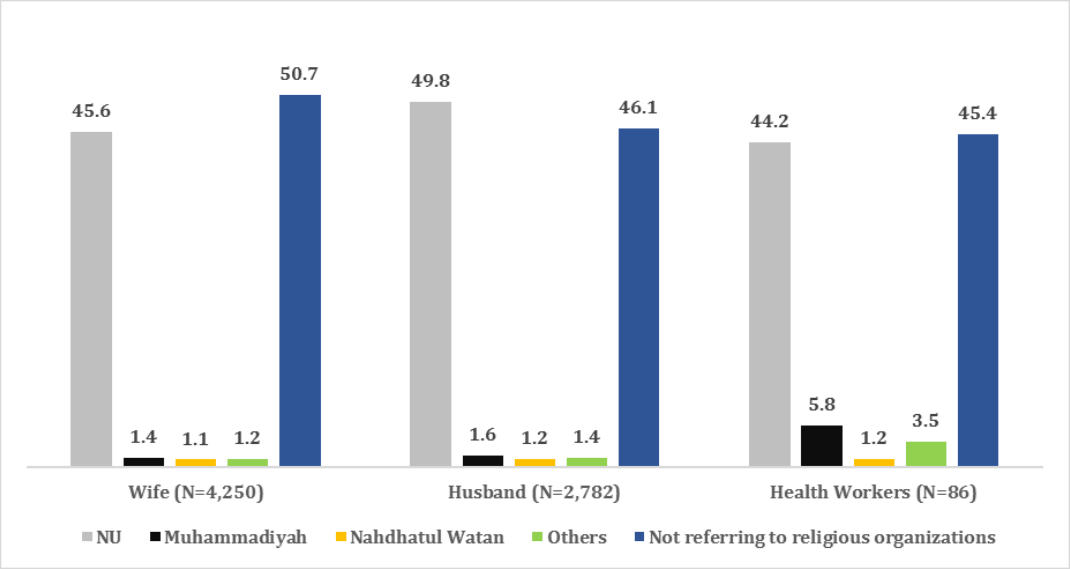
Ethnicity - 24.4% of the sample identified as of Malay descent and 18.6% were Sundanese. Other significant groups were Banjar (11.6%); Gorontalo (11.6%); Javanese (9.3%) and Mandar (9.3%).

Table 5: Ethnic Composition of Respondents (PSKK UGM, 2017)

Ethnic	Wife		Husband		Health Service Provider	
	N	%	N	%	N	%
Java	402	9.5	303	10.9	8	9.3
Madura	28	0.7	16	0.6	1	1.2
Sundanese	951	22.4	498	17.9	16	18.6
Malay	823	19.4	547	19.7	21	24.4
Dayak	19	0.5	14	0.5	0	0.0
Sasak	249	5.9	180	6.5	4	4.7
Bugis	97	2.3	77	2.8	3	3.5
Mandar	424	10.0	298	10.7	8	9.3
Makassar	3	0.1	3	0.1	0	0.0
Banjar	557	13.1	369	13.3	10	11.6
Batak	21	0.5	17	0.6	2	2.3
Gorontalo	481	11.3	355	12.8	10	11.6
Minang	70	1.7	36	1.3	0	0.0
Palembang	7	0.2	5	0.2	0	0.0
Jambi	5	0.1	2	0.1	0	0.0
Tapanuli	3	0.1	1	0.0	0	0.0
Betawi	10	0.2	2	0.1	0	0.0
Pattae (Polewali Mandar)	43	1.0	26	0.9	1	1.2
Bima	6	0.1	5	0.2	0	0.0
Kutai	22	0.5	7	0.3	1	1.2
Others	29	0.7	21	0.8	1	1.2
Total	**4,250**	**100.0**	**2,782**	**100.0**	**86**	**100.0**

Religious affiliation – All study participants identified as Muslim. Approximately half were not affiliated with any religious organization and half with *Nahdlatul Ulema* (NU). Only 2.8-9% of couples claimed belonging with other religious organization (Muhammadyah, Nahdathul Wathon). Organizational affiliation of health service providers patronized by respondents only loosely correlates with these affiliations. Approximately 80% of health service providers utilized by the households were associated with NU while 11% of families relied on MUI services.

Figure 2: Respondent Religious Organization Membership (PSKK UGM, 2017)



Cultural variation in FGM/C Practices

Linguistic terms - FGM/C is semantically embedded in diverse linguistic terms across the Indonesian archipelago. The qualitative part of the study reported use of the following terms in some of the study areas:

- Gorontalo: *liho lolimo/molu bingo*.
- South Kalimantan: *basunat / besunat*.
- West Sulawesi: *Masunna*
- Banten: *nyepitan* or *capitan*
- Lombok: *murni*
- Bangka Belitung: *selam/diselam*

Ceremonial contexts and myths – FGM/C is a customary practice subject to a variety of ritual and symbolic elaboration. In Jambi and West Java, cutting takes place secretly and FGM/C is a taboo; it is a procedure that cannot be spoken of. In these places FGM/C has no ritual dimension or is accompanied by a small celebration. In Gorontalo a large celebration accompanies the FGM/C ritual; another family is said to pay for this considerable expense. Even a simple celebration, such as the kind found in Banten, can cost a family up to 10 million rupiah (USD$738).

Among practicing communities FGM/C is a symbolically rich procedure read for signs of fortune and misfortune. For instance, in the Pandeglang District (Banten Province) a heavy flow of blood is considered a sign that the girl will be good at science or trading when she grows up. In Bone Bolango District (Gorontalo Province) heavily bleeding is taken as a bad omen: it suggests the girl will be grown up to be sexually loose. In Bone Bolango, fortune is read when light emerges from the fresh wound – if the area were the clitoris is cut glows the girl is believed to one day

be lucky in trade. In this same region, the excised clitoral tissue is mixed with lemon to create a talisman that is said to bring luck in trade. This highlights how the removed genital part can be subject to ritual observance. For instance, in West Java "the part of the clitoris that is cut off is wrapped with a small piece of turmeric, then rapping it in a cotton cloth, and then buried under a *kelor* tree (*moringa oleifera*)". FGM/C has important cultural meaning and these vary across context, but they generally related to the idea of what it means to be a "good" woman.

The following table provides some examples of ritual elaboration of FGM/C procedure in some study areas.

Table 6: Ceremonial Contexts of FGM/C in Nine Study Areas (*Komnas Perempuan, 2017*)

Areas	Ceremony
Gorontalo	The baby is bathed with ablution water, the TSP and baby are covered with white fabric and FGM/C is performed under this white fabric. After blood flows, the baby is showered with lemon water, sprayed with fragrance and dressed in traditional clothes. Then the *injak piring* (stepping on plates) ceremony is performed followed by a *shalawat* (invocation of the prophet) where the extended family gathers.
West Sulawesi	A TSP recites the *shalawat* (invocation of the prophet) and other prayers before the baby is bathed in ablution water and sits on the mother's lap on a pillow covered with young banana leaf. TSP, mother and baby recite *shalawat* (invocation of the prophet) together. TSP performs FGM/C recites *basmalah* (prayer to open/bless an activity). The baby's genital area rubbed by cotton and the cotton kept in the house pillars or *sokoguru* (house pillars) as *jimat* (talisman). A good process perceived if blood exist as an evidence of Islamic blood. After FGM/C process, the baby showered with water purifier.
South Kalimantan	Conducted along with piercing rituals and *akekah* (slaughtering a lamb, an Islamic tradition usually 40 days after the birth). Prior to the ceremony, TSP will recite al-fatihah (the first verse in Quran)
East Kalimantan	The family brings a ritual gift known as *pinduduk* prior to FGM/C ceremony consisting of: money, rice, plantain and sugar. Recite 4 times of *syahadat* (a prayer that testifies to a singular faith in Allah) prior to the FGM/C process and *shalawat* (invocation of the prophet) after the FGM/C.
Riau	The family provides fresh flour made by pandan leafs and some leafs tighten with rice, over cooked rice, powder and yellow rice. The powder and flour sown over the baby's body. The FGM/C performed accompanied by prayer and *zikir* (a repeatedly uttered prayer that glorifies Allah). Praying in the beginning of FGM/C process and *shalawat* (invocation of the prophet) at the end of process.
Lombok	The family prepares *andang-andang*, a concoction that consist of: rice, betel leaves, etc prior to the FGM/C process

Areas	Ceremony
Jambi	No special ceremony. FGM/C is considered taboo to be discussed openly.
West Java	No special ceremony. FGM/C is considered taboo to be discussed openly.
Banten	FGM/C is conducted on the top of a bamboo woven tray known as *gelodog* (where rice is kept) in the southern Pandeglang area. Some communities perform FGM/C on top of white fabric. Praying takes place after FGM/C performed, for praying is believed to create a baby who will respect its parents and the land. Some stomp on a coconut around the baby simultaneous to praying, a rite believed to create a calm baby.

Age at FGM/C

Half of all cuttings occur when the girl is between 1 and 4 months old. Around 25% are cut between 1 and 3 years of age and 8% of FGM/C happens within the first ten days of life. FGM/C is less likely as the girl gets older, with nine years of age the reported upper limit for the procedure.

Table 7: Average Age of FGM/C by Region (PSKK UGM, 2017)

Average Age of Girls	Urban		Rural		Total	
	N	%	N	%	N	%
Day						
1 - 10	112	6.8	325	9.0	437	8.3
11 - 20	55	3.3	73	2.0	128	2.4
21 - <30	17	1.0	22	0.6	39	0.7
Month						
1 - 4	1.093	66.3	1.536	42.6	2.629	50.1
5 - 8	150	9.1	288	8.0	438	8.3
9 - <12	32	1.9	152	4.2	184	3.5
Year						
1 - 3	153	9.3	1.124	31.2	1.277	24.3
4 - 6	22	1.3	64	1.8	86	1.6
7 - 9	7	0.4	10	0.3	17	0.3
Don't Know	7	0.4	9	0.2	16	0.3
Total	**1,648**	**100.0**	**3,603**	**100.0**	**5,251**	**100.0**

According to the qualitative study, the age distribution of FGM/C in the study areas is as follows:

- Bangka Belitung: 7 - 44 days
- South Kalimantan: 8 months – 3 years
- East Kalimantan: 5 months - 1 year
- West Sulawesi: 0 - 3 years

- Gorontalo: 1 - 2 years
- Lombok: 0 - 7 days
- Banten (West Java): 40 days - 3 years
- West Java: 40 days - 1 year
- Jambi: 5 days - 1 year

Some respondents in the qualitative study noted that compared to before, girls are now being circumcised at a younger age. Speculating on reasons for this shift, a number of ideas emerged. Some mentioned that parents preferred to cut their girls younger because a baby feels less pain than an older girl, who can be traumatized from being held down and cut. Other reasons suggested for the shift in age is that FGM/C was now offered soon after birth, as a service in the birth packet and that the procedure was moved to coincide with the Marhabah and Akekah, religious ceremonies that are an important life-cycle event for boys and girls.[8]

Providers and the Place of FGM/C

Service –provider preferences - On average the study found a preference for TSPs (61.4%) over Health Service Providers (38.5%). When aggregated by location, 66% of urban respondents preferred midwives and 74% of respondents from rural areas preferred TSPS. The qualitative study found that in Gorontalo communities only allowed TSPs to perform FGM/C and midwives were prohibited from performing what is seen as a customary practice. It also mentioned there was "a crisis because TSPs are an ageing cohort not being replaced by the younger generation.

Table 8: Service Provider Preference, by Region (PSKK UGM, 2017)

Service provider of FGM/C	Urban		Rural		Urban+Rural	
	N	%	N	%	N	%
Health Service Provider	1,087	66.4	930	25.8	2,017	38.5
Traditional Service Provider	546	33.4	2,671	74.1	3,217	61.4
Don't Know	4	0.2	2	0.1	6	0.1
Total	**1,648**	**100.0**	**3,603**	**100.0**	**5,251**	**100.0**

Place of FGM/C - 53% of FGM/C takes place in the home of the girl and 3% of cases occur in the home of a relative. 27% of cases take place in the doctor or paramedics clinic and 11% of FGM/C occurs where the TSP works. Only 5% of FGM/C takes place at the community health center and 2% of cases were reported for hospitals.

[8] Akekah refers to the Islamic tradition of slaughtering a lamb, usually 40 days after the birth, Marhabah is a ritual feast, held soon after a baby is born, to bless his/her arrival and future in the world. In West Java it can involve naming the child and the first cutting of the child's hair. The hair's weight is converted to the cost of the same weight in gold, which is offered as rupiah to be used as alms. To receive the alms, the family must slaughter a goat and before they are donated to charity, the notes of rupiah are folded into decorative ships, flags etc..

Respondents in the qualitative study said that TSPs are more likely to practise FMG/C in the client's home while midwives are more likely to do it, not in the hospital or community clinic, but a private clinic some operate from their own homes.

Table 9: The Location Where FGM/C is Practised (PSKK UGM, 2017)

The location of FGM/C Practice	Urban		Rural		Urban+Rural	
	N	%	N	%	N	%
Hospitals	40	2.4	43	1.2	83	1.6
Primary Health Care (Puskesmas)	170	10.3	100	2.8	270	5.1
Doctor's/ Paramedic's Clinic	789	47.9	625	17.4	1,414	26.9
Place where the TSP/ Circumciser Practice	109	6.6	445	12.4	554	10.6
Respondent's House	501	30.4	2,279	63.3	2,780	52.9
House of Respondent's Family	35	2.1	104	2.9	139	2.7
Others	3	0.2	4	0.1	7	0.1
Don't Know	1	0.1	3	0.1	4	0.1
Total	**1,648**	**100.0**	**3,603**	**100.0**	**5,251**	**100.0**

Cost

By local standards, FGM/C is not an expensive service. However, the cost for celebrations of the procedure in some communities can be upward of 10,000,000 rupiah (USD $740.00). The quantitative study found that 40% of midwives and 54% of TSPs were said to charge between 50,000 – 100,000 rupiah (USD$3.70-7.40) for FGM/C. Overall 31% of midwives, compared to 19% of TSPs, were said to charge less than 50,000 rupiah (USD$3.70). Midwives do not charge for cleaning the vulva (symbolic FGM). At the higher end, 12% of TSPs are reported to charge above 100,000 rupiah (USD$7.40) while only 4% of midwives would charge over 100,000 rupiah.

According to parents only 5% of FGM/C by midwives (and 6.1% of TSPs) included the service in the childbirth packet. When service-providers were asked about this, the figure was considerably higher. Ten percent of midwives and 11.5 % of TSPs claimed FGM/C was a service offered as part of a childbirth packet. 11% of midwives report no charge for FGM/C while only 4% of TSPs offer the service free.

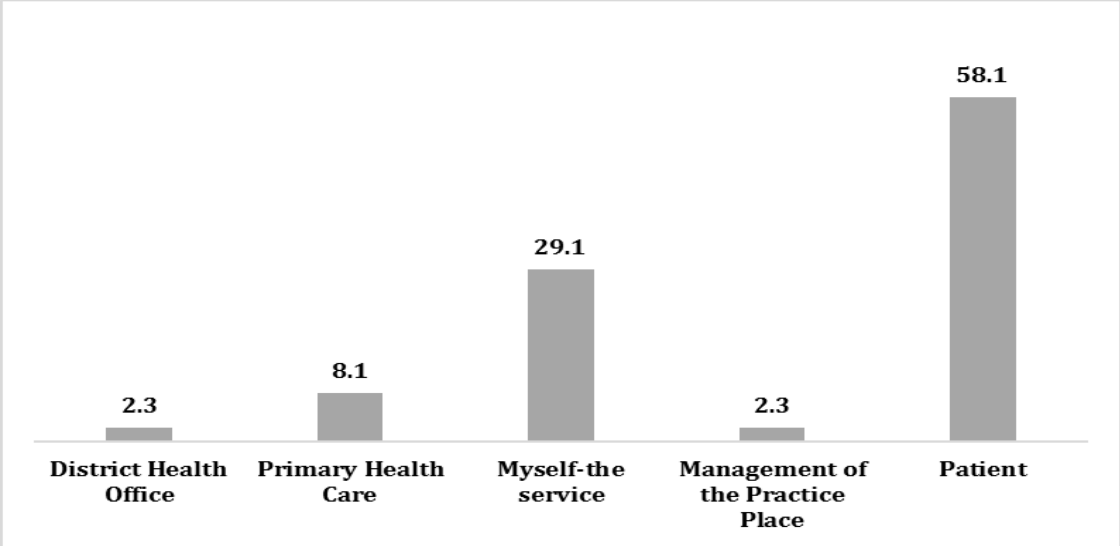
Table 10: Cost of FGM/C (PSKK UGM, 2017)

The Cost of FGM/C	The Operator of FGM/C							
	Health Service Provider		Traditional Service Provider		Don't Know		Number	
	N	%	N	%	N	%	N	%
< 50.000,00	619	30.7	617	19.1	0	0.0	1,236	23.5
50.000,00 - 100.000,00	800	39.7	1,736	53.8	0	0.0	2,536	48.3
>100.000,00	79	3.9	397	12.3	0	0.0	476	9.1
Free (No Cost)	227	11.3	126	3.9	0	0.0	353	6.7
Include in Childbirth Package	98	4.9	196	6.1	0	0.0	294	5.6
Don't know	194	9.6	155	4.8	6	100.0	355	6.8
Refused to answer	0	0.0	1	0.03	0	0.0	1	0.02
Total	**2,017**	**100.0**	**3,228**	**100.0**	**6**	**100.0**	**5,251**	**100.0**

Setting the price – The qualitative study found that the cost of FGM/C service was far more flexible than the survey results would suggest. Respondents claimed that TSPs don't actually set a price but they are paid what the client can afford to pay. This finding was supported by the responses of health service providers in the quantitative study: 58% said the client sets the fee and 29% said they set the fee

The qualitative study also found that remunerating TSPs often takes the form of groceries, fabric, chickens and other kinds of non-monetized payments or part-payments.

Figure 3: Service Provider Beliefs about Who Establishes the FGM/C Fee (PSKK UGM, 2017)



CHAPTER 4: PARENTS' ATTITUDES, VALUES AND BEHAVIORS

All men and women in the study knew about FGM/C but referred to it as *sunat perempuan* or *khitan perempuan*. This term reflected beliefs that FGM/C was a religious practice that helped a girl become a member of the *umat* (*Muslim community*). That FGM/C is not in fact a uniform Muslim practice highlights the divergent views on whether it is necessary or not and also the power of tradition, or rather people's attachment to tradition, to reproduce customary behaviors, in the social reproduction of FGM/C. Both the qualitative and quantitative studies reported the same results for men and women. That such a high proportion of respondents shared opinions and understandings about FGM/C supports the notion that among practicing communities, FGM/C is highly normative.

Types of FGM/C (according to parents)

Table 11 provides data on the types of FGM/C, from the perspective of parents. Only 1.2% of parents said that midwives did 'symbolic FGM/C', while 0.07% of TSPs were said to perform this type, namely FGM/C with no cutting of the genital tissues.

32% of cases reported by parents were analyzed as corresponding to the WHO typology 1a (removal of the clitoral hood or prepuce). 33% of cases described by parents were presented as 'type 4' – the WHO type that covers "harmful procedures such as pricking, piercing, incising, scraping and cauterization".

PSKK UGM did not fit the remaining cases in the WHO typology. 28% of parents reported types that cut part of the clitoris and prepuce and 6% were said that FGM/C involves scratching or scraping part of the urethra.

The difference in kind of cutting between service-providers is interesting. Parents reported 45.5% of midwives as cutting off the clitoral hood or prepuce, compared to 23% of TSPs. At the same time, they reported TSPs are almost two times more likely (34%) than midwives (18%) to cut into, as opposed to cut off, part of clitoral region. TSPs are said to be almost two times more likely (7% compared to 4%) to scratch or scrape the urethra.

Table 11: Types of FGM/C, and the Providers (PSK UGGM, 2017)

Type of FGM/C	The Operator of FGM/C							
	Health Service Provider		Traditional Operator		Don't know		Total	
	N	%	N	%	N	%	N	%
Type of FGM/C from WHO classification								
Type 1a (removal of the clitoral hood or prepuce only)	917	45.5	749	23.2	3	50.0	1,669	31.8
Type 4 (All other harmful procedures to the female genitalia)	613	30.4	1,129	35.0	1	16.7	1,743	33.2
Type of FGM/C based on Survey								
Cutting part of clitoris and preputial (Prepuce)	370	18.3	1,101	34.1	2	33.3	1,473	28.1
Scratching or scraping part of urethra (urethral opening)	74	3.7	226	7.0	0	0.0	300	5.7
Only symbolic without cutting	40	2.0	22	0.7	0	0.0	62	1.2
Don't Know	3	0.2	1	0.0	0	0.0	4	0.1
Total	2.017	100.0	3,228	100.0	6	100.0	5,251	100.0

Motives

When asked why they had chosen FGM/C for their daughters, 91.6% of parents responded that it was a religious order; 80.4% answered that it was a cultural tradition and 72.1% said it was family tradition. Other reasons given for performing FGM/C include: health (49.8%), social sanction (25.5%); raising the sex drive of her future husband (17.5%) and reducing the sex drive of girl when she becomes a wife (16.7%) (NB: Multiple choices were allowed).

A few notable differences were found between the respondents. Urban women (73%) are 8% more likely to stress the importance of community tradition compared to their husbands (65%). They are also 12% more likely than their husbands to report FGM/C as a family tradition. Rural women (89%) were 16% more likely than urban women (73%) to see FGM/C as important because it was a community tradition. 34% of rural women, compared to 18% of urban women, saw FGM/C as socially sanctioned. Urban men and women (57%) were more likely than their rural counterparts (50%) to frame the value of FGM/C in terms of health.

The qualitative study found the respondents widely believed FGM/C to be essential for being Muslim. Being circumcised was said to mark one as Muslim, and differentiate Muslims from Christians and Buddhists.

Table 12: Motives for Seeking FGM/C for a Daughter (PSKK UGM, 2017)

The Reason Still Imposed FGM/C	Wife (%)			Husband (%)		
	Urban	Rural	Urban+Rural	Urban	Rural	Urban+Rural
Religious Order	90.7	93.6	92.7	88.9	92.6	91.6
Community Tradition	73.3	88.9	84.1	64.9	85.8	80.4
Social Sanction	18.0	33.8	28.9	15.7	28.9	25.5
Family Tradition	71.0	82.2	78.7	59.2	76.6	72.1
Health Reason	59.0	55.9	56.9	52.9	48.7	49.8
Grown Adult	10.1	16.5	14.5	10.7	15.1	14.0
Increasing the Sexual Drive of the Husband	17.2	17.9	17.7	13.0	19.0	17.5
Reducing the Sexual Drive of the Wife	20.2	17.1	18.1	16.3	16.9	16.7
Maintain One Partner Commitment	8,9	11,9	11,0	7,0	11,5	10.4
No FGM/C Practice	2,8	0,5	1,2	4,5	2.0	2.6
Total N	**1.309**	**2.941**	**4.250**	**718**	**2,064**	**2,782**

The qualitative study corroborated these findings and elaborated reasons why FGM/C was seen as beneficial. In addition to traditional and religious obligations, respondents mentioned that FGM/C purified the 'dirty part', so that the girl is pure enough to pray (ngaji). Some thought that if a girl was not circumcised, than the prayer water wouldn't stick to the body.

In addition, qualitative reports found that many respondents believed the FGM/C eased delivery in childbirth; made the girl more obedient to parents, and helped prevent diseases such as syphillis. Other reasons offered for why FGM/C was considered beneficial was because it accelerates a girls' growth and makes her genitalia more attractive.

Above all the qualitative study stressed the importance of reducing *nafsu* (sexual desire, lust) as well as the proclivity to flirt (genit) and seek sexual attention. This theme was especially pronounced in Jambi where almost all parents said the FGM/C was necessary because it prevents the girl from engaging in flirtatious (*genit*) or attention-seeking behaviors (*kecentilan*, has sexual overtones).

A few believed that FGM/C helped a woman achieve greater sexual pleasure in marriage and made the sexual relationship with her husband 'comfortable (*nyaman*).

The sense that FGM/C was an important religious and traditional requirement was not arrived at from self-conscious reflection or examination of the hadith. Parents spoke of it as a given, as something that should be done because it had always been done. It was considered a good thing because it was handed down from generation to generation. In the words of one

respondent "because it has been going on for generations, nobody questions it anymore." (male, 59 years old, Bogor district).

Influences

When asked "what or who influenced them to subject their daughters to FGM/C?", the vast majority (81.5%) of parents mentioned their parents as influencing their beliefs. This was followed by the response that their extended family was a source of influence (37%) as well as religious leaders (10%), neighbours (16%), health service providers (3.5%) and TSPs (7%). School (1%) and media (0.5%) rated low in the scale of responses.

Table 13: Stated Influences on Understandings and Attitudes about FGM/C (PSKK UGM, 2017)

Informants	Wife (%)			Husband (%)		
	Urban	Rural	Urban+Rural	Urban	Rural	Urban+Rural
Parents	82.1	89.7	87.3	74.8	83.8	81.5
Neighbor	12.3	15.6	14.6	12.5	17.2	16.0
Family	32.6	34.4	33.9	34.1	37.5	36.6
Health Service Provider/ Paramedic	9.0	7.9	8.2	4.0	3.5	3.7
Traditional Birth Attendant (TBA)	6.3	17.4	14.0	3.3	8.6	7.3
Religious Leader/ Village Leader	6.7	7.7	7.4	12.0	8.7	9.6
Mass Media	0.7	0.6	0.6	0.1	0.6	0.5
School Curriculum	1.8	0.3	0.8	1.4	0.8	1.0
Friends	0.5	0.2	0.3	0.3	0.3	0.3
Total N	**1.309**	**2.941**	**4.250**	**718**	**2.064**	**2.782**

Intergenerational Transmission

Consistent with the belief that FGM/C is a time-honoured tradition, high inter-generational continuity was found in FGM/C practice. 97% of women who circumcised their daughters had been circumcised as girls and 95% had a mother who was circumcised.

Table 14: Mothers and Grandmothers Who Have Been Circumcised (PSKK UGM, 2017)

Mothers who have experienced FGM/C	Daughters experienced FGM/C	
	N	%
Yes	4,137	97.2
No	57	1.3

Don't Know	63	1.5
Total	**4,257**	**100.0**
Grandmother's who have experiences FGM/C	**Mother of HH age 0-11 Experience FGM/C**	
	N	**%**
Yes	380	94.8
No	8	2.0
Don't Know	13	3.2
Total	**401**	**100.0**

Decision Making

Who decides on FGM/C – Both in urban and rural, 69% of household respondents believed that mothers made the decision to circumcise their daughters and 16% responded that the decision lay with the grandmother. Only 8% said that the father made this decision and 0.6%, the grandfather. In relation to seeing the father as the decision maker, there was a 0.08% difference between urban (7.5%) and rural (8.3%) respondents (Table 15).

In the qualitative study interviewees did not mention men as decision makers, FGM/C was seen as women's issue and the decision is made by mothers and grandmothers. The study found that fathers gave passive support in the form of giving money or other resources, and inviting men and religious leaders to the *marhabah* celebration (see footnote 8 for a definition).

How to account for the differences between the quantitative data, where a few mentioned that men made the decision, and the qualitative data, that found the decision to circumcise lay solely with the mother and grandmother? It is possible that there was more variation in gendered behavior in the quantative study. It is also possible that interviewees responded to the surveys in ideal-normative manner. In Indonesia, it is respectful to think of men as involved in decision making processes at the household level.

Table 15: Perspectives on Who Holds the Power to Decide On If and When a Girls Will Be Subject to FGM/C (PSKK UGM, 2017)

Who decides on FGM/C?	Urban		Rural		Urban+Rural	
	N	%	N	%	N	%
Herself (the Girls)	3	0.2	2	0.1	5	0.1
Mother	1,114	67.6	2,518	69.9	3,632	69.2
Father	124	7.5	300	8.3	424	8.1
Grandmother	271	16.4	563	15.6	834	15.9
Grandfather	10	0.6	24	0.7	34	0.6
Health Service Provider	18	1.1	19	0.5	37	0.7
Parent (Father and Mother	94	5.7	158	4.4	252	4.8

Others	10	0.8	16	0.5	26	0.5
Don't Know	4	0.2	3	0.1	7	0.1
Total	**1,648**	**100**	**3,603**	**100**	**5,251**	**100**

Choosing a service-provider – Parents had different reasons for choosing a TSP or a midwife and only *5*.8% reported the cost of FGM/C as a reason. The most significant reason for choosing a TSP is that she is seen to be the appropriate choice for performing this customary practice (80%). Other reasons given for choosing a TSP over a midwife was that she comes recommended by family (22%); she is a friend of the family (16.5%) and because TSPs in their area are more ready available than midwives (15%).

The preference for midwives tended to be based on the view that this was the safer option (52%). Other reasons offered were that midwives were readily available in the area (33%) and that her service was included in *paket persalinan* (childbirth package). The *paket persalinan* is a one-off charge for a range of clinical and traditional pre-natal and post-natal care services.

The qualitative findings supported the quantitative but there was more use of the word 'trust' (*kepercayaan*). Particular health service providers were chosen because they were either a trusted part of the community, a trusted friend of the family or trusted to perform a safe operation or a customary procedure.

Table 16: Reasons for Choosing a Type of FGM/C Provider (PSKK UGM, 2017)

Reason	Health Service Provider		Traditional Operator		Don't Know		Total	
	N	%	N	%	N	%	N	%
Low/cheap cost	98	4.9	204	6.3	0	0.0	302	5.8
Tradition	120	6.0	2,575	79.8	0	0.0	2,695	51.3
Family's suggestion	271	13.4	705	21.8	0	0.0	976	18.6
Include in Childbirth package	448	22.2	196	6.1	3	50.0	647	12.3
Close/ Easy to Access	682	33.8	495	15.3	0	0.0	1.177	22.4
Knowing well the person/ has family relationship	370	18.3	532	16.5	0	0.0	902	17.2
More medically safe	1,050	52.1	20	0.6	0	0.0	1.070	20.4
No availability of health service provider	101	5.0	94	2.9	0	0.0	195	3.7
Don't know	0	0.0	2	0.1	3	50.0	5	0.1
Others	6	0.3	14	0.4	0	0.0	20	0.4
Total	**2,017**	**100.0**	**3,228**	**100.0**	**6**	**100.0**	**5,251**	**100.0**

Consent

Table 17 shows the percentage of mothers who were asked permission from service providers prior to FGM/C being performed on their daughter. It also provides figures for the girls who were asked for their consent before the FGM/C procedure.

Mothers felt that 93% of midwives and 95% of TSPs asked their permission to circumcise their girls. Only 3% of girls were asked if they agree to having FGM/C performed on them by midwives and 4% by TSPs.

In the qualitative study, health workers said they don't always provide information and seek informed consent because, they said, the service is requested by the girl's parents. Health information about the procedure is only given if the parents ask. This study recorded one instance of a mother deciding to not circumcise her child after receiving information from health personnel that FGM/C has no health benefits.

Table 17: Request for Consent by Health Worker (PSKK UGM, 2017)

Consent for FGM/C	Mother of HH Member				The Girls who undergone FGM/C			
	Health Service Provider	Traditional Operator	Don't Know	Total	Health Service Provider	Traditional Operator	Don't Know	Total
Being Asked for The Consent	1,884	3,068	5	4,957	67	130	0	197
%	93.4	95.0	83.3	94.4	3.3	4.0	0.0	3.8
Not Asked for the Consent	131	155	0	286	1,948	3,087	5	5,040
%	6.5	4.8	0.0	5.5	96.6	95.6	83.3	96.0
Don't Know	2	5	1	8	2	11	1	14
%	0.1	0.2	16.7	0.2	0.1	0.3	16.7	0.3
Total	**2,017**	**3,228**	**6**	**5,251**	**2,017**	**3,228**	**6**	**5,251**
%	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Questioning and Disagreement

The vast majority (98%) of parents believed that girls need to undergo FGM/C and that it was a tradition worth continuing. The reasons for this align with beliefs that FGM/C benefits the health and sexuality of girl and that it is an important time-honored tradition. These results are clear and consistent across data sets.

Is FGM/C necessary? - The quantative research found that 7% urban respondents (4% of women and 3% of men) did not believe girls needed to be circumcised. Only 2% of rural respondent (1% men and 1% women) had the same opinion.

Table 18: Perceptions of Whether or Not Girls should Undergo FGM/C (PSKK UGM, 2017)

Do women need to undergo FGM/C?	Wife (%)			Husband (%)		
	Urban	Rural	Urban+Rural	Urban	Rural	Urban+Rural
Yes (%)	96.0	99.0	98.1	96.7	98.6	98.1
No (%)	4.1	1.0	1.9	3.3	1.4	1.9
Total N	1,309	2,941	4,250	718	2,064	2,782

Should FGM/C continue to be practised? - 1.5% of parents believed that FGM/C was a tradition not worth continuing and fraction more (0.7%) expressed uncertainty about whether it should or shouldn't be. This opinion was more often expressed by urban (2.5%) as opposed to rural (0.08%) mothers, and urban (3.3%) as opposed to rural (0.09%) fathers.

Table 19: Parental Opinions on Whether FGM/C should Continue or Not (PSKK UGM, 2017)

Opinion	Wife (%)			Husband (%)		
	Urban	Rural	Urban+Rural	Urban	Rural	Urban+Rural
Continue (%)	95.7	98.8	97.8	95.1	98.7	97.8
Stop (%)	2.5	0.8	1.3	3.3	0.9	1.5
Don't Know (%)	1.8	0.5	0.9	1.5	0.4	0.7
Total N	1,309	2,941	4,250	718	2,064	2,782

Beneficial or harmful? When asked the question of why they thought FGM/C was not necessary, only 0.09% of parents mentioned it had no benefit (0.9%). Within this tiny fraction, 0.5% elaborated that it was not an Islamic order and 0.1% said it was an act of violence that caused vaginal pain.

Table 20: Reasons for Refusing FGM/C (PSKK UGM, 2017)

Reason FGM/C must be Terminated	Wife (%)			Husband (%)		
	Urban	Rural	Urban+Rural	Urban	Rural	Urban+Rural
It is not an Islamic Order	0.9	0.1	0.4	1.1	0.3	0.5
There is no Benefit	0.8	0.3	0.4	2.2	0.4	0.9
It's Violence against Women	0.3	0.1	0.1	0.1	0.1	0.1
It can cause trauma for	0.1	0.1	0.1	0.0	0.0	0.0

the girls						
No legal basis	0.1	0.0	0.0	0.1	0.0	0.0
FGM/C already is abandoned	0.3	0.1	0.2	0.0	0.1	0.0
Causes health Impact to the girls' (causes pain)	0.2	0.1	0.1	0.1	0.1	0.1
Others	0.1	0.0	0.1	0.0	0.0	0.0
Total N	**1,309**	**2,941**	**4,250**	**718**	**2,064**	**2,782**

The qualitative study supported the quantitative part and found that some mothers did not agree that FGM/C was necessary. The reasons cited for this view was that it had no benefits and that cutting the genitals will negatively influence her sexual life in the future. Some mentioned that FGM/C was *sunnah,* a recommended piety but not obligatory within Islamic law). These women said they felt *kasihan* (sorrow, pity, love) for their girls.

Despite internal conflict and personal doubt, few of these parents felt they could oppose pressure from their families and their sanctioning community.

Health and Psychological Impacts

Approximately 3.8% of respondents responded that FGM/C causes acute pain for girls when they urinate in the days after the operation and 1.5% mentioned that FGM/C caused fever and 1% mentioned the problem of nausea and bleeding. While death was not reported as a health impact, in one area, interviewees reported the case of a girl who had problems with blood clotting and died after the procedure (Table 21).

Table 21: Perceptions on the Health Impacts of FGM/C (PSKK USM, 2017)

Health issues/problems	Have Health Problems/ Issues		No Health Problems/ Issues		Don't Know		Total		Average Day With the Health Problem
	N	%	N	%	N	%	N	%	
Infection	2	0.0	5,235	99.7	14	0.3	5,251	100	2
Bleeding	5	0.1	5,232	99.6	14	0.3	5,251	100	1
Fever	81	1.5	5,156	98.2	14	0.3	5,251	100	2
Headache	2	0.0	5,235	99.7	14	0.3	5,251	100	3
Nausea	3	0.1	5,234	99.7	14	0.3	5,251	100	3

Health issues/problems	Have Health Problems/ Issues		No Health Problems/ Issues		Don't Know		Total		Average Day With the Health Problem
	N	%	N	%	N	%	N	%	
Pain during urinate	199	3.8	5,038	95.9	14	0.3	5,251	100	2

The psychological impacts of FGM/C were less noticeable than the physical effects. Approximately 2% of interviewees mentioned that FGM/C created a fear of visiting health workers and less than 1% said that FGM/C caused nightmares, fear of water and medical tools (Table 22).

Table 22: Perceptions on the Psychological Impacts of FGM/C (PSKK UGM, 2017)

Psychological Impact	N	%
Nightmare	5	0.10
Afraid to go to the health service provider/traditional healer	82	1.56
Afraid to go to health facilities	3	0.06
Afraid of the medical equipment/ tools	2	0.04
Afraid of the water	1	0.02
No psychological impact	5,130	97.70
Don't Know	28	0.53
Total N	**5,251**	**100,00**

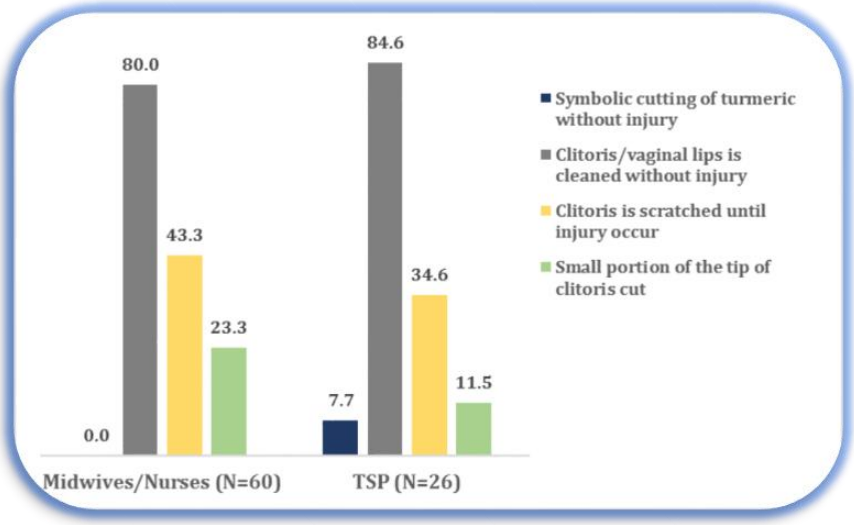
CHAPTER 5: HEALTH SERVICE PROVIDER ATTITUDES, VALUES AND BEHAVIORS

Compared to mothers and fathers in practising communities, there was a greater diversity of responses within the service-provider cohort. In general TSPs were less likely than midwives to question the value of the operation. Even though most midwives did not agree that FGM/C was necessary, they did not feel that they could refuse the request of a client and so, many performed FGM/C anyway.

Types of Cutting: Service Providers Perspectives

Service-provider responses to the question of type of FGM/C were classified into four categories: no wounding (placing turmeric on the clitoris and slicing the turmeric, 'symbolic FGM/C'); washing the vulva without wounding, rubbing the clitoris until a wound is created, cutting of the tip of the clitoris. Approximately 80% of midwives and 85% of TSPs said that they clean the vulva of the girl, either with warm water of topical medications. In addition, 43% of midwives and 34% of TSPs say they rub the clitoris to a wound while 23% of midwives and 11.5% of TSPs reported slicing off the top of the clitoris. Symbolic FGM/C, or that leave no wound, were claimed by 7.7% of TSPs. However, none of the midwives mentioned this type.

Figure 4: Types of FGM/C according to service-providers (PSKK UGM, 2017)



Tools and Topical Treatments

Tools – The tools and topical treatments of service-providers were varied. Midwives reported using surgical scissors (43%) or else a knife/cutter/razor (31%). Approximately 10.5% said that they used a needle and 78% of TSPs were reported by parents to have used a knife/cutter/razor. The data of the qualitative study supported this range of tools and furthermore, reported some midwives as saying the used a needle because it was listed as best-practice tool in the 2010 MoH regulations.

The use of a coin by a small percentage (1.9%) of TSPs was elaborated by the qualitative data. Sometimes a coin is rubbed over the clitoris and/or urethra until an abrasion forms, often with the presence of blood. Some TSPs described pressing a traditional coin (with a hole in the middle) around the clitoris. Using the coin as a template, the emergent part of the clitoris is sliced off.

Table 23: Parental Recollections of Types of Tools Used in the FGM Procedure (PSKK UGM, 2017)

Type of Tools	The Operator of FGM/C							
	Health Service Provider		Traditional Operator		Don't know		Total	
	N	%	N	%	N	%	N	%
Knife/ Cutter/ Razor	618	30.6	2,509	77.7	0	0.0	3,127	59.6
Scissor	864	42.8	215	6.7	1	16.7	1,080	20.6
Needle	211	10.5	156	4.8	0	0.0	367	7.0
Bamboo/ nil	2	0.1	28	0.9	0	0.0	30	0.6
Finger nail	1	0.1	25	0.8	0	0.0	26	0.5
Turmeric	2	0.1	11	0.3	0	0.0	13	0.3
Cotton	49	2.4	29	0.9	0	0.0	78	1.5
Bandage gauze	25	1.2	0	0.0	0	0.0	25	0.5
Tweezers	86	4.3	54	1.7	0	0.0	140	2.7
Coin	0	0.0	60	1.9	0	0.0	60	1.1
Chicken feet/combs	1	0.1	43	1.3	0	0.0	44	0.8
Nail clipper	4	0.2	8	0.3	0	0.0	12	0.2
Others	0	0.0	10	0.3	0	0.0	10	0.2
Don't know	154	7.6	80	2.5	5	83.3	239	4.6
Total	**2,017**	**100.0**	**3,228**	**100.0**	**6**	**100.0**	**5,251**	**100.0**

Topical medication – TSPs or midwives reported the use of different kinds of topical medications to manage the wounds caused by FGM/C, though 32% of TSPs and 15% of health workers reported using no medications at all.

No painkillers were offered by either service provider. In 76% of cases alcohol, betadine and other antiseptics are the topical medicines of choice among midwives. TSPs, on the other hand, reported using a wider range of medications including 'other traditional herbs and medicines' (24%); turmeric (19%); flower-infused water (23%); and sacred water (*jampi jampi* or water infused with the power of prayer) (20%).

Table 24: Health Workers Recollections of Types of Topical Medications Used in FGM/C Procedure (PSKK UGM, 2017)

Topical medications	The Operator of FGM/C							
	Health Service Provider		Traditional Operator		Don't know		Total	%
	N	%	N	%	N	%	N	%
Turmeric	12	0.6	617	19.1	0	0	629	12.0
Flower-immersed water	4	0.2	729	22.6	0	0	733	14.0
Sacred water (*jampi jampi*, water infused with the healing energies from the prayer is has been exposed to)	10	0.5	656	20.3	0	0	666	12.7
Other traditional herbs/ spices	6	0.3	786	24.4	0	0	792	15.1
Alcohol, betadine, and other antiseptic	1.530	75.9	689	21.3	1	16.7	2,220	42.3
Other drugs	68	3.4	10	0.3	0	0	78	1.5
Oil (coconut oil, cooking oil, eucalyptus oil)	5	0	94	2.9	0	0	99	1.9
Coconut water	1	0.1	43	1.3	0	0	44	0.8
Others	3	0.2	24	0.7	0	0	27	0.5
Don't know/ don't remember	142	7.0	99	3.1	4	66.7	245	4.7
Not given any herbs/drugs	306	15.2	1,043	32.3	1	16.7	1,350	25.7
Total	**2,017**	**38.4**	**3,228**	**61.5**	**6**	**0.1**	**5,251**	**100.0**

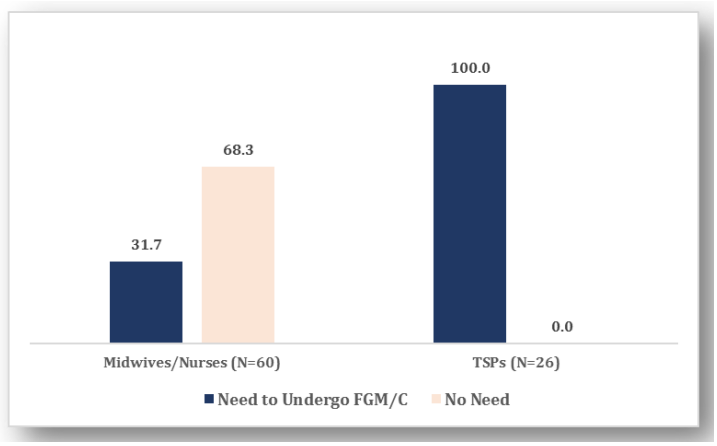
The Importance of FGM/C

Necessity - The PSKK UGM (2017) study found that all TSPs believed FGM/C to be necessary but only 36 % of midwives believe FGM/C is a necessary procedure.

The *Komnas Perempuan* (2017) study found that some health workers no longer practiced FGM/C because, they said, it is against the the Ethical Guidelines; it endangers health; it is a

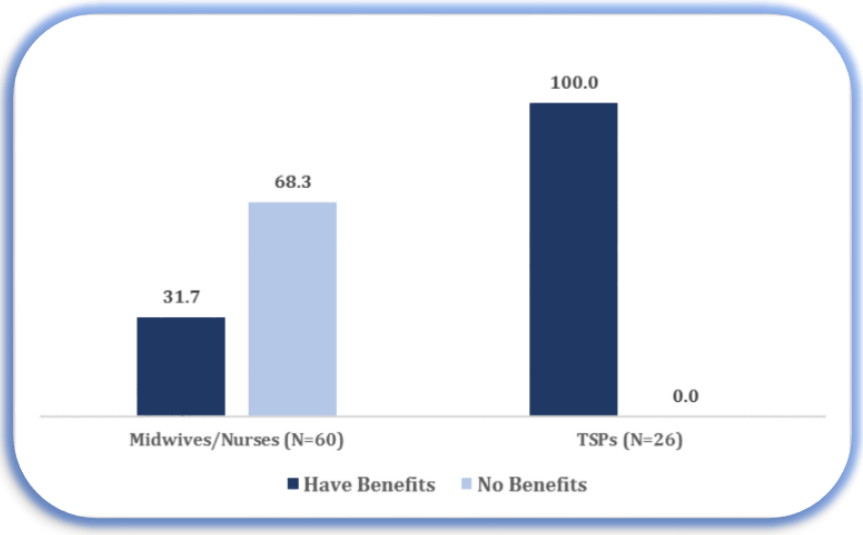
form of violence against women; it causes haemorrhage when infants are unable to form blood clots.

Figure 5: Health Workers' Opinions on Need for FGM/C (PSKK UGM, 2017)



Benefits – Similarly, 100% of TSPs believed FGM/C to be beneficial while only 32% of midwives agreed that FGM/C had benefits.

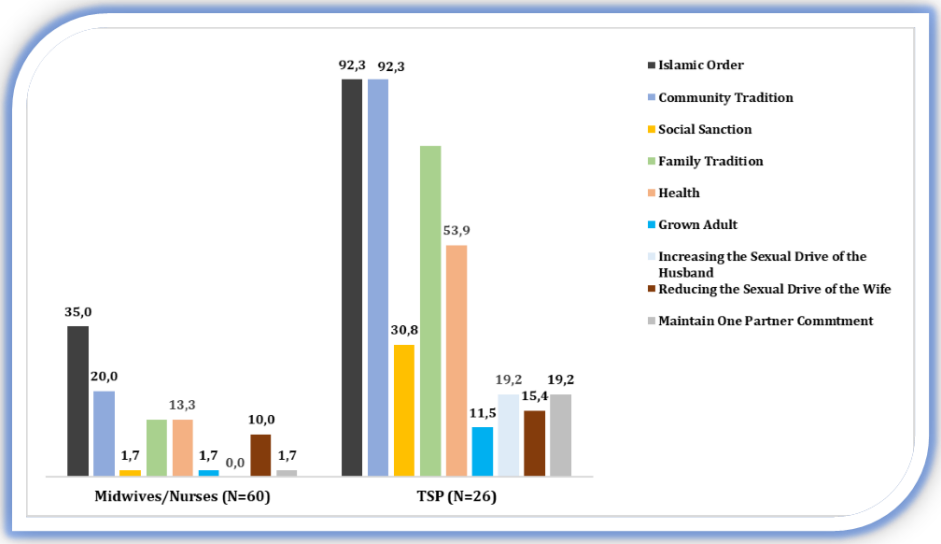
Figure 6: Health Workers' Opinions on Whether FGM/C is Beneficial (PSKK UGM, 2017)



What benefits? - TSPs perceived FGM/C as important because they saw it as a religious order (92%), a community tradition (92%) and a family tradition (77%). For midwives 35% considered FGM/C to be a religious order, 20% considered it a tradition and 13% believed it to be valuable because it was a family tradition.

The similarity between the views of TSPs and parents can be explained by the fact that TSPs are more likely than midwives to be part of the same community as their clients.

Figure 7: Health Workers' Opinions on Why FGM/C is Beneficial (PSKK UGM, 2017)



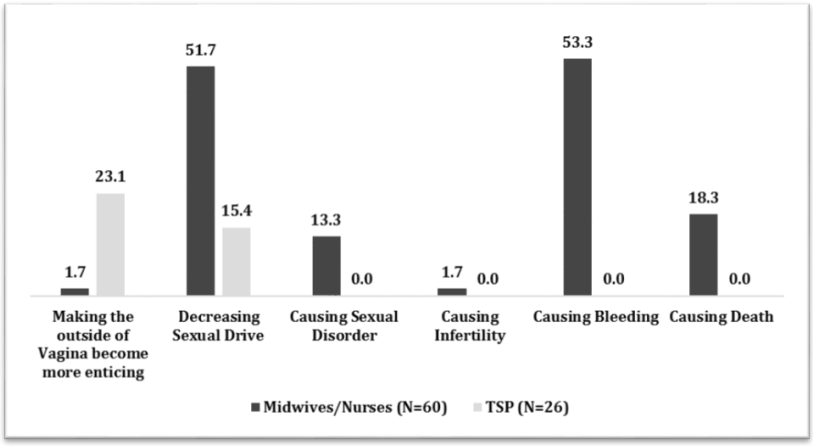
Health Impacts

Compared to 1.7% of midwives, 23% of TSPs claimed that FGM/C made the vulva more attractive. 15% of TSPs thought is was helpful for decreasing the future sex drive of the girl.

In the quantitative study, midwives stated that FGM/C caused bleeding (53%); decreased sex drive (52%); death (18%) and infertility (2%). In the qualitative part of the study, midwives and TSPs said the baby and girl's response to being circumcised is shock. Some cry, some do not. A few said that holding a baby down and inflicting pain on them causes trauma.

Overall, the qualitative study found that informants believed that FGM did not negatively impact a girls' sexuality. This was based on the idea that she could still have sexual pleasure and bear children. Some, however, did express concern, including two midwives from Dumai and Pandeglang who reported that the FGM/C they endured when young has permanently destroyed their ability to feel sexual desire and pleasure.

Figure 8: Health Workers' Opinions About the Health Impacts of FGM/C (PSKK UGM, 2017)

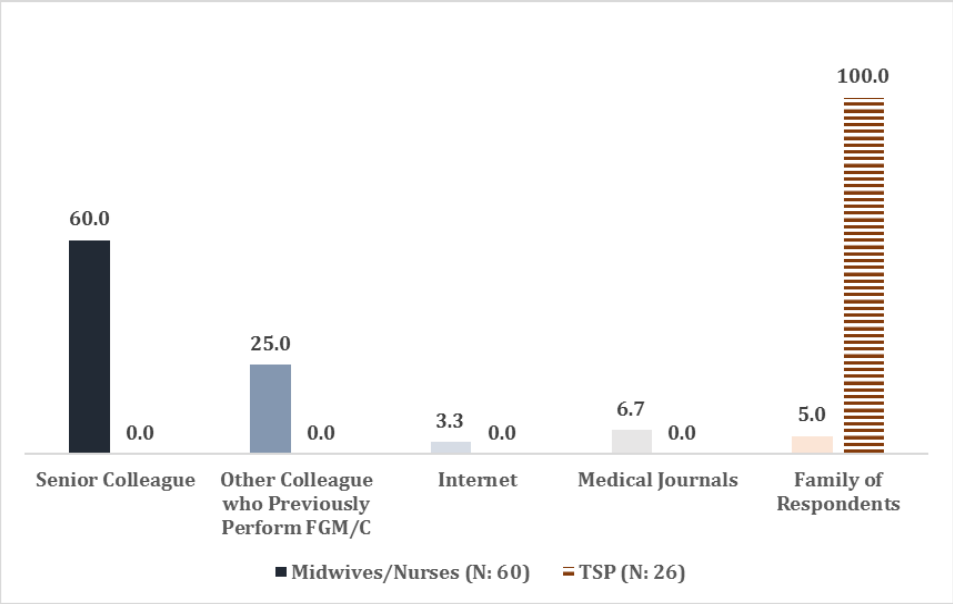


Knowledge of the procedure

There is no formal training for FGM/C operations in Indonesia. In this context, midwives and TSPs sought information about how to perform the operation through different channels. According to the qualitative study, midwives said they learnt from senior staff in their work place while TSPs had been taught how to do FGM/C by their mother or grandmother, who had themselves been taught by forebears in the matrilineal line. Midwives also reported looking to the Quran or book of *fiqh*, health magazine and "mouth to mouth" for information.

These findings were supported by the quantitative study. Approximately 100% of TSPs reported learning FGM/C procedure from experienced members in their family. Midwives, on the other hand, reported to turn to senior medical staff or else experienced medical staff for this information. They also reported reading articles in medical journals and Internet for technical information on FGM/C operations.

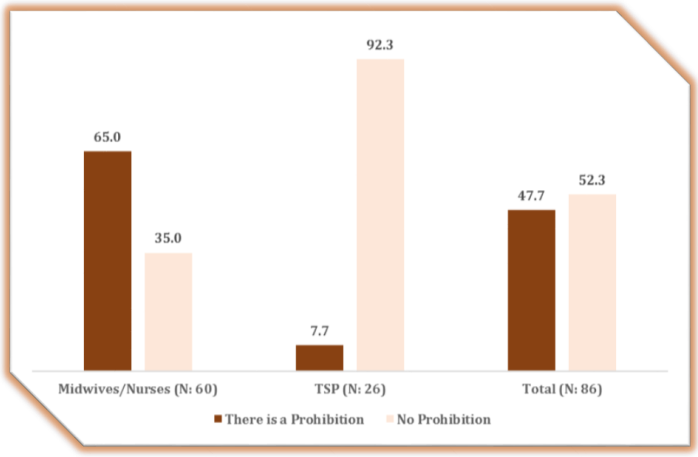
Figure 9: Sources of Learning for Health Workers on Performing FGM/C (PSKK UGM, 2017)



Knowledge of national FGM/C prohibition - 86 service providers (60 midwives and 26 TSPs) were asked if they knew of the 2014 MoH Decree that forbids FGM/C. Approximately 65% of midwives acknowledged that they had heard of this ban while only 8% of TSPs said that they had heard of this legislation.

The qualitative study found that that the midwives and TSPs who knew that FGM/C is prohibited practise it anyway. This implies that policy is not strong enough to override the pressure they felt to concede to a client's request for FGM/C.

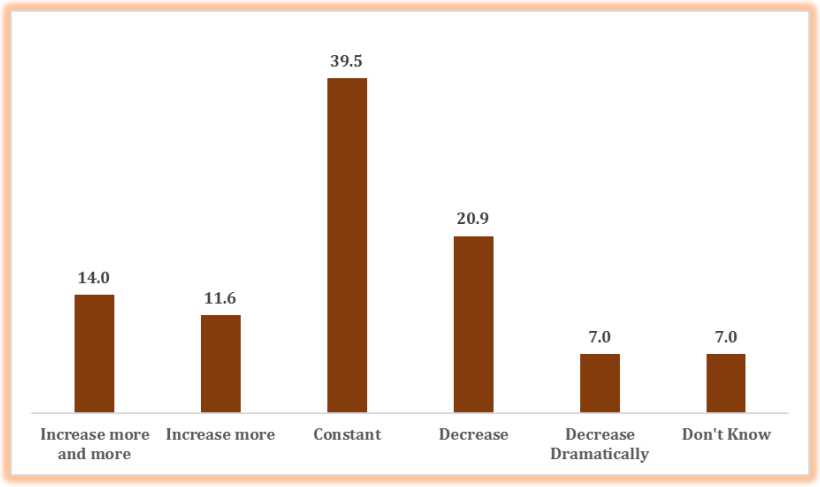
Figure 10: Knowledge of the most recent government legislation banning FGM/C (PSKK UGM, 2017)



Dynamics of FGM/C

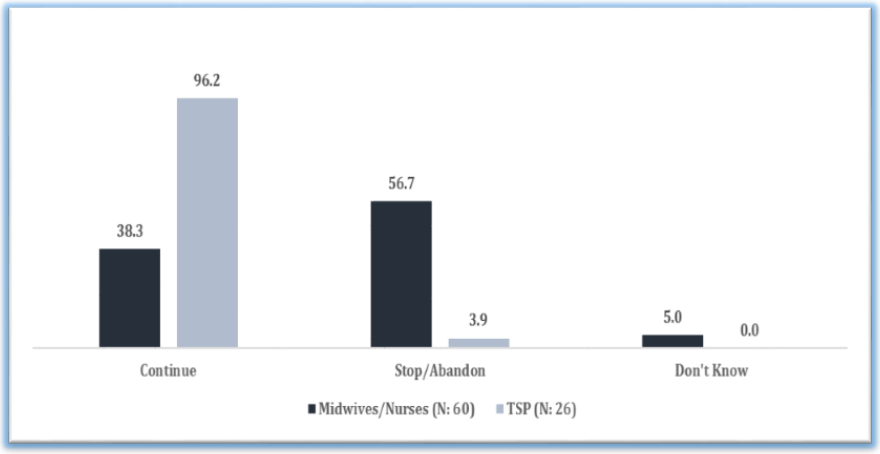
Has FGM/C increased or decreased since the 2010 - According to 40% of health workers, demand for FGM/C has remained steady since 2010, the year that the MoH supported the medicalization of FGM/C through issuing a decree. Approximately 28% said the practice had decreased, 26% said it had increased and 7% said they couldn't tell.

Figure 11: Health Workers' Perception of Changing Demand for FGM/C Since the 2010 Health Regulation (PSKK UGM, 2017)



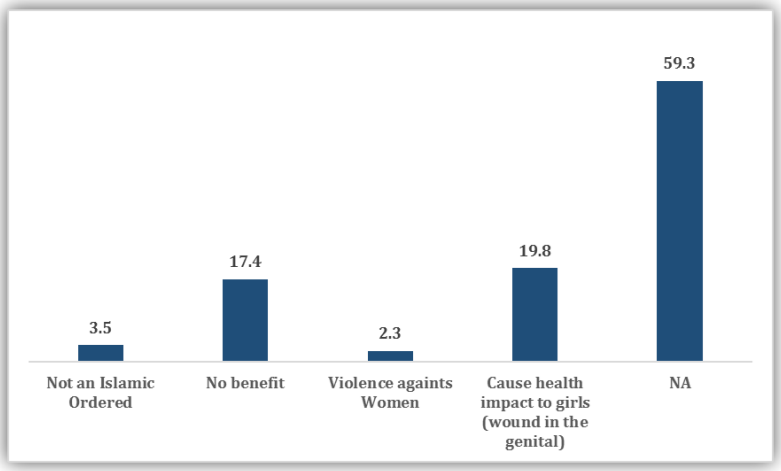
Should FGM/C continue or be abandoned? - Although all TSPs agreed that FGM/C is necessary and beneficial, 4% said that it was a tradition that should be terminated. This number was much higher among midwives. Approximately 57% of this cohort believed that FGM/C was a tradition that should be abolished.

Figure 12: Health Workers' Opinions on Whether FGM/C Should Continue or Be Abandoned (PSKK UGM, 2017)



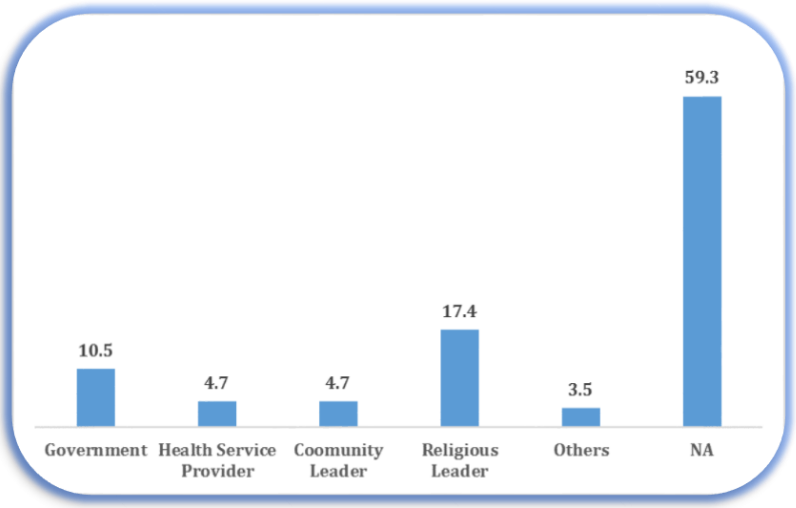
Why should FGM/C be abandoned? Among the health workers who disagreed with the practice, 17% said it had no benefits and 20% mentioned the pain inflicted on a girl's vagina. 3.5% of health workers said it was not an Islamic order and 2.3% considered it form of gendered violence. The 59% (NA) bar refers to those who believe that should FGM/C continue and so considered this question irrelevant.

Figure 13: Health Workers' Opinions on Why FGM/ C Should Be Discontinued (PSKK UGM, 2017)



Responsibility for the abandonment of FGM/C - Service providers were asked of their opinions on who should take responsibility for initiating the abandonment of FGM/C practice. The quantitative research found that 17% of midwives thought that religious leaders should take the lead while 10.5% saw the government as responsible for ending FGM/C. Approximately 4.7% thought it was up to the health workers; 4.7% said it was the responsibility of community leaders and 59% gave no answer as they considered the question irrelevant in light of their support of FGM/C.

Figure 14: Health Workers' Opinions on Who Should Take Responsibility for Preventing FGM/C (PSKK UGM, 2017)



CHAPTER 6: ANALYSIS OF THE DATA

Analysing the findings of the study as presented in the last few chapters, nine significant points emerge:

1. FGM/C occurs at a young age in Indonesia

Compared to the past and to other world regions where FGM/C is found, the average age of FGM/C is exceedingly young in the study areas. Approximately 61% of FGM/C occurs before the girl is 4 months old and a further 36% occurs between 4 months and 3 years of age. The qualitative study (*Komnas Perempuan*, 2017) notes a shifting trend in the age of FGM/C and documents parents' perspectives on the reasons for this demographic shift. Some parents suggested that lowering the age in Banten and West Java was a pragmatic decision to allow FGM/C to coincide with the 40-day celebration of Marhabah and Akekah[9]. This idea is consistent with the findings of anthropologists that in the modern era, traditions are more likely to be preserved if they make economic sense, in terms of not demanding too great a time and money commitment (Knauft, 2002).

Respondents also mentioned that girls get cut at an earlier age because babies, compared to older children, feel less pain. This assumption is based on observations that babies struggle less during the procedure. It is the case that babies don't consciously remember, but MRI scans of babies in pain reveal that they feel as much pain as adults (Goksan, 2015). The other reason parents gave for declining age of FGM/C was medicalization. This opinion aligns with the empirical trend to offer FGM/C as a clinical service bundled into pre-natal and antenatal care packages.

Since FGM/C usually occurs at an age before conscious memory there is little to no potential for a groundswell of victim advocates of the kind that have been change heroes in Africa.

[9] Akekah refers to the Islamic tradition of slaughtering a lamb, usually 40 days after the birth, Marhabah is a ritual feast, held soon after a baby is born, to bless his/her arrival and future in the world

2.Mothers and grandmothers are the key decision-makers for FGM/C.

The study shows that mothers and grandmothers hold the power to make decisions about whether or not a girl will be circumcised. This maternal concentration of power and influence has clear implications for intervention approaches. Top down approaches are effective for addressing the supply side, but unless maternal demand is addressed there is a risk of driving FGM/C underground (UNFPA, 2017).

3.FGM/C is diverse but in all cases, a normative practice anchored in relationships to religion and tradition

Types of FGM/C, cultural understandings of benefits, and the celebratory context of the procedure vary between ethnic groups. For practising communities FGM/C is more than a cultural expression; it is a rite that makes one a real Muslim and conveys respect for the family's traditional heritage. As a religious and traditional value, FGM/C is entwined in beliefs about sexuality, marriageability, piety, gendered power, identity, place and history.

That FGM/C is a norm – a shared idea that structures beliefs and influences behaviour - is supported by the quantitative findings that cite religion, tradition and family as reasons for choosing FGM/C. The qualitative finding found that almost all FGM/C clients experienced FGM/C as girls. This point to FGM/C a family practice reproduced through the generations.

Though FGM/C has inherent value as a cultural tradition (FGM/C has been practised from generation to generation and perceived as inherent values/traditions and taken for granted without anyone questioning it), most respondents experienced it as a religious obligation. The belief that FGM/C was an obligation was held as a taken-for granted fact rather that an idea discovered and debated in interpretations of the hadiths. This finding was supported by the statistic that only 10% of parents considered religious leaders as the source of influence for their understandings of FGM/C (PKK UGM, 2017).

In the qualitative study, religious leaders reported rarely raised or discussed the topic of FGM/C in the mosque. Most religious leaders were unable to explain the theological basis of female circumcision and some expressed that it was a women's matter. As deeply internalized practice, religious knowing is created and reinforced through bodily practices, such as praying and reciting from the Qur'an or Syahadat (a prayer that testified to singular faith in Allah) while performing FGM/C.

The implication that FGM/C is a social expectation over a theological knowing is that a social norms approach (UNFPA, 2016) is best suited for future intervention strategies.

4. FGM/C in Indonesia is rarely 'only symbolic'

The findings challenge stereotypes of FGM/C in Indonesia as largely symbolic or a mere a nick or prick that causes vulva bleeding but does not alter genital appearance. Symbolic FGM/C (involving no trauma to the genital tissue) compromised an exceedingly small number of cases in the study areas. The PSK UGGM (2017) team found that only 1.2% of parents claimed that FGM/C caused no wounding to their daughter's genitals.

In relation to the question of what kinds of FGM/C was conducted in the areas, the findings support other studies that most FGM/C types in Indonesia correspond to WHO types 1 and 4 (Budiharsana et al, 2003; Uddin 2010; Badan Litbang Kesehatan, 2013; Habsjah, 2013). What percentage fit into these classifications is only suggestive because the number of respondents and coding of the answers between parents and service-providers were not comparable.[10]

Looking closely at the quantitative data, 65% of parents gave responses about type of cutting that could be readily accommodated into WHO types 1 or 4. Other responses were considered so unique that the research team decided they should stand alone, because they did not fit it into the WHO classification. In particular, 5.7% scratched or scraped part of the urethra to enlarge the opening, akin to part of the procedure during male circumcision. The other type, cutting part of the clitoris and prepuce, was reported for 28% of cases. Given that WHO type 4 covers a broad-spectrum of "harmful procedures to the female genitalia" these types could have arguably fitted into the WHO classification scheme.

The responses of health workers to the question of type of cutting were classified into four different categories: no wounding (placing a slice of turmeric,); washing the vulva without wounding; rubbing the clitoris until a wound is created[11], and cutting of the tip of the clitoris. By paying attention to how they responded to the latter two categories, keeping in mind that this survey allowed multiple answers, some conclusions can be made about rates of harm. Midwives said they scratched the clitoris to injury in 43% of cases and cut the tip of the clitoris off 23% of the time. TSPs, on the other hand, reported scratching the clitoris to injury in 34% of cases and cut the tip of the clitoris off 11.5% of the time.

Notwithstanding the incommensurability of coding the data sets between parents and service providers, two conclusions can be drawn:

1. Where parents claimed only 1.2% of FGM/C was symbolic, the rate of symbolic FGM/C of service providers was higher. Reasons for this discrepancy should be studied further and could be due to i) modification of answers in light of awareness that a truthful

[10] According to the PSKK UGM research team, the differences in coding emerged from the range of answers provided by respondents in the different surveys.

[11] 'Rubbing the clitoris until a wound is created' was not operationalized in the study but historical reports of FGM/C in Indonesia suggest the likely meaning. Rubbing using a coin or blade removed layers of tissue until blood rises to the surface or flows. In some cases the clitoris was rubbed off entirely (Schrieke 1922, quoted from Feillard & Marcoes, 1998). If rubbing involves this latter degree of wounding then 'rubbing to a wound' might present as FGM/C type 1 (cliterodectomy).

answer would be to confess to violating MoH regulations or, ii) clients mis-remembering the 'midwives compromise' (see point 8, this chapter) in line with their expectation of FGM/C as a cutting practice.

2. Midwives perform more and more invasive types of FGM/C than TSPs; elaborated in point seven.

5. FGM/C causes physical, psychological and social harm

Irrespective of details, the research data from both studies clearly demonstrates that FGM/C almost always causes pain, bleeding and trauma. It can even, as once respondent in the qualitative study reported, lead to death. Though only one case was mentioned, this tragedy likely indexes other unreported cases. This is especially so in light of evidence, to recap from literature review, that type 1 FGM/C is proven to cause short-terms complications such as haemorrhage, severe pain, local and systemic infection, shock from blood loss and potentially, death (Shell-Duncan 2001: 1016).

Due to myriad confounding variables it is more difficult to prove how FGM/C effects mid and long-term health and wellbeing. A small percentage of parents and a significant number of midwives believed that FGM/C has negative physical, sexual and psychological consequences. That the procedure was seen as painful and even traumatic can also be found in explanations that the age for the procedure had been lowered. Unlike babies who are trusting of the world and in-the-moment, it was distressing for parents to see older girls anticipate, fear and struggle against the operation.

The non-consensual injuring of a baby or girl's sexual reproductive organs constitutes a form of sexual, child and gendered violence. From a human rights and development perspective, FGM/C hurts communities and is an obstacle to a socially just and economically prosperous nation. The dominant belief that FGM/C is important for decreasing female sexual libido upholds gender ideologies of men as active and women needing to be passive. Women's equality and empowerment requires ideological models where women are not framed as passive.

6. The trend of medicalization is predicted to grow

The study found that 66% of urban and 26% of rural respondents used midwives for FGM/C services while 74% of rural respondents preferred TSPs. In Gorontalo, TSPs are the only service-provider because the community sees FGM/C as a tradition that requires a ritual specialist. Compared to historical data, when TSP (referred as solely as *dukun*) was the only choice, midwives have emerged as another choice of service providers. The shift to medicalization is validated by studies of FGM/C in Indonesia (Putranti, 2008; Budiharsana et al, 2003) and supported by narrative reports of mothers who experienced FGM/C as a child from a *dukun* yet had taken their child to a midwife for the operation.

On average, 39% of respondents chose midwives and 61% chose TSPs. Keeping in mind that the regions and sample sizes were different; this average is similar to the findings of the Population Council (Budiharsana et al, 2003) yet dissimilar to the findings of Badan Litbang Kesehatan (2013). The former found that in the six study areas, 32% of parents preferred to enlist the services of medical personnel and 68%, TSPs. Calculated nationally, 51% of parents relied on midwives and 40% used TSPs (Badan Litbang Kesehatan, 2013).

The qualitative study found that TSPs are an occupation in decline. This is due to them being an ageing cohort moving to retirement and not being replaced by a new generation. Assuming that the demand for FGM/C remains steady; an increase in demand for FGM/C from health workers can be projected.

7. **Medicalization will cause greater harm, when measured in terms of more invasive surgical procedures.**

The projected increase in the trend to medicalization is alarming in light of the PSKK UGM study's correlation between FGM/C by health workers and obstetric violence. Approximately 45% of parents reported that midwives performed type 1a (cliterodectomy) compared to 23% of TSPs. On the other hand, 43% of midwives, or 8% more than the figure reported by TSPs (35%), said they rubbed the clitoris to 'a wound'. Approximately 23% of midwives reported perform cliterodectomy, 12% more than the figure reported by TSPs (11.5%).

Although precise figures differ, responses from both parents and service providers point to the same conclusion. That is, rates of cliterodectomy and other forms of violence are higher among medical workers. This finding is consistent with Foldes and Martz's (2015) observation that using surgical scissors in clinical contexts encourages deeper cuts and removes more genital tissue than in traditional practice. The study demonstrates that medicalization is more damaging and highlights the falsity of beliefs that medicalization is safer and a way to "Harm Reduction".

8. **Most midwives do not perceive FGM/C as necessary or beneficial.**

A significant number of midwives (63%) did not share their clients' views that FGM/C was necessary. Unlike their clients and TSPs most midwives were aware of the physical and psychological impacts of FGM/C; they knew of health regulations that ruled against the practice (PSKK UGM, 2017) and 57% believed FGM/C should be abolished. Less willingness to accept FGM/C as beneficial can be attributed to at least two factors. One, midwives were more likely than TSPs to have migrated to the area and as a result, were less likely to share cultural understandings of the communities they served. Two, midwives were exposed to different ideas about FGM/C. In addition to being influenced by their own cultural traditions, many midwives have come into contact with information on best-practice mandates about FGM/C from their interactions with bio-medically trained peers and professional development activities. For

example, several mentioned that they has learned about regulations that prohibited FGM/C from the Indonesian Midwives Association (IBI, *Ikatan Bidan Indonesia*).

9. Midwives Compromise

Even when they personally disagreed with FGM/C or were of the MoH prohibition, midwives admitted to performing FGM/C to meet the expectations of clients. In some cases, midwives reported that they avoided avoid inflicting harm by swaying parents to accept a thorough medical cleansing of the genital area. A few mentioned they promoted this to adhere to the MoH ban on FGM/C (*Komnas Perempuan,* 2017).

This finding, which might be called the 'midwives compromise', represents a kind of surreptitious resistance known by anthropologists (Scott, 2008) as a "weapon of the weak". Specially, faced with the inability to refuse a course of action that is unpalatable, the midwives performed a compromise that pleased the client while advancing their ethical agency. This compromise is a creative response to a personal dilemma but it does not challenge the status quo of medicalization.

Conclusion

In this chapter nine significant points emerge from the empirical findings. Namely, that FGM/C occurs at a young age; mothers and grandmothers make the decision about circumcising a girl; and it is rarely a symbolic practice. FGM/C was found to most often be a painful procedure that injured the genital issue and for a few, could lead to physical harm and even death. Given that TSPs are retiring and not being replaced, the trend towards medicalization is predicted to grow. Given that midwives were found to be more likely than TSPs to cut off part of the clitoris, so too will more invasive forms of FGM/C violence. Importantly, most midwives do not agree that FGM/C is worthwhile and necessary and some try to influence parents to accept cleansing over cutting. These findings form the basis of the next chapter which outlines recommendations for future FGM/C advocacy.

CHAPTER 7: RECOMMENDATIONS TO REDUCE THE PREVALENCE OF FGM/C

The following seven recommendations have been developed from an analysis of the data; an understanding of national and local conditions and; evaluations of best-practice strategies for reducing FGM practice in other world regions. Overall, they capture the view that a plan of action requires multi-sectoral commitments that address both the supply and the demand for FGM/C and the willingness to monitor demographic prevalence over time.

1. Develop data to chart the prevalence of FGM/C in Indonesia for SDG indicators

For purposes of monitoring and evaluation, and securing long-term national government commitment, FGM/C must be integrated into demographic meta-data sets. Measuring the prevalence of FGM/C can be integrated into the existing indicators that track progress towards the SDG (Sustainable Development Goal) number 5: 'Achieve Gender Equality and empower all women and girls'. Specifically, monitoring FGM/C prevalence can be tied to SDG indicator 5.3.2 (on FGM/C), including the type of FGM/C being practices in Indonesia.

2. Create and develop a multi-sectoral model for regional application

A focused and multi-sectoral approach that works comprehensively and intensively with different government agencies, religious leaders and CSOs is recommended for a few of the study areas to abandon the practices of FGM/C. Just as the data produced in this report attest to the culturally varied expressions of FGM/C, the success of future programs will depend on designs that are sensitive to local values and conditions in specific areas. After these projects progress through a series of tests and evaluations, the next phase of scaling-up and integration can be entertained.

3. Educate doctors, midwives and health service providers on FGM/C

To address the supply side of FGM/C, the following activities are recommended:

- Initiate dialogue with the Ministry of Health and the Ministry of Higher Education to mainstream FGM/C prevention into reproductive health services and education. This

should involve the integration of information about the short, medium and long-term consequences of FGM/C into the curricula of medical, nursing and midwifery students.

- Initiate professional development workshops with midwives who work in community health services, hospitals and other health care centres. To create a zero tolerance environment this training will raise awareness of FGM/C as a medical risk, an instance of medical malpractice (include the sanction), legislative reforms, and strategies to refuse a client's request for the service.

4. Policy Reform – Strengthen regulatory frameworks

FGM/C policy needs to be developed for consistency and comprehensiveness. This requires revising existing legislation and other measures, integrating policy on FGM/C into the Sexual Violence Bill. Implementing policy begins by opening dialogue with key stakeholders including MOWECP, Ministry of Justice, National Commission on Violence against Women (NCVAW), National Commission of Child Protection (NCCP/ KPAI), and National Commission of Human Rights and community and religious leaders (NCHR / Komnas HAM)

5. Engage women and youth with the support of government and NGOs

Top-down (policies and legislations) to be developed side-by-side with bottom-up programs that leverage social dynamics to transform awareness and FGM/C norms. Above all, it is important to target women – as the clients of FGM/C services – and youth – as the future clients. Community-focused programs can best be achieved by working with government, CSOs, and NGOS working on issues with youth, gender violence, and reproductive health. Regional and sub-regional governments can provide the legal basis and infrastructure (i.e. schools) for communicating materials about gender violence, gender norms and FGM/C. CSOs and NGOs are valuable because they have technical knowledge, local knowledge and experiences that are valuable for creating locally-relevant FGM/C initiatives.

6. Work with religious leaders

As authoritative figures on Muslim laws, religious leaders have the potential to sway the beliefs of FGM/C clients practicing communities. Working with faith based organizations and individual prominent religious scholars are needed to spread the true stand of Islam regarding FGM/C. Discussions with religious leaders should use various forums including: open dialogue, seminars and workshops (*halaqah*). Working with religious leaders in Indonesia also involves working with community mosque councils; with government [12]; and, with the two large faith based organizations: Nahdatul Ulama and Muhammadyah.

It is recommended that the work of Al-Azhar should be shared with the religious leaders to motivate them to have similar work and/or to translate Al-Azhar work to the local languages.

[12] This includes the Coordinating Minister for Human Development and Culture, Ministry of Religious Affairs, Ministry of Health, Ministry of Women Empowerment and Child Protection (MOWE CP/ KPP PA), and National Population and Family Planning Board (BKKBN).

The *istiqra* method also has great potential for this consultative process. This tradition of theological inquiry takes into account empirical facts in deciding on Islamic laws and so, encourages the reassessment of the existing beliefs with historical changes in the lived world. Within this consultative mode, empirical findings of the short-term and long-term complications of FGM/C can be discussed in relation to different interpretations of the hadith and in particular, understandings of FGM/C as not an Islamic law

7. Conduct further research

The findings of this mixed methods study raise more questions that should be the basis of future research. This research will refine an evidence-based for well-tailored interventions and community-focused programs to tackle the underlying beliefs and behaviours that perpetuate FGM/C. Some questions include:

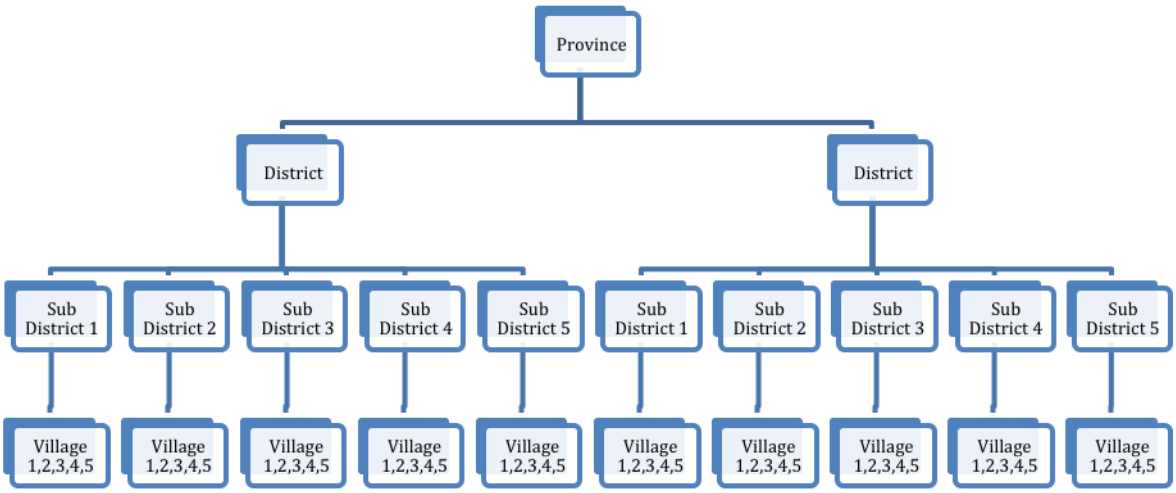
- *What hospitals offer FGM/C services?* There is a need to map the hospitals, in the national capital and other mega-cities and provincial areas that provide FGM/C services. Related to this is the question of whether and how bundling FGM/C in the birth packet is driving FGM/C to become more socially entrenched.
- *Costing*? What are the direct economic benefits of FGM/C to service providers?
- *Why do people abandon FGM/C*? Why do some communities of practice stop performing FGM/C? Studying the process of personal motivation to subject a daughter to FGM/C is important for identifying critical ingredients for behaviour change programs.
- *What do people actually do and feel in relation to FGM/C*? Verbal reports are distance in time and reflect 'idealizations'; that is, ideal-typical responses to events. It is recommended that rapid ethnographic research be conducted to deepen understandings by exploring potential discrepancies being what people say is done, or say they believe and what is actually done and felt in relation to FGM/C practices.
- *The views of men*? Advocacy work on FGM/C in Africa has found that as the fathers and partners of those who experience FGM/C, men have been found to play an important role in change programs (Varol et.al, 2003). In Kenya, Nigeria, Senegal and Sudan, programs that taught men how FGM/C hurts women and encouraged opened dialogue between men created a bridge for the prohibition of FGM/C (UNFPA, 2017). In their self-identified roles as protectors of women, better data on what men actually want and value in relation to FGM/C is required
- What critical factors were involved in success dialogue on the topic of FGM/C with religious leaders - who then became champions of the cause (UNFPA-UNICEF 2017) - in countries such as Egypt and Guinea?

Conclusion

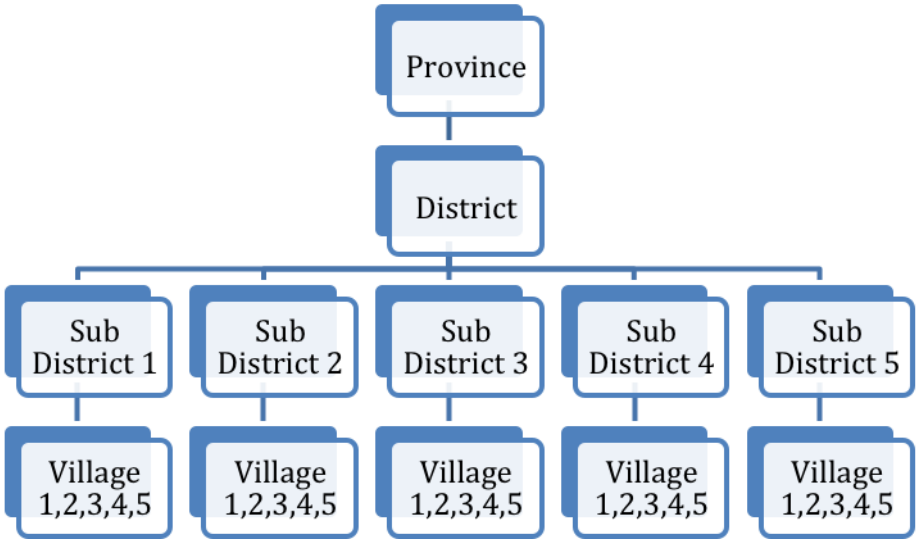
The two studies have generated a solid evidence-base of attitudes, understandings and values that perpetuate the supply (by service-providers) and demand (parents of young girls) for FGM/C. This evidence must be used to guide future efforts, in particular to integrate FGM/C in national data sets for demographic monitoring; build a multi-sectoral model for regional

application; educate medical students and retrain midwives; reform policy frameworks; engage women and youth; work with religious leaders and, conduct further research. Only then will it be possible, as has been observed in other world regions, for the elimination of FGM/C in Indonesia to proceed “slowly at first, and then, as new tipping points are reached, all at once” (UNFPA, 2017: 7).

Annex 1: Diagram of Multistage Cluster Sampling for Quantitative Study (Survey) based on Highest Prevalence on FGM/C (7 Provinces: Gorontalo, Bangka Belitung, Banten, Riau, South Kalimantan, West Java, West Sulawesi)



Annex 2: Diagram of Multistage Cluster Sampling for Quantitative Study (Survey) based on Provinces with District that have Local Regulation on FGM/C (East Kalimantan, Jambi and West Nusa Tenggara)



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Annex 5: Quality Assurance of the Research

As collection of accurate data representative of the community is key to the success of this research, several quality assurance measures have been built into the process, ranging from a rigorous selection process of trainees, to ongoing monitoring and evaluation in the field.

Rigorous selection process for interviewers & supervisors

In order to ensure good quality interviewers and supervisors, screening was carried out at different stages as follows:

- Local authorities were contacted to nominate the best of those that were eligible to be interviewers.
- From this list and their background, the most qualified were selected as trainees.
- Initial phone interview was carried out by members of the team and would-be trainees were evaluated on their language fluency and communication skills.
- Extensive training sessions were carried out, during which each trainee was given an equal opportunity to actively participate several times in the practical sessions and they were evaluated on their performance.
- A written test was then conducted to evaluate trainees

Trainees who passed these different stages were selected to be part of the data collection team.

Extensive training of interviewers

Interviewers were extensively trained to ensure adequate understanding of data collection tools and appropriate interviewing techniques. Proper structuring of training sessions, and the following considerations helped to ensure good quality training:

- Training was interactive and each trainee had several opportunities to participate actively in the training process.
- Survey questionnaires were reviewed question by question, to ensure understanding of the questions being asked, possible responses to each question, and proper pronunciation.
- This was followed by debriefing sessions to address any questions or concerns that the interviewers may have before interviews commenced.
- Trainee interviewers sat with experienced supervisors in the same sessions so they (interviewers) could benefit from their experience.
- Supervisors were actively involved in the role-play sessions, so that they could give their feedback and at the same time evaluate individual interviewers.
- At the beginning of each day, trainee interviewers met with their trainers and discussed any questions or concerns they had, before field work was scheduled to commence.

- Continuous monitoring and evaluation of interviewers by survey supervisors and the research team was initiated during the training period, and continued through field work, to facilitate immediate feedback and improve performance of interviewers, and address concerns, questions, or retraining issues.