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# The Implementation of Female Circumcision by Midwives in Aceh

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**ABSTRACT**

The practice of Female Genital Mutilation (FGM), also known as female circumcision, is still maintained, especially in Aceh, despite being banned by the WHO and the government. This practice is not taught in the school, including the midwifery school, as midwives are among the healthcare providers who generally offer this service. The dynamics of policy changes and deeply rooted differences in religious and cultural views create confusion for midwives in the field, particularly given the still high demand and community encouragement. The purpose of this research was to analyse the factors influencing the implementation of female circumcision by midwives. This was a cross-sectional study with the population of midwives who were working in the Aceh Province region in 2024. The sample of this study consisted of midwives who provide female circumcision services in Aceh, with a sample size of 86 people. Statistical analysis used the Chi-Square test with the SPSS v.25 . The majority of midwives performed circumcision about 1-2 times a month, and midwives perceived circumcision as a social necessity. Midwives aged ≥ 43 years, with work experience ≥ 13 years, working for ≥ 20 years, possessing good knowledge, and having a positive attitude tended to perform risky circumcisions. The results of the statistical test indicated that there was no significant relationship between age, years of service, duration of providing female circumcision services, knowledge, attitude, and social needs regarding the implementation of female circumcision. The research results indicated that midwives in Aceh continue to practice female circumcision, with the majority performing it in a risky manner. Although midwives have positive knowledge and attitudes, social necessity factors are the main drivers in its implementation

***Keywords:*** knowledge, attitude, social needs, implementation of female circumcision, midwives



## 1. INTRODUCTION

Female Genital Mutilation (FGM) or Female Genital Cutting (FGC) is a procedure that removes or injures female genitalia without medical reasons. This practice does not provide health benefits and can cause bleeding, urinary problems, cysts, infections, complications during childbirth, and increase the risk of newborn death. More than 230 million girls in 30 countries in Africa, the Middle East, and Asia have undergone this practice, generally between infancy and 15 years of age. The treatment costs resulting from FGC practices are estimated to reach US $1.4 billion per year and continue to rise [1].

Indonesia is the fourth highest country in the world for the practice of female circumcision, with a percentage of 49%. Gorontalo Province has the highest percentage of female circumcision practices, exceeding 80%. Aceh Province has a high prevalence of FGC, with a percentage between 51-80% [2].

The Indonesian government has undergone several policy changes regarding the practice of FGC. Based on the latest regulation issued by the government in Government Regulation (PP) Number 28 of 2024, Article 102, and the IBI circular stating that the practice of female circumcision is prohibited [3].

The Indonesian Ulema Council (MUI) in its fatwa in 2008 stated that circumcision for women is a noble act, and the prohibition of circumcision contradicts Islamic teachings [4]. The chairman of the Aceh Ulema Consultative Assembly (MPU) mentioned that the MPU Aceh's Taushiyah Number 7 of 2024 emphasizes that the law of female circumcision is sunnah, allowing the community the choice to perform it or not. The government regulation prohibiting female circumcision is considered inappropriate and contrary to the principles of Sharia, and it is better to provide options to the community according to religious law [5].

The dynamics of regulatory changes and differing decisions between the Ministry of Health and religious figures such as MUI and MPU Aceh create confusion for medical personnel in their implementation. This is evident as there are still many requests or pressures from the community to continue performing circumcision on girls. Meanwhile, midwives must comply with the regulations issued by IBI and the Government Regulation. The eradication of FGC practices cannot be abruptly stopped due to cultural demands, beliefs, and social support from close family and neighbors in deciding the implementation of FGC on girls. This is reflected in previous research conducted in Banda Aceh City in 2023, where 94.3% of parents reported performing circumcision on their daughters, and the majority (62.5%) had it done by midwives
[6]. However, midwives are never taught the procedures and methods of performing FGC in their education [7].
The results of the study indicate that many people still practice female circumcision. Therefore, this study aims to analyze the factors that influence the practice of female circumcision by midwives. The results of the study are expected to serve as a reference for the government in formulating policies to address the issue of P2GP in Acehnese society today.

## 2. METHOD

This quantitative research employs a Cross-Sectional Study approach. The study was conducted across all districts/cities in Aceh Province from June 2024 to May 2025. The population consisted of independent midwives in Aceh, totaling 874 individuals. The sample size for this study is determined using proportionate sampling methods calculated through Open Epi, resulting in a sample value of 78.89, rounded to 79 samples [8], An additional 7 samples are added, making a total of 86 samples. Sampling was be conducted using purposive sampling methods. Data collection will be done using questionnaires filled out by respondents via Google Forms. Data analysis will be performed using Chi-Square tests.

The dependent variable of the study was the practice of female circumcision, which was categorized into risky (not performing disinfection and using dangerous methods such as inflicting wounds on the female genital area) and non-risky (performing disinfection and only cleaning the genital area). Meanwhile, the independent variables consist of age, duration of providing female circumcision services, duration of working as a midwife, knowledge, attitude, and social needs. The number of knowledge-related questions consists of 8 questions related to knowledge of implementation and the medical risks or complications. For favorable questions, the answer “yes” is scored as 1 and “no” as 0. For unfavorable questions, the answer ‘yes’ is scored as 0 and “no” as 1.

The number of attitude questions consists of 7 questions regarding midwives' opinions or statements related to the practice of female circumcision from a medical, ethical, and human rights perspective. Favorable questions are scored as follows: “strongly agree” = 4 points, “agree” = 3 points, “disagree” = 2 points, and “strongly disagree” = 1 point. Unfavorable questions are scored as follows: “strongly agree” = 1 point, “agree” = 2 points, ‘disagree’ = 3 points, and “strongly disagree” = 4 points. The measurement results were categorized into “agree” (strongly agree and agree) and “disagree” (disagree and strongly disagree).

The number of questions on social needs consists of five questions regarding respondents' opinions on the social and cultural aspects of female circumcision. Favorable questions are scored as follows: “strongly agree” = 4 points, “agree” = 3 points, “disagree” = 2 points, and “strongly disagree” = 1 point. Unfavorable questions are scored as follows: “strongly agree” = 1 point, “agree” = 2 points, ‘disagree’ = 3 points, and “strongly disagree” = 4 points. The measurement results were categorized into “agree” (strongly agree and agree) and “disagree” (disagree and strongly disagree).

## 3. RESULTS AND DISCUSSION

### 3.1 Univariate Analysis

**Table 1 Descriptive Analysis**

| Variable | n | % |
|---|---|---|
| **Female Circumcision** | | |
| Not at risk | 8 | 9,3 |
| At risk | 78 | 90,7 |
| **Age** | | |
| ≥ 43 years | 43 | 50,0 |
| < 43 years | 43 | 50,0 |
| **Duration of Providing Female Circumcision Services** | | |
| ≥ 13 years | 43 | 50,0 |
| < 13 years | 43 | 50,0 |

| | | |
|---|---|---|
| **Duration of Working as a Midwife** | | |
| ≥ 20 years | 44 | 51,2 |
| < 20 years | 42 | 48,2 |

Based on the table above, it shows that the majority of respondents, 90.7%, perform female circumcision in a risky manner, with 50% aged ≥ 43 and 50% < 43 years, 50% providing female circumcision services for ≥ 13 years and 50% < 13 years, 51.2% working as midwives for > 20 years. 65.1% have good knowledge, 58.1% have a positive attitude, and 59.3% feel social needs as a necessity.

### 3.2 Bivariate Analysis

**Table 2. Relationship of Characteristics with the Implementation of Female Circumcision in Aceh**

| Variable | Implementation of Female Circumcision | | Total | P | OR |
|---|---|---|---|---|---|
| | At risk | Not Risky | | | |
| | n (%) | n (%) | n (%) | | |
| **Age** | 37 (86) | 6 (14) | 43 (100) | 0,265 | 0,301 |
| ≥ 43 years | 41 (95,3) | 2 (4,7) | 43 (100) | | |
| < 43 years | | | | | |
| **Duration of Providing Female Circumcision Services** | 41 (95,3) | 2 (4,7) | 43 (100) | 0,265 | 3,324 |
| ≥ 13 years | 37 (86) | 6 (14) | 43 (100) | | |
| < 13 years | | | | | |
| **Duration of Working as a Midwife** | 39 (88,6) | 5 (11,4) | 44 (100) | 0,714 | 0,600 |
| ≥ 20 years | 39 (92,9) | 3 (7,1) | 42 (100) | | |
| < 20 years | | | | | |

Based on Table 2 above, it is known that the characteristics of the respondents, namely age, duration of providing female circumcision services, and length of work as midwives, each have a p-value > 0.05, which means there is no significant relationship with the implementation of female circumcision. Midwives aged ≥ 43 years have a 69.9% lower chance of performing high-risk female circumcision practices compared to midwives aged < 43 years. This is evident from the percentage of midwives, where almost all midwives over 43 years old have risky circumcision practices (95.3%). Furthermore, regarding the variable of duration of providing female circumcision services, it appears that midwives with ≥ 13 years of experience are more involved in high-risk circumcision practices, at 95.3%, compared to those with < 13 years of experience. Midwives who have provided female circumcision services for ≥ 13 years have a 3.32 times greater chance of performing high-risk female circumcision practices compared to midwives who have just provided services for < 13 years.In the variable of length of work as a midwife descriptively, midwives with ≥ 20 years of service slightly more often perform non-risky actions (11.4%) compared to midwives who have worked < 20 years (7.1%). The OR value shows that midwives with ≥ 20 years of work experience have a 40% lower chance of performing high-risk female circumcision practices compared to midwives who work < 20 years.

**Table 3. Midwives' Knowledge of Female Circumcision in Aceh**

| Knowledge Questions | Implementation of Female Circumcision | | Total | P-value |
|---|---|---|---|---|
| | Risky | Not Risky | | |
| | n (%) | n (%) | n (%) | |
| **Female circumcision is not dangerous** | | | | |
| Yes | 38 (95) | 2 (5) | 40 (100) | 0,275 |
| No | 40 (87) | 6 (13) | 46 (100) | |
| **Female circumcision can cause complications such as bleeding and infection** | | | | |
| Yes | 30 (96,8) | 1 (3,2) | 31 (100) | 0,249 |
| No | 48 (87,3) | 7 (12,7) | 55 (100) | |
| **Female circumcision has no psychological effect on women in adulthood** | | | | |
| Yes | 27 (96,4) | 1 (3,6) | 28 (100) | 0,265 |
| No | 51 (87,9) | 7 (12,1) | 58 (100) | |
| **Female circumcision is beneficial for women's reproductive health** | | | | |
| Yes | 25 (83,3) | 5 (16,7) | 30 (100) | 0,121 |
| No | 53 (94,6) | 3 (5,4) | 56 (100) | |
| **Female circumcision is not dangerous if performed by health professionals** | | | | |
| Yes | 56 (91,8) | 5 (8,2) | 61 (100) | 0,686 |
| No | 22 (88) | 3 (12) | 25 (100) | |
| **Female circumcision is performed by cutting part of the female genitalia** | | | | |
| Yes | 44 (95,7) | 2 (4,3) | 46 (100) | 0,138 |
| No | 34 (85) | 6 (15) | 40 (100) | |
| **Female circumcision can cause scarring** | | | | |
| Yes | 23 (100) | 0 (0) | 23 (100) | 0,102 |

| | | | | |
|---|---|---|---|---|
| No | 55 (87,3) | 8 (12,7) | 63 (100) | |
| **A sign that a girl has been circumcised is bleeding** | | | | |
| Yes | 14 (100) | 0 (0) | 14 (100) | 0,343 |
| No | 64 (88,9) | 8 (11,1) | 72 (100) | |

Table 3 shows that there is no significant relationship between each knowledge question item and the practice of female circumcision. Overall, midwives with good knowledge tend to perform risky circumcisions. A total of 40 (46.5%) midwives believe that female circumcision is not dangerous. A total of 31 (36%) midwives stated that female circumcision can cause complications such as bleeding and infection. A total of 28 (32.6%) midwives stated that female circumcision has no long-term psychological effects. A total of 30 (34.9%) midwives considered female circumcision beneficial for women's reproductive health. A total of 61 (70.9%) respondents believed that female circumcision is not harmful if performed by health professionals. Meanwhile, 46 (53.5%) acknowledged that female circumcision involves cutting part of the female genitalia. Additionally, 23 (26.7%) midwives stated that circumcision can cause scars. Furthermore, 14 (16.3%) midwives believe that the sign of a girl having been circumcised is bleeding, and all of them also engage in risky practices.

**Table 4. Midwives' Attitude of Female Circumcision in Aceh**

| Attitude Questions | Implementation of Female Circumcision | | Total | P-value |
|---|---|---|---|---|
| | Risky n (%) | Not Risky n (%) | n (%) | |
| **I support the practice of female circumcision** | | | | |
| Agree | 45 (88,2) | 6 (11,8) | 51 (100) | 0,464 |
| Disagree | 33 (94,3) | 2 (5,7) | 35 (100) | |
| **Female circumcision is permitted as long as it is performed by medical personnel** | | | | |
| Agree | 66 (89,2) | 8 (10,8) | 74 (100) | 0,593 |
| Disagree | 12 (100) | 0 (0) | 12 (100) | |
| **I believe that female circumcision can prevent sexual aggression** | | | | |
| Agree | 52 (89,7) | 6 (10,3) | 58 (100) | 1,000 |
| Disagree | 26 (92,9) | 2 (7,1) | 28 (100) | |
| **I feel that female circumcision can preserve a woman's virginity or purity** | | | | |
| Agree | 38 (92,7) | 3 (7,3) | 41 (100) | 0,716 |
| Disagree | 40 (88,9) | 5 (11,1) | 45 (100) | |
| **I believe that circumcision cannot cause sexual dysfunction in women** | | | | |
| Agree | 47 (90,4) | 5 (9,6) | 52 (100) | 1,000 |
| Disagree | 31 (91,2) | 3 (8,8) | 34 (100) | |
| **I am sure that bleeding and pain are normal and will not be harmful to the health of girls after circumcision** | | | | |
| Agree | 42 (93,3) | 3 (6,7) | 45 (100) | 0,470 |
| Disagree | 36 (87,8) | 5 (12,2) | 41 (100) | |
| **Female circumcision is not a form of violence against women** | | | | |
| Agree | 58 (89,2) | 7 (10,8) | 65 (100) | 0,673 |
| Disagree | 20 (95,2) | 1 (4,8) | 21 (100) | |

Table 4 there is no significant relationship between midwives' attitudes and the practice of female circumcision based on all questions. Descriptively, both midwives with positive and negative attitudes tend to perform risky circumcisions. Based on percentages, 51 (59.3%) midwives stated that they support the practice of female circumcision, 74 (86%) midwives believe that circumcision can be performed as long as it is done by medical personnel, 58 (67.4%) midwives believe that circumcision can prevent sexual aggression, 41 (47.7%) midwives believe that circumcision can preserve a woman's virginity or purity, 52 (60.5%) midwives believe that circumcision does not cause sexual dysfunction, 45 (52.3%) midwives state that bleeding and pain after circumcision are normal and harmless, and 65 (75.6%) midwives state that circumcision is not a form of violence against women.

**Table 5. Midwives' Social Needs of Female Circumcision in Aceh**

| Social Needs Questions | Implementation of Female Circumcision | | Total | P-value |
|---|---|---|---|---|
| | Risky n (%) | Not Risky n (%) | n (%) | |
| **Female circumcision is a good tradition and should be preserved** | | | | |
| Agree | 50 (86,2) | 8 (13,8) | 58 (100) | *0,049 |
| Disagree | 28 (100) | 0 (0) | 28 (100) | |
| **If female circumcision is not performed, it will result in social sanctions by the community** | | | | |
| Agree | 35 (100) | 0 (0) | 35 (100) | *0,019 |
| Disagree | 43 (84,3) | 8 (15,7) | 51 (100) | |
| **I feel that there is social and cultural pressure or demand from the parents of circumcised children, which encourages me to perform circumcision on girls** | | | | |
| Agree | 59 (92,2) | 5 (7,8) | 64 (100) | 0,416 |

| | | | | |
|---|---|---|---|---|
| Disagree | 19 (86,4) | 3 (13,6) | 22 (100) | |
| **I have experienced conflicts with patients' families or communities regarding your decision to perform or not perform circumcision on girls** | | | | |
| Agree | 46 (92) | 4 (8) | 50 (100) | 0,715 |
| Disagree | 32 (88,9) | 4 (11,1) | 36 (100) | |
| **I believe that female circumcision is a religious recommendation** | | | | |
| Agree | 55 (87,3) | 8 (12,7) | 63 (100) | 0,102 |
| Disagree | 23 (100) | 0 (0) | 23 (100) | |

Table 5 shows that there is a significant relationship between several aspects of social needs and the practice of female circumcision. Overall, most midwives continue to perform female circumcision, which is risky. A total of 58 (67.4%) midwives stated that circumcision is a good tradition and should be preserved (p = 0.049). A total of 35 (40.7%) midwives stated that if female circumcision is not performed, they will face social sanctions from the community, and all of them (p = 0.019). A total of 64 (74.4%) midwives felt that there was social and cultural pressure or requests from the child's parents that encouraged the practice of circumcision, and 50 (58.1%) midwives admitted to having experienced conflicts with the patient's family or community regarding the decision to perform or not perform circumcision. Meanwhile, midwives who had never experienced conflicts still showed a high tendency (88.9%) to perform risky procedures. Additionally, 63 (73.3%) midwives believed that circumcision was a religious recommendation.

## DISCUSSION

### Age of Midwives Regarding the Implementation of Female Circumcision

Based on the analysis results, it was found that the majority of midwives from both age groups, both those aged ≥ 43 years and < 43 years, perform female circumcision in a manner categorized as high-risk. In the age group ≥ 43 years, 95.3% perform high-risk circumcision, while in the age group < 43 years, 86% perform similar actions. Although there is a proportional difference, the statistical test results show that there is no significant relationship between the age of midwives and high-risk circumcision practices (p-value = 0.265). The OR results indicate that midwives aged ≥ 43 years have a 69.9% lower chance of performing high-risk circumcision compared to midwives aged < 43 years, but this difference is not statistically strong enough. These findings indicate that high-risk circumcision practices are still widely performed by midwives across various age groups, suggesting that age is not the only factor influencing perspectives and practices regarding circumcision

Previous research indicates that age has a significant relationship with the medical personnel's decision to continue performing female circumcision [9]. However, the results of this study show that age does not have a significant relationship with the practice of female circumcision. Other studies, however, indicate that there is a significant relationship between age and how midwives provide healthcare services [10][11].

Based on interviews with a senior midwife, they have accompanied traditional midwives in performing circumcision, so the senior midwife is aware of how the circumcision is performed, which likely causes the senior midwife to be more dominant in carrying out circumcision. Meanwhile, younger midwives tend to perform female circumcision less frequently because they lack experience and skills, leading them to refuse to perform it [12].

Age is also closely related to experience, which in turn influences perspectives and knowledge. This aligns with previous research that indicates a significant relationship between age and midwives' knowledge in the practice of female circumcision [13]. Based on the results of this study, those aged above 43 years and below 43 years have almost equal frequencies of high-risk and low-risk practices. Therefore, the researchers assume that regardless of the midwife's age, both young and old tend to perform high-risk circumcision. Thus, age is not the only determining factor in how female circumcision is performed by midwives.

### Duration of Female Circumcision Services by Midwives

Based on the research results, no significant relationship was found between the duration of midwives providing female circumcision services and the practice of female circumcision. The frequency distribution data shows that the work experience of midwives in performing circumcision procedures varies, with a range of work experience in circumcision services between 1 to 30 years, and most midwives have around 10 years of experience (17.4%). There is a balanced distribution between midwives with more than 13 years of experience and those with less than 13 years. The OR value indicates that midwives with ≥13 years of circumcision service have a 3.3 times greater chance of performing high-risk circumcision compared to those who have provided services for <13 years.

Longer work experience is often associated with increased skills and understanding in clinical practice. A midwife who has worked for decades likely has more opportunities and knowledge to handle various cases and acquire skills compared to a midwife who has just started providing female circumcision services [14].

In the context of healthcare services, such as antenatal care, previous research has shown that the longer someone works, the better the quality of service provided [15]. Previous studies indicate that training and education for healthcare personnel have a significant relationship with awareness and a high initiative to counsel families of children who are circumcised against performing female circumcision [16].

Other research results also indicate an increase in midwives' knowledge and awareness after receiving training on the practice of female circumcision [13]. This has been implemented in various countries such as Sudan, Spain, Australia, Egypt, Belgium, and others, referring to the WHO guidelines from 2022 on "Person-Centred Communication For Female Genital Mutilation Prevention" [17]. Therefore, it is important for health institutions to continuously enhance midwives' competencies through training, regardless of their length of work experience. Even if midwives have worked for decades, if they are not equipped with good knowledge and skills in communication, they will continue to engage in high-risk practices.

**Duration of Working as a Midwife**

The results of this study indicate that descriptively, midwives who have worked for ≥ 20 years perform slightly more low-risk practices (11.4%) compared to midwives who have worked for < 20 years (7.1%). This suggests that longer work experience is associated with safer practices in the execution of female circumcision. Additionally, the OR value indicates that midwives with ≥ 20 years of work experience have a 40% lower chance of performing high-risk female circumcision compared to those who have worked for < 20 years. Although statistically, there is no significant difference in the practice of female circumcision (p-value > 0.05).

The length of work theoretically describes how experienced a midwife is in providing midwifery services. In this process, midwives not only hone their technical skills but also undergo a social and professional learning process that shapes their understanding of patient needs, service norms, and ethical responsibilities as healthcare providers [14]. This finding aligns with the theory of work experience, which states that extensive experience contributes to work competence and professional attitudes in serving patients [14]. Furthermore, other studies also indicate that the length of work significantly correlates with the quality of antenatal care services, suggesting that work experience not only strengthens technical skills but also has the potential to shape a more thoughtful and humane service mindset [15].

Based on the results of the study, the researchers suggest that work experience may encourage safer behavior among healthcare workers and improve their ability to communicate effectively with patients' families to prevent the practice of female circumcision.

**Knowledge of Midwives Regarding the Practice of Female Circumcision**

Based on the results of this study, there is a descriptive diversity of perceptions among respondents regarding female circumcision. Almost half of the respondents still consider that female circumcision is not dangerous, believe that circumcision can provide benefits to women's reproductive health, and agree that circumcision can be performed if carried out by healthcare professionals. The results of this study show that there is no significant relationship between knowledge and the practice of female circumcision by midwives.

Previous research indicates that healthcare professionals with comprehensive knowledge significantly influence the prevention or rejection of female circumcision practices [18]. Previous studies show that the majority of healthcare workers in Iran have good knowledge regarding female circumcision [19].

However, according to Notoatmodjo, having good knowledge does not automatically mean that a midwife will also take good actions. There are other factors that also influence a midwife's actions [20]. This is consistent with research in Egypt and Nigeria, where 28% of respondents believe that female circumcision can help maintain virginity [21].

The beliefs held by midwives seem to justify the practice and make them feel safe if it is performed by healthcare professionals. Although non-medical practitioners, such as traditional birth attendants, lack understanding of the anatomy and physiology of female reproductive organs and do not perform the procedure in a sterile manner, this does not mean that midwives, as healthcare professionals, are allowed to perform it. This practice certainly carries risks whether performed by medical or non-medical personnel [22].

The researchers assume that good knowledge among respondents does not necessarily align with their decisions or actions regarding the practice of female circumcision. This may occur due to other factors influencing midwives' decisions to perform female circumcision, such as culture, social pressure, religious beliefs, and prevailing norms in society

**Social Needs of Midwives Regarding the Practice of Female Circumcision**

The research findings indicate that there is no significant relationship between social needs and the practice of female circumcision. As seen in the research conducted in Pangonan Village, Central Java, circumcision has been practiced for a long time and has become a tradition in the community. This tradition is very difficult to eliminate because circumcision is considered sacred and a social obligation in that society. The people of Pangonan Village believe that circumcision can cleanse the female genitalia from sukert or impurities. The circumcision procedure will be concluded with a ceremony called berjanjen, which is a communal prayer event for the safety of the child being circumcised [23].

In addition, previous research in Gambia, Nigeria, Spain, and Sudan indicates that female circumcision is still preserved by healthcare workers as it is considered part of the tradition and identity of the community [24][13][9][22][25][21]. Other research in Somalia mentions that midwives are concerned about receiving social

sanctions if they prohibit this circumcision practice, as it has become part of the customs and religious rituals of the community [16].

Similarly, regarding the social needs of midwives, previous research in Sudan and Kenya found that performing female circumcision is necessary to be recognized and accepted in society [22]. These social needs are closely related to culture. Culture is one aspect of social life that develops from one generation to the next, shaping the way individuals think, their attitudes, beliefs, and behaviors in social life [26]. Therefore, socio-cultural factors are one of the main foundations for the continued practice of female circumcision in certain segments of Indonesian society [4].

The researchers argue that the practice of female circumcision among midwives is strongly influenced by social norms, culture, and societal pressure, even though ethically and legally this practice should be stopped. The belief that circumcision is a good tradition and the fear of social sanctions are the main factors driving midwives to continue performing it. Additionally, concerns about Islamic identity and the fear of patients turning to traditional birth attendants further reinforce the continuation of this practice. Therefore, efforts to stop female circumcision must involve a cross-sectoral approach with strategies that are culturally sensitive in the community, strengthening public education, and providing concrete support to midwives to enable them to perform their professional roles without social pressure.

**Midwives' Attitudes Towards the Practice of Female Circumcision**

The results of this study indicate that there is no significant relationship between attitudes and the practice of circumcision by midwives. Positive or negative attitudes towards female circumcision do not serve as the main determining factor in its implementation. Consistent with previous research findings, the scraping of the female clitoris aims to limit libido and control the emergence of hyperlibido. Midwives also consider that what they do is not harmful and carries minimal risk. However, further investigation reveals that after circumcision performed by midwives, children experience pain when urinating and suffer from bleeding [27].

In contrast to previous research in Nigeria, 93.2% of doctors and nurses surveyed stated that the practice of circumcision on girls is not a good practice. Similarly, in Egypt, 81.4% of doctors expressed uncertainty about the benefits of female circumcision. Additionally, the majority of healthcare workers in Belgium and America refuse to perform female circumcision as it is illegal [22]. Research in Australia also shows that all midwives interviewed expressed disapproval of the practice and felt concern for all women who suffer negative medical consequences from this practice [28].

Meanwhile, the normalization of the practice of female circumcision, justified by most midwives in this study, is evident in the descriptive results of this research. Among other things, midwives believe that circumcision can prevent sexual aggression, maintain the virginity or purity of women, does not cause sexual dysfunction, and consider bleeding and pain as not dangerous and not a form of violence against women.

Scientific evidence shows that there are no medical benefits to female circumcision. On the contrary, this practice has negative impacts such as infections, sexual disorders, psychological trauma, and complications during childbirth [1][22]. Research results in Jeddah, Saudi Arabia [28] indicate that there are significant differences between groups of women who undergo circumcision and those who do not in terms of sexual satisfaction. Therefore, the still strong support for female circumcision among midwives as practitioners of circumcision indicates that regulation alone is not enough to eliminate this practice. The erroneous beliefs about the benefits of female circumcision emphasize the need for a stronger evidence-based approach in educating healthcare workers and the community.

Research conducted in Jeddah, Saudi Arabia, in [28] found that there was a significant difference between women who underwent circumcision and those who did not in terms of sexual satisfaction. Therefore, the continued strong support for female circumcision among midwives as practitioners of the procedure indicates that regulation alone is insufficient to eliminate this practice. Misconceptions about the benefits of female circumcision underscore the need for a more evidence-based approach in educating healthcare workers and the general public.

## CONCLUSION

There is no significant relationship between the age of midwives, the duration of providing female circumcision services, the length of time working as a midwife, knowledge, attitudes, and social needs regarding the execution of female circumcision.

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