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Qualitative Study of Midwives' Perceptions and Responses to the Implementation of Female Genital Mutilation (Circumcision) by Midwives in Aceh Post-Regulation

Eka Mulyana[1*], Nurjannah Nurjannah [2], Nasrul Zaman [3], Irwan Saputra [4] , Maidar Maidar [5]

[1]Magister of Public Health, Faculty of Medicine, Universitas Syiah Kuala, Banda Aceh, Indonesia
[2,3,4]Department of Public Health, Faculty of Medicine, Universitas Syiah Kuala, Banda Aceh, Indonesia
[5]Master of Public Health Study Program, Muhammadiyah University of Aceh, Banda Aceh, Indonesia

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Corresponding Author:
Nurjannah Nurjannah,
Department of Public Health,
Faculty of Medicine,
Universitas Syiah Kuala, Banda Aceh, Indonesia
Email:
nurjannah_dr@usk.ac.id

ABSTRACT

Background: Female circumcision (*khitan*) remains a deeply rooted traditional and religious practice for girls in Aceh. While Indonesia has ratified international agreements banning Female Genital Mutilation/Cutting (FGM/C), implementation faces unique challenges in Aceh due to strong cultural and religious influences on healthcare practices. Objective: This study examined midwives' implementation of female circumcision following 2024 regulations, exploring practice challenges, conflicts between professional ethics and cultural values, and clinical implications. Methods: We conducted qualitative, phenomenological interviews with 18 midwives from four Aceh regions (Banda Aceh, Southwest Aceh, Central Aceh, and East Aceh), selected through snowball sampling, to capture diverse experiences. Results: Perceptions and responses to FGM regulations, along with value conflicts between legal requirements, professional ethics, and cultural/religious norms. Conclusion: The 2024 regulations have positioned midwives as key agents of change in eliminating FGM/C.However, effective implementation is hindered by information gaps, strong cultural resistance, and insufficient government support.

Keywords: regulations, khitan, women, perceptions, responses, midwives

1. INTRODUCTION

Female circumcision, also known as Female Genital Mutilation/Cutting (FGM), has become a profound global dilemma due to the tug-of-war between universal human rights principles and local cultural and religious values, while also drawing global attention in the health field given its invasive nature without medical indication [1]. In response to the circular letter, the Indonesian Ulema Council (MUI) issued a legal fatwa prohibiting female circumcision, which was then met with a counter-response from the Ministry of Health by replacing it with Minister of Health Regulation No. 1636/MENKES/PER/XI/2010 on Female Circumcision. This regulation is suspected to have triggered an increase in the practice of FGM/C among the community [2].

As a form of support for this national policy, the Indonesian Midwives Association (IBI) in 2024 proactively issued Circular Letter Number 0319/PPIBI/II/2024 regarding the Elimination of Female Genital Cutting and Mutilation Services. This professional policy not only reflects compliance with national regulations but also emphasizes the strategic role of midwives as the frontline in protecting women's reproductive health. This circular letter serves as an important instrument to ensure consistency in implementation at the clinical practice level while also strengthening efforts to transform public health norms [3].

Although this practice is not included in the midwifery education curriculum and lacks a medical basis, many midwives continue to perform it to meet community expectations, often opting for a 'minor circumcision' version as a compromise to minimize health risks [4][5]. This dilemma is further complicated by several key factors. First, there is a policy misalignment between the official ban from the Ministry of Health and the support from the Indonesian Ulema Council (MUI), which considers FGM as part of religious practice. Second, there is a strong cultural belief that this procedure is necessary to control women's sexuality and enhance their marriage prospects in the future. Third,

there is a lack of clear operational guidelines and a protection system for midwives who choose to refuse to perform FGM [6].

Midwives in Indonesia often find themselves in difficult situations when dealing with FGM practices. On one hand, they have a professional obligation to protect women's reproductive health based on medical standards. On the other hand, they face strong pressure from families and communities that view FGM as an important cultural and religious ritual [7]. This situation is exacerbated by the fact that, despite government efforts to eliminate the practice through various regulations, FGM continues to occur quietly in various regions. Midwives, as the frontline of healthcare services, often feel the most impact of this contradiction, caught between adhering to official regulations and meeting the expectations of the communities they serve [8].

Midwives, as the frontline, face a complex conflict between professional obligations based on medical ethics and strong socio-cultural pressures, where many are forced to compromise with a 'lighter' version of FGM even though the Indonesian Midwives Association (IBI) has explicitly prohibited it (2024). The problem is compounded by the ongoing practice in various regions of Indonesia, including Aceh, which shows a gap between a strong legal framework (Health Law 2023 and Government Regulation 28/2024) and the socio-cultural realities in society, as well as the lack of a protection system for healthcare workers who refuse to perform the practice. Based on this background, this research aims to examine how the implementation of the FGM prohibition policy in Aceh is perceived by midwives in response to FGM.

2. METHOD

This research is a qualitative study using a phenomenological approach by conducting in-depth interviews with midwives providing direct services to patients. The study was conducted in four regional districts/cities in Aceh Province, namely the central region (Banda Aceh), eastern region (Aceh Timur), central region (Aceh Tengah), and western region (Aceh Barat Daya) during September to October 2024. The informants in this study are midwives from the four regional districts/cities who provide direct services to patients. The inclusion criteria for participating midwives are those who work in villages (village midwives), health centers, private practices, or hospitals, are willing to participate in in-depth interviews, and have performed female circumcision at least 10 times. Four to six individuals were selected from each region,with a total of 18 informants involved in this study. The sample was taken using non-probabilistic sampling methods, specifically snowball sampling. Data were collected through in-depth interviews.The data analysis obtained from the audio-recorded interviews was transcribed into text format and subsequently processed using the Miles and Huberman mode.

3. RESULTS AND DISCUSSION

3.1 Result

Midwives face a dilemma between rejecting FGM and the cultural and religious pressures that regard it as a traditional obligation. Although the demand for FGM is starting to decline, the practice persists due to the influence of religious figures, medical myths, and family pressure. Collaboration among midwives, religious leaders, and the community is needed to align health policies with local values to sustainably end FGM. This theme explores midwives' perceptions and responses to FGM regulations, as well as the value conflicts between legal demands, professional ethics, and cultural/religious norms. This theme consists of 3 sub-themes, namely:

1) Views and Roles of Midwives in FGM Practice

The majority of midwives, based on their understanding and perspective from a health standpoint, believe that FGM provides no medical benefits and is unnecessary, and may even reduce women's ability to experience sexual pleasure. They also reject cleanliness claims, as there is no dirt or impurity in the clitoral area. This is reflected in the following quotes:

"Actually, it is no longer necessary; there are no germs there." (B4) "So, there are children who have never experienced climax, never experienced maximum orgasm; that is the result of research, and it is straightforward." (A1)

However, respondents also view this practice more as a cultural and religious obligation than a medical procedure. They consistently describe FGM as a practice deeply embedded in the local belief system, emphasizing the strong influence of ancestral traditions in maintaining it. As explained by one participant:

"As Acehnese people, it is difficult; it is customary, and all descendants are circumcised." (A2)

Meanwhile, there are differing views regarding the legality of female circumcision among respondents. One participant explained: *"...but from a religious perspective, it must be done, because why? Women, they say, have stronger desires, so at the end, it is... therefore, it is not all of this, even though that is not the nerve that is affected, it seems like the skin is like that, right? Some opinions say it is like dirt, that is what needs to be cleaned" and "...because we are Muslims, yes, it means that what is commanded by religion we still do, but without... causing injury, so to speak." (A4)*

b) Midwives' Views on Strategies to Change FGM Practices

Informants encourage the government to establish partnerships with religious authorities, as public statements from religious figures that FGM is not a religious obligation can significantly weaken social acceptance of

this practice. B4 emphasizes the importance of cooperation between the government and religious leaders, stating: *"It would be better if the government cooperates with the religious leaders, because most people (in the community) believe in religion, explaining ee… what this is, what it is called ee… has no relation to the shahada, you know. So, if they already know that, they will definitely (know) there is no connection anymore. If we still do it, it is still heard even though we have conveyed it, they have not heard it directly, they are not (sure) about this, right." (B4)*

Another effective strategy is to utilize respected community figures, particularly senior midwives and individuals who have the authority to provide advice or influence in the community, as campaigners to disseminate information and challenge the normalization of FGM practices. B6 highlights the potential of this approach in shaping public opinion through trusted voices. She stated: *"For example, there is one midwife, including midwife kak *** (one of the senior midwives) earlier, if here, she is still automatically heard. So, we can cooperate with someone who is still trusted by the community. Especially here, there are still those who are like the teungku, you know. For instance, if there is a midwife who has many patients, she is still heard, so that could be an approach through that." (B6)*

c) Midwives' Perceptions of Trends in Change and the Future of FGM Practices

As observed by B6, there is a noticeable shift in public perception regarding the practice of FGM. Some parents are beginning to question the urgency of the procedure as awareness grows that FGM has no medical or religious basis. This change in attitude is key to weakening social acceptance of the practice.

"It seems that there has been a change compared to the past." and "What I mean is ee… how, right?, in the past, there were many who did (circumcision). But now, I hear that my child is not circumcised, why should she be circumcised, you know." (B6)

The observed decline in FGM occurrences is also linked by D4 to a decrease in demand from the community. This indicates a gradual decline in prevalence driven by increasing awareness of the negative impacts of FGM and changes in social norms:

"Decreasing, Ma'am, decreasing. In the past, we used to have circumcision every day, but now it's only about twice a week." (D4)

Participant D4 expressed optimism that the practice of FGM can change, following the path of family planning programs. Through continuous education and awareness-raising, public attitudes towards FGM can shift, leading to a gradual decline in the practice. D4 stated:

"…so this (female circumcision) will also be like this later, Ma'am. Slowly, slowly it will change, Ma'am." (D4)

2) The Role of Belief Systems and Social Structures in Sustaining The Practice of FGM

a) The Influence of Beliefs and Customs on the Continuation of FGM Practices

Most respondents emphasized that society views FGM as an important part of legitimate Muslim identity or to be a "true Muslim." Girls or women who are not circumcised are considered less religiously perfect, and some even equate them with non-Muslims: *"Parents say there is no difference between us and non-Muslims." (B3) "…because, Ma'am, if not circumcised, if the perception in society is that, yes, she is a child born to a Muslim mother, a Muslim mother. But, if she is not circumcised, it means her Islam is not perfect." (D1). "The assumption is like that of a non-believer; if not circumcised, she is considered a non-believer." (B1)*

Participants described a strong social stigma against women who are not circumcised. C3 expressed:

"This is said to be a fear of... what is it called, huh? What is the term later, grentelan? Maybe it's a bit flirtatious. Later, one husband won't be enough." (C3)

"Yes, if not circumcised, they say it's hypersexual, later the excess of sex will be here, right? Women's desires are here." (C2)

One participant also described misconceptions about female anatomy and the need for FGM, reflecting the belief that female circumcision is performed to prevent physical abnormalities:

"…because, ma'am, the opinion in the village is that if it is not cut, it (the clitoris) will be long." (D1)

b) Role of Family and Religious Leaders

The Role of Family and Religious Figures in Sustaining FGM Practices

Parents, family members, and religious figures have a significant influence in perpetuating FGM practices across generations. Even highly educated parents can succumb to pressure from older family members, especially grandmothers, who insist on continuing the tradition. Another midwife expressed a similar sentiment:

"Because it's hard for us to say, even though sometimes the parents' education is high, but later the input from the grandmother comes in." (B4)

Grandmothers often become the main drivers of FGM, even when parents are hesitant or starting to open up to alternative perspectives. C1 emphasizes this role: *"They accept it, but one who doesn't accept it is the grandmother, that's the one who wants it." (C1)*

Religious figures are also actively instructing families to ensure that their children remain circumcised, often disregarding medical advice and legal prohibitions. B2 reinforces this by stating:

"When they came, they said, 'Actually, mmm… Ma'am, you are the one who should be doing this together with the children, just 6 of them, 4 of them…' and 'How come my child hasn't been circumcised yet?'. 'It's okay, they're already in 4th grade, what else? No need to circumcise anymore, Ma'am'. 'Ma'am, the teacher said'. 'There's nothing wrong with that, it's just a matter of tradition'. 'Well, Ma'am, the point is you should just do it." (B2)

c) Involvement of health workers in preserving FGM practices

Participants expressed that even health workers, who should be the ones rejecting this practice due to their medical background and higher education level, are actually involved in or support FGM due to cultural, religious, and social pressures. One participant emphasized this contradiction: *"Even though they are health professionals, school teachers too, they still take their children to be circumcised. The health workers are the same, 'Please, help me circumcise my child. You know, Ma'am, according to the law, it's not allowed to circumcise girls anymore. But, how about it, Ma'am, it's Islam.'" (C2)*

Another participant shared their personal experience, showing how health workers themselves continue this practice. This reflects that their awareness of the negative impacts of FGM has not fully changed their behavior:
"Personally, I also circumcised my child. Even though I did it myself, you know. I mean, we might be afraid, right, Ma'am? It seems that in the past, almost half of them did it, right? It can cause rigidity, you know, Ma'am. So, it can create future problems for family health, maybe, Ma'am. That's why if we already know about this, we shouldn't take it to the extreme as a requirement, because if we take too much, yes, Ma'am. Because that area is, you know, maybe they are afraid of that." (B3)

Even health workers with higher education, such as specialist doctors, still seek female circumcision services for their children, which further reinforces the normalization of this practice in society. This is illustrated by B5: *"As I said earlier, even the child of a specialist doctor doesn't want to be uncircumcised. They were brought to me." (B5)*

The strong influence of religious beliefs is one of the main drivers for health workers to continue this practice, even though they have a professional understanding of its negative impacts. A3 emphasizes this:
"Health professionals, ma'am, on average. If I say the children of midwives and doctors, religion, ma'am. But if it's the children of health professionals, they look at what I do in more detail, they really want to know, 'Ma'am, how is it?'" (A3)

3) Ethical Dilemmas and Professionalism of Midwives and Policy Harmonization

Midwives express that they face a complex dilemma between the medical obligation to protect women's health and cultural demands. They are in internal conflict between professional demands and concerns about legal consequences, where midwives are aware of the inconsistency of this practice with health regulations but find it difficult to refuse community requests. This situation creates moral distress, where midwives know the ethically correct action but are constrained by cultural norms that limit their professional autonomy.
"It feels like I want to say 'just to me, just to me'. If I say that, I announce it, I'm afraid to post it on social media, and then I'm asked, it seems like we... we are the ones recommending our place when our intention is to break that chain. But I don't dare, right? It's impossible to reprimand, right, ma'am." and "Because I have done it before, ma'am. I just set conditions because I am really afraid of the regulations. I mean, I'm also afraid, right? Afraid, I mean suddenly, what if, ma'am? First for her, then honestly I'm also afraid for our practice, we don't want our practice to be affected because of things like that." (A3)

Participants also describe female circumcision as a complex dilemma, referring to it as "eating the fruit of simalakama," which reflects the conflict between medical responsibility and cultural demands. This forces midwives to be in a difficult position, where they must balance professional ethics and societal expectations.
"(Female circumcision) is actually like eating the fruit of simalakama for us, especially if we are from health." (B6)

Caught between cultural tradition and legal uncertainty, some midwives report anxiety when practicing FGM, fearing legal consequences even though the practice has long been rooted in society. One midwife stated:
"Because we have known this for several years now, right? We know this is the rule, so we are also afraid, right? I mean, we hope no one reports this to the government, right." (B3)

B3 also highlights the need for collaborative policy development between religious leaders and health authorities to resolve conflicts between traditional practices and medical standards, as well as to ensure that midwives have consistent guidance:
"Just synchronize the agreement between the scholars and health. Don't confuse us who are on duty, right?" (B3)

3.2 Discussion

1. The Opinions and Roles of Midwives in FGM Practices

The research results indicate that respondents' views on FGM practices are influenced by three main factors: medical, cultural, and religious. From a health perspective, most of them do not accept this practice because it lacks medical benefits and can even pose negative impacts, including decreased sexual pleasure for women. In regions like Aceh, this practice is considered a hereditary legacy tied to Islamic identity. Some of them also believe that FGM has religious or moral purposes, such as purifying the body or controlling women's sexual desires.

Tarr-attia et al. (2019) also explain that although they are aware of various health complications related to FGM, including sexual function disorders and issues during childbirth, most midwives still advocate for the cessation of the practice. On the other hand, they also argue about the importance of maintaining traditional values for girls [9].

Research results in Nigeria reveal that more than 90% of respondents (doctors and nurses/midwives) identify this practice as harmful [10]. Most nurses and some doctors are still influenced by their cultural values, even

continuing the practice within families because they feel it is an obligation that must be fulfilled [11]. In Australia, midwives also show a strong rejection of FGM and deep empathy for female victims of FGM, emphasizing the various negative impacts of the practice on women's health [12].

Isman et al. (2013) state that midwives view FGM as a significant cultural and religious practice, often feeling conflicted between their professional duties and personal beliefs against it. Many midwives acknowledge the harmful consequences of FGM, having experienced it themselves, which enhances their counseling effectiveness [13].

To create sustainable change, uniformity in midwives' views on FGM is necessary and can be achieved through standardized training and dialogue spaces to align medical knowledge with socio-cultural realities.

In this study, participants also emphasized the importance of forming partnerships with religious leaders to change community perceptions. It was stated that official statements from religious scholars regarding the non-obligation of FGM in Islamic teachings are considered more effective in changing community attitudes compared to campaigns conducted solely by health workers. This strategy is supported by Mahmoodi's (2016) findings, which highlight the importance of re-evaluating religious interpretations, as this is one of the main reasons why communities continue to uphold the practice of female circumcision [14].

In addition to religious leaders, midwives also see the importance of involving community figures, such as senior midwives, in conveying messages of change. This approach aligns with Rogers' (2003) Diffusion of Innovations theory, which states that social innovations are more quickly accepted when communicated by figures who have authority and are respected by the community [15].

The involvement of religious and community leaders in anti-FGM campaigns is not only an effective strategy but a crucial one, as the transformation of culturally rooted practices requires legitimacy from authorities recognized by the community, while also demonstrating that sustainable social change must arise from within the community itself, rather than being imposed from the outside. Some midwives also noted a decrease in demand for FGM practices in recent years, indicating a shift in social norms. This finding is reinforced by Shabila's (2021) report on the significant decline in female circumcision practices, especially among younger age groups, highlighting the crucial role of women's education that needs to be a primary focus in efforts to eliminate it [16]. According to Shell-Duncan et al. (2016), there are indications that communities in some areas are beginning to show openness to change and the possibility of abandoning FGM practices. Furthermore, most women who have undergone circumcision wish for the practice to be stopped or feel uncertain about whether it should continue [17].

The reported decrease in demand for FGM by informants indicates that investments in women's education and reproductive health awareness are beginning to yield results; however, this momentum needs to be strengthened with evidence-based interventions targeting the younger generation while empowering women as agents of change within their families and communities. Nevertheless, they remain wary of the possibility that this practice may continue among traditional healers if there is no strict oversight and regulation. Pressure from family and social environments remains a major barrier in efforts to eliminate this practice. Therefore, a holistic and sustainable strategy is needed, including strengthening legal regulations, involving religious and community leaders, and empowering women as key actors in social change.

2. The Role of Belief Systems and Social Structures in Perpetuating FGM Practices

The research findings indicate that FGM practices are considered an integral part of Islamic identity in Aceh society. Women who are not circumcised are perceived as not fully practicing their religion, and in some cases, are equated with non-Muslims. This belief is reinforced by the view that FGM is related to spiritual purity, such as eligibility to lead in religious activities. These findings align with studies showing that many communities believe that FGM has religious foundations, particularly in Islamic teachings, thus considering it a religious obligation or a requirement to maintain the purity and Islamic identity of women [17]. The misconception linking FGM with Islamic identity in Aceh calls for a more intensive religious education approach, where scholars and community leaders need to be actively involved to correct the interpretation of Islamic teachings.

The FGM practice is also viewed as a means to control women's sexuality. According to the respondents, the community believes that this action is necessary to suppress women's sexual desires and to avoid behaviors considered immoral, such as infidelity towards partners. This notion reflects the influence of the patriarchal system in controlling women's bodies through social norms.

Similar to the report by Oguntoye et al. (2009) that FGM is often practiced with the belief that it controls women's sexuality, ensures purity, and reduces promiscuity. This belief is common in many communities where FGM is practiced, as it is seen as a way to uphold cultural traditions and social norms [18]. FGM is also often justified within a patriarchal system as a means to control women's sexuality and ensure virginity before marriage, which is considered important for maintaining family honor [19]

The claim that FGM is a controller of women's sexuality actually reflects gender injustice within a patriarchal system, where control over women's bodies is legitimized through moral and cultural narratives. Therefore, efforts to deconstruct social norms based on gender equality are needed to change this paradigm. Additionally, this study found medical misconceptions in society, such as the belief that the clitoris will grow too long if not cut. In line with the findings of Atibinye et al. (2007), various myths surrounding FGM circulate, one of which is that the clitoris is cut

before a woman gives birth to prevent the baby's head from touching the clitoris, as it is believed to cause the baby's death during childbirth [20].

This indicates that accurate education on anatomy and reproductive physiology must be prioritized to correct dangerous medical myths surrounding FGM that have become embedded in the collective consciousness of society. FGM is also maintained through cultural inheritance across generations, positioning tradition as something that must be preserved without question. Ancestors are regarded as the highest cultural authority, and any form of rejection of this tradition is seen as a deviation from local values. This phenomenon aligns with Pierre's (1977) theory of habitus, which explains how socially inherited practices become so internalized that they are considered normal and natural [21].

Furthermore, the results of this study also show that the family environment, older generations, especially grandmothers, play a significant role in maintaining the practice of FGM. Even when parents have doubts or higher levels of education, including the role of fathers, they often find it difficult to reject the requests of previous generations due to strong cultural pressure. Children are also not free from the influence of social norms, with peer pressure being a factor that reinforces the continuation of this practice from an early age.

Grandmothers often serve as the primary decision-makers in the practice of FGM, holding significant authority over gender and social norms within families and communities. Additionally, peer pressure, especially among women, plays an important role in maintaining the practice of FGM. Women who have undergone the procedure often exert social pressure on their peers to conform to the practice [22]. The role of men, particularly fathers, husbands, and community leaders, is crucial in stopping FGM. Their acceptance or rejection of this practice largely depends on social constructs, religious doctrines, and health literacy. [23].

Religious leaders have a significant influence in legitimizing the practice of FGM according to the respondents. They are often the primary reference for the community regarding matters considered related to religion, including supporting or advocating for the implementation of FGM. In some cases, they also pressure health workers to continue this practice. This phenomenon indicates that the influence of religious leaders on religious issues can surpass state authority or public health policies.

The report by Mahmood et al. (2022) explains that religious leaders are often viewed as key figures in shaping community behavior and attitudes toward FGM. In areas such as the Kurdistan Region of Iraq, religious leaders are frequently consulted for advice on FGM, highlighting their potential influence in either perpetuating or challenging the practice [24]

The data from this research also proves that although midwives and other health workers ideally play a role as primary agents of change in preventing the practice of FGM, the reality still shows a disparity between scientific understanding and implementation at the community level. A study by Suluhan et al. (2023) revealed significant differences in the intention to perform FGM between groups of female health professionals (30.6%) and the general mothers' group (99.7%). These findings indicate that higher education levels and better economic status among health workers correlate with a more critical assessment of the practice of FGM. Nevertheless, the fact that nearly one-third of health workers still consider continuing this practice indicates that the transformation of knowledge does not always align linearly with changes in attitudes and practices [25].

FGM persists through cultural inheritance reinforced by the roles of grandmothers, peer pressure, religious legitimacy, and the incongruence of health workers' roles, necessitating a multisectoral approach targeting all key actors simultaneously.

3. Dilemma of Ethics and Professionalism of Midwives and Policy Harmonization

This research reveals that midwives face complex ethical and professional dilemmas between the obligation to protect women's health according to medical standards and the pressure of cultural norms that still accept female circumcision. The multidimensional complexity faced by respondents in implementing the ban on FGM in Indonesia, particularly in regions with strong traditions like Aceh, creates conflicts. On one hand, midwives' efforts to reduce risks by taking over the practice create dual ethical conflicts: this practice contradicts the principle of non-maleficence as it perpetuates unnecessary medical interventions, while on the other hand, these efforts reflect the tension between the principle of beneficence (protecting reproductive health) and respect for the autonomy rights of clients and families in culturally-based decision-making.

On the other hand, midwives are caught in a profound structural dilemma between the professional obligation to comply with health regulations and the socio-cultural demands of a society that views FGM as an integral part of religious identity and ancestral traditions. This situation creates a paradox where midwives strive to minimize harm while still engaging in medically unjustified practices, all while balancing professional obligations and respect for patient autonomy in a unique cultural context. Furthermore, this is exacerbated by unclear regulations and inconsistencies in policy implementation at the local level, creating a gray area that triggers cognitive dissonance among healthcare workers, where midwives are forced to violate formal rules to meet social expectations.

According to Festinger (1957), this cognitive dissonance is a psychological condition where an individual feels uncomfortable due to both professional responsibilities and moral obligations because there is a dissonance between their beliefs, attitudes, or behaviors [26]. Midwives experience moral pressure as they are considered to

"betray" religious values if they refuse FGM and professional stress due to the lack of clear guidance between medical standards and societal demands, thus creating a highly pressurized environment for them to maintain the status quo.

The study conducted by Johansen et al. (2013) illustrates that laws prohibiting FGM can prevent the practice, provide legal protection for women, and support healthcare workers in refusing FGM requests. The effectiveness of the law increases when accompanied by education, advocacy, and good implementation. One of the legal challenges related to FGM is that this practice tends to be carried out secretly to avoid sanctions [27].

Respondents emphasized the importance of synergy between health authorities and religious leaders to create consistent policies. This approach is consistent with the study by Winter (2014), which states that health authorities often collaborate with local organizations and religious institutions to create awareness programs that highlight the harmful effects of FGM and promote its abandonment [28]. International and national health organizations advocate for the involvement of religious leaders in campaigns against FGM, recognizing their potential to influence community norms and practices [29].

This approach is also in line with the recommendations of Norwegian Church Aid (NCA), which suggests interdisciplinary dialogue to address harmful practices without disregarding local values. According to its report, several religious figures and local authorities have expressed a joint commitment to reject FGM practices, as a result of cooperation between NCA and its partners. Some religious leaders even set positive examples by personally choosing to protect their daughters from FGM practices and early marriage. In some regions, such as Puntland, religious leadership has become more organized and connected through coordination with the Ministry of Justice, thus supporting efforts to reject this practice more effectively [30].

Without systemic support addressing the structural dilemmas faced by midwives, the ban on FGM will only be a policy on paper that fails to address the cultural and religious complexities on the ground, making strategic collaboration between health authorities and religious leaders key to creating effective policies that integrate religious legitimacy with medical evidence while ensuring that normative changes are not only top-down but also culturally accepted..

4. CONCLUSION

The results of this research illustrate the complexity of midwives' roles in FGM as implementers of circumcision at the request of the community and as agents of change providing education. They are also in a unique position: on one hand, they strive to comply with health regulations; on the other hand, they face deeply rooted societal expectations.

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