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What makes a woman? Understanding the reasons for and circumstances of female genital mutilation/cutting in Indonesia, Ethiopia and Kenya

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ABSTRACT

This study presents the reasons for, and circumstances of, female genital mutilation/cutting (FGM/C) in Indonesia, Ethiopia and Kenya. Data were collected in 2016 and 2017 by means of a household survey conducted with young people (15–24 years) and through focus group discussions, in-depth interviews and key informant interviews with youth and community stakeholders. The study findings confirm previously documented reasons for FGM/C, noting that these reasons are interconnected, and are rooted in gender norms. These reasons drive the alterations of bodies to produce a 'cultured' body in the form of the 'pure body' among Sundanese and Sasak peoples in Indonesia, the 'tame' body among the Amhara people in Ethiopia and the 'adult body' among the Maasai people in Kenya. While health workers and parents are important decision-makers in each setting, young Maasai women are, at times, able to exercise their agency to decide whether to undergo FGM/C, owing to their older age at circumcision. Changing legal and social contexts in each setting have brought about changes in the practice of FGM/C such as increased medicalisation of the procedure in Indonesia. The clear links between the different drivers of FGM/C in each setting demonstrate the need for context-specific strategies and interventions to create long-lasting change.

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Introduction

Female Genital Mutilation/Cutting (FGM/C) or Female Circumcision,[1] includes any partial or total excision of the external female genitalia for non-medical/non-therapeutic purposes (United Nations Population Fund (UNFPA) 2020). It is a practice found in some communities in Sub-Saharan Africa and Asia. Cited reasons for FGM/C include

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psychosexual reasons that aim to limit the sexual desire of women and maintain their virginity, sociological reasons which include initiation rites, hygiene and aesthetic reasons, myths about the enhancement of fertility, and religious reasons (United Nations Population Fund (UNFPA) 2020). Convention theory posits FGM/C as a self-enforcing practice. Community-wide social sanctions influence individuals to conform to social norms to continue the practice (Mackie 1996). Across contexts and settings, there is considerable variation in the practice and its social meaning. This study presents findings from three case study investigations unpacking the reasons for and circumstances of FGM/C and their social meaning within the Sundanese and Sasak communities in Indonesia, the Amhara community in Ethiopia, and the Maasai community in Kenya.

In Indonesia, FGM/C is increasingly medicalised. From an initial ban imposed by the government in 2006, the practice was allowed to be conducted by health providers in 2010 following a *fatwa* issued by the Indonesian Ulema Council. This *fatwa* stated that FGM/C was considered a rule of Islam and that the membrane covering the clitoris should be removed. In 2014, this law was repealed (UNICEF 2019). However, medical FGM/C still continues. International agencies have strongly condemned such practices, citing research that more skin is being removed by health providers using scissors as opposed to a traditional prick of the clitoris (Newland 2006; Budiharsana, Amaliah, and Utomo 2003). Almost half of girls under the age of 12 have undergone some form of FGM/C in Indonesia, mostly between the ages of 1 and 5 months (UNICEF 2019). Type 4, Type 1 and symbolic methods have most commonly been reported in seven regions in Indonesia (Imelda et al. 2018). Religious Islamic discourse, medicalisation and the desire for cultural preservation perpetuate the practice and have shifted the discourse to one focusing on hygiene (Putranti et al. 2003; Putranti 2008).

In Ethiopia, the type of FGM/C, its timing and the reasons for it differ by ethnic group, although it is usually carried out on the eighth day after birth (28TooMany 2013). FGM/C is practised as a pre-requisite to marriage or childbirth, to control the sexual desire of women, as a marker of cultural identity, as part of a puberty rite, for religious reasons, to guarantee social acceptance, for reasons of hygiene, and to safeguard a woman's virginity (Boyden, Pankhurst, and Tafere 2012; Bogale, Markos, and Kaso 2014; Gebremariam, Assefa, and Weldegebreal 2016). FGM/C has been criminalised in Ethiopia since 2006. In the Amhara region, according to the 2016 Demographic Health Survey (DHS), 65% of women were exported to have undergone FGM/C, with a majority reporting a type that 'involved cutting and removal of flesh' (CSA Ethiopia and ICF 2017)

In Kenya, FGM/C is prohibited by law. While the national prevalence of female genital cutting (women 15–49 years), was 21% in 2014, among the Maasai, it was 78% (KNBS 2015). Of these Maasai women, 92% reported being 'cut and having some flesh removed' by a traditional circumciser, and more than half reported being circumcised between 10 and 14 years. For the Maasai, FGM/C constitutes a rite of passage or initiation ceremony from childhood to adulthood and plays an important role in defining women's roles and identity including those of being a wife and mother (Esho et al. 2010). However, norms may be changing as a majority of Maasai women in the 2014 DHS national study did not find it a requirement for the community and thought that it should not continue (KNBS 2015).

Methodology

Study settings

The mixed methods study was part of a baseline investigation conducted for the *Yes I Do* (YID) programme aimed at reducing child marriage, teenage pregnancy and FGM/C.[2] The programme and study was implemented in West Lombok and Sukabumi districts in Indonesia, Bahir Dar and Qewet *woredas* (districts) in Ethiopia, and Kajiado County (West and Central) in Kenya due to the reported prevalence of child marriage and FGM/C in these contexts.

Data collection

In each setting, focus group discussions (FGDs) were held with young women and men (15–24 years) separately, and with parents or caregivers. Purposive sampling ensured that participants had varying genders, ages, education levels, and marital statuses. In-depth interviews (IDIs) were also conducted with young people, parents and caregivers, traditional or religious leaders, elderly women – some of whom were (former) circumcisers, teachers, health and social workers and community-based and youth organisation staff. Key informant interviews (KIIs) were conducted with district level and non-governmental organisation staff.

A two-stage cluster household survey was also carried out in each country setting, randomly sampling about 1400 young people (15–24 years). Table 1 details the methods and study participants. An overview of the sampling of study participants is presented in online supplemental file 1. Data were collected between July and September 2016 in each country. In Ethiopia, an element of data collection took place in July-August 2017 due to security concerns.

Quantitative data were collected using ODK Collect on tablets. Qualitative and quantitative data collection tools were contextualised, translated and piloted in each country. The tools were informed by Mackie's (1996) social convention theory (Mackie

Table 1. Overview of methods and participants.[a]

Method	Participants/Respondents	Indonesia	Ethiopia	Kenya
Focus Group Discussions	Young women (15–24 years)[b]	8	11	4
	Young men (15–24 years)[c]	6	7	3
	Parents, caregivers, elderly women and chiefs[d]	2	4	4
In-depth interviews	Young women (15–24 years)	7	10	4
	Young men (15–24 years)	5	13	4
	Parents, caregivers, elderly women	4	2	4
	Traditional/ religious leaders	4	3	2
	Teachers	3	3	1
	Health/ social workers	9	6	1
	Community-based/ youth organisation staff	3	1	1
Key informant interviews	Non-governmental organisation staff	3	1	1
	District-level government officials	9	7	4
Survey		1,534	1,602	1,368

[a]The total number of interviews and FGDs varied per country, depending on when data saturation was being reached regarding all the issues covered by the baseline study, i.e. issues around child marriage, teenage pregnancy and FGM/C.
[b]These were disaggregated by age (15–19, 20–24).
[c]These were disaggregated by age (15–19, 20–24).
[d]The FGD with Chiefs was only conducted in Kenya.

1996). Approximately 10% of the survey and a larger part of the FGD and IDI topic guides focused on FGM/C. The data were collected by a team of research assistants, led by co-authors from each country. Research assistants interviewed participants of the same gender and from similar age groups. They were trained on ethics, research techniques and the importance of 'doing no harm', given the sensitive nature of the topic. Daily de-brief sessions were held by co-authors to discuss challenges arising and how they might be overcome.

Data analysis

Descriptive statistics relating to the quantitative data were calculated using Stata.

Qualitative data were audio-recorded with consent, transcribed verbatim and a content analysis was conducted using NVivo. The co-authors developed an iterative coding framework based on the study objectives and main emerging themes. Analysis took place inductively and informed the development of cases. The three settings as cases aim to capture the nuances and context-specific nature of FGM/C (Crowe et al. 2011). In each country, during data analysis, validation sessions were conducted to discuss preliminary findings with key stakeholders such as civil society, government officials, traditional and religious leaders, parents, health workers and young people.

Ethical considerations

Study participants provided written informed consent. In the case of minors, consent was obtained from parents or caregivers, and assent from the child. Where needed, approval was obtained from the district office and from traditional leaders. Ethical approval for the study was granted by the KIT Royal Tropical Research Ethics Committee and the Research Ethics Committee of the Faculty of Public Health, University of Indonesia, the Ethical Review Committee of the Amhara Region Public Health Institute in Ethiopia, and the ethics committee of the African Medical and Research Foundation (AMREF) in Kenya.

Findings

The principal demographic characteristics of survey respondents are shown in Table 2. In Ethiopia and Kenya, many young people participating in the IDIs and FGDs had a minimum of primary education, while in Indonesia, more participants had received secondary education. In all countries, there was a mix of married and unmarried young participants. The majority of key informants were male in Ethiopia and Kenya, while in Indonesia, there was a mix of key informants who were male and female.

Table 2. Demographic characteristics of survey respondents (%).

Variable	Indonesia	Ethiopia	Kenya
Total (N)	1,534	1,602	1,368
Gender			
Female	75.4	70.6	74.4
Male	24.5	29.3	25.5
Missing	0.0	0.0	0.0
Age			
15–19	62.7	63.1	64.8
20–24	37.2	36.5	35.1
Missing	0.3	0.0	0.0
Marital status			
Married	26.6	23.0	21.2
Single	49.2	62.3	64.5
Boy/girlfriend(s)	21.1	6.5	12.4
Other (divorced, widowed, separated)	3.0	8.1	1.3
Missing	0.0	0.0	0.3
Religion			
Christian	0.07	77.5	94.3
Muslim	97.1	7.6	0.3
Hindu	2.8	0.0	0.0
Other	0.0	0.0	0.1
No religion	0.0	14.5	3.7
No answer	0.0	0.0	0.5
Missing	0.0	0.1	0.8
Schooling status			
In school	43.3	86.2	69.5
Out of school	56.1	13.8	25.0
Missing	0.4	0.0	5.3
Ever dropped out of school			
Yes	15.3	51.9	22.4
No	84.6	45.4	76.7
Missing	0.0	2.6	0.8

Sundanese and Sasak community in West Lombok and Sukabumi districts, Indonesia

The act of FGM/C

Among the Sundanese and Sasak peoples, FGM/C was known locally as *coke*, *koet*, *dicongkel* -terms which mean 'to scoop out' in Sukabumi, and *tesuci* or *tesucian* meaning 'to sanctify the female genitals' in West Lombok. Ninety-two percent (92%) of young women in Sukabumi and 53% in West Lombok reported being circumcised. In some cases (14.5%), however, young women did not know if they had been circumcised. If they did know, they did not know the type of FGM/C, as the procedure usually occurred on the 30th or the 40th day after birth. There was variety in how they described the act, indicating a lack of knowledge or a diversity of practices. According to one key informant in Sukabumi, the act of circumcision was a formality with almost no bleeding involved, while a traditional birth attendant in West Lombok explained that there was no cutting involved.

Traditionally, FGM/C was reported to be carried out by a traditional birth attendant (*paraji, mak beurang* or *belian*). Due to the prior enactment and consequent repeal of a law preventing health workers from conducting FGM/C, many parents still mentioned going to the midwife, nurse or doctor, some of whom still conducted FGM/C.

> 'When we go to the midwife [for FGM/C], we were told not to. Then [we would] go to [the] *paraji* [instead]. The *paraji* would say, "Don't tell the midwife" [that you are here for FGM/C]' – Parent, FGD, Sukabumi

According to the traditional birth attendants in Sukabumi, FGM/C was carried out by 'nicking' the clitoral hood with a knife or a needle, while two colonial Dutch coins (*sekepeng*) were used to rub the clitoris in West Lombok. This was done until 'the dark part' was removed or some liquid or blood was shed, after which prayers were said. If a blade was used, it was to 'leave a mark' or at times make a small cut.

Reasons for FGM/C

Young people indicated that circumcision was intended to 'remove excrement' or *najis* (i.e. impurities) from the girl. Women were perceived to have more *najis* than men, and if not removed, 'the part' would become dirty. Young people, particularly men, believed that FGM/C would ensure cleanliness and some parents referred to it as 'purification' or 'sanctification'. A young woman (FGD, 20–24 years, Sukabumi) said that FGM/C could 'save the woman' from diseases, a reasoning shared by male participants for male circumcision. Another young woman (FGD, 20–24 years, Sukabumi) mentioned that circumcision helped prevent the lips of the vagina from becoming too big.

According to young people and stakeholders in West Lombok and Sukabumi, circumcision was considered an 'obligation' in Islam or *sunnah* (i.e. recommended). Its absence was *haram*. One key informant, however, acknowledged that *khitan* (FGM/C) was performed prior to Prophet Ibrahim's time and although it was obligatory for men, it was optional for women and should be limited to cutting the wrapping skin (referring to the clitoral hood) which Islam permitted. She emphasised that 'If it will do harm to the patient, doctors won't do it'. Seventy-three percent (73%) of young people indicated that their religion recommended FGM/C. However, when young men in Sukabumi were asked to elaborate on which *hadith* or verse indicated this, they could not do so.

FGM/C was also believed to control sexual desire in a woman, a perspective particularly prevalent in Sukabumi. Uncircumcised women were considered as having a bigger sexual drive than men in both districts by women and men of all ages. In both districts, there was a common belief, particularly among young men, that FGM/C would reduce a woman's sexual desire which would otherwise be nine times that of a man's.

Marriageability was not a major driving force behind FGM/C. However, in line with the survey data, 63% of young men reported preferring circumcised partners– despite not knowing any specific advantages of the practice (see supplemental file 2). Most participants and a majority of young people did not think that FGM/C caused menstrual, sexual, fertility or labour-related problems.

Decision-making

In West Lombok and Sukabumi, parents were primary decision-makers but were influenced by the circumcisers' willingness. The family and community were influential in the decision-making process and mothers were held accountable if their daughters had not been circumcised.

Of the young people surveyed, 76% of young women and 69.5% of young men wished to circumcise their daughter in the future. Parents and few young women justified this as they had gone through this themselves. Midwives and some traditional birth attendants refused to conduct FGM/C but they had to negotiate their role with parents. A traditional birth attendant in West Lombok opposed FGM/C, but neither actively prohibited or supported it in her practice while a traditional birth attendant (in Sukabumi) would make exceptions (breaking the law) if parents had travelled from afar. In response to parents' insistence, nurses in West Lombok and Sukabumi would pretend to do FGM/C by rubbing cotton (on the clitoris) so as to appease parents.

> 'From the perspective of health and my religion [Islam], there is no teaching about FGM/C … We are not allowed to mutilate it because … if the nerves were damaged … I am not sure whether she can experience orgasm … I have never advised, but, I also have never prohibited such practice. You may do it if you think the myth fits with your beliefs and understandings … ' – Traditional birth attendant, IDI, West Lombok

Amhara community in Bahir Dar and Qewet districts, Ethiopia

The act of FGM/C

In Bahir Dar and Qewet, young women (FGDs) and key informants, and a young man (IDI, 19 years, Bahir Dar) reported that FGM/C was 'still' practised, albeit in a clandestine way. While 22% of surveyed young women did not know whether they had been circumcised, 54% reported having been cut. However, three-quarters of these women did not know the type of FGM/C, which might be explained by the early age of FGM/C (seven days post-birth). According to one young woman (FGD, 15–24 years, Bahir Dar) and a key informant, the likelihood of FGM/C fell after the eighth day and decreased further after two years of birth. Qualitative data point to elderly women acting as circumcisers.

> 'On the 7th day of the birth, FGM/C would be practised … but sometimes a girl may stay [uncircumcised] till [she] becomes 2 years. If [the] girl's age passes two years, the probability of circumcision will decrease.' – Young woman (15–24 years), FGD, Bahir Dar

Due to FGM/C's illegal status, different strategies were used to evade the law and maintain anonymity such as arranging for circumcisers from outside the community to undertake the procedure or travelling to remote villages. However, as one key informant explained, bringing in circumcisers from outside the village was an expensive affair which deterred some parents. At times, according to the same key informant, parents pretended they had sons, or that they were celebrating another male circumcision or social gathering, when organising their daughter's FGM/C.

Reasons for FGM/C

The community, including young people, believed that FGM/C would help a young woman find a good husband in the future. One young woman (FGD, 15–19 years, Qewet) shared that uncircumcised women could be cut by private health professionals at the time of marriage. An uncircumcised woman was perceived as being disobedient and aggressive (towards the husband), as stated by a young man (FGD, 15–19 years,

Qewet) and two key informants. She would 'break utensils', a metaphor commonly used to describe disobedience and aggression, as reported by a few young people and a grandmother. There were accounts of women being returned or divorced by their husbands if they were found to be uncircumcised.

> '… no parents would be willing to face the humiliation of their daughter returned to her parents after marriage when the husband finds that she is not circumcised.' – Key informant, Bahir Dar

Although there seemed to be a clear link between FGM/C and marriage, our survey results showed that only a few young men (24%) preferred a circumcised partner.

FGM/C was also perceived as making women feminine, with two key informants reporting that uncircumcised women were called *woshela* or someone with masculine traits. Participants including parents, key informants and young people frequently mentioned that FGM/C was perceived to influence a woman's sexual desire and performance. Some believed this was due to changes in the anatomy of the vulva and the clitoris, but others stressed changes in sexual satisfaction. As indicated by young women, key informants, a grandmother and fathers, it was commonly believed that husbands faced difficulty penetrating an uncircumcised woman and satisfying her due to her high(er) sex drive.

Avoidance of complications during childbirth was another reason for FGM/C. According to some participants, including young people and mothers, there was a belief that if uncut, the clitoris or the 'upper part' of the vagina would grow and gradually cover it, which would cause difficulties giving birth.

> 'If clitoris is not removed, it is believed that females face severe labour and maternity complication because clitoris grow and cover the entire female genital organ.' – Mother, FGD, Qewet

Many participants including young women described instances where labour was harder for uncircumcised women. Hence, circumcisers, who had previously been dissuaded to continue this practice, were asked to return.

Other reasons for FGM/C included hygiene, ease of urination and maintaining moral purity. There seemed to be few links to religion, a fact that which was confirmed by an Orthodox Christian religious leader, and most young people (64%) did not believe that their religion promoted FGM/C. While people were largely convinced of the benefits of FGM/C, there were some dissenting voices (including one religious leader) in the community. There was considerable awareness regarding the harmful effects of FGM/C – particularly on women's health, however young men exhibited low levels of awareness. A few young men, a key informant and a teacher felt that rates of FGM/C were declining faster than those of child marriage.

Decision-making

Because of the early age of FGM/C, parents were the primary decision-makers. Women, particularly mothers, played an important role in this respect.

> 'Mostly mothers assisted by paternal uncles or aunts are responsible for FGM/C.' – Young man (24 years), IDI, Bahir Dar

> 'No doubt, even currently, mothers acknowledge FGM/C as important. They say FGM/C is not important if you ask them because they know that it is criminalised. Otherwise they all need FGM/C for their daughters.' – Religious leader, Bahir Dar

Extended family members such as grandmothers, aunts or paternal uncles may assist mothers in their decision-making and help with arrangements for the FGM/C. In only a few cases fathers are involved. According to one young man (IDI, 24 years, Bahir Dar), because mothers mainly care for the baby, fathers are unable to prevent FGM/C.

Most young people spoke of other people's beliefs, and their own position on FGM/C was not always clear. Forty percent (40%) of self-reported circumcised young women in the survey said they felt 'bad' about it. Citing the example of uncircumcised women in the community who successfully married and gave birth, some young women said they would not wish to continue the practice. Of young people surveyed, 72% indicated that they would not circumcise their daughters due to various reasons – including the fact that it was illegal and perceived of as unhealthy. In contrast, those who did wish to do so cited cultural reasons as a motivator.

Health workers played an important role as giving birth at health centres prevented FGM/C. According to a young woman (FGD, 20–24 years, Bahir Dar), when delivering at the health centre, mothers were advised not to let their daughters undergo FGM/C. Several (non) governmental efforts were also underway to curb the practice and enforce the law.

Maasai community in Kajiado County, Kenya

The act of FGM/C

In Kajiado County, 60% of respondents agreed with the statement that 'FGM/C is a social norm'. Seen as a form of initiation, it signified the transition from childhood to adulthood. While a few participants such as caregivers and a teacher shared that FGM/C was universally practised, only 52% of young women in Kajiado reported being circumcised, indicating a possible gap between community perceptions and actual practice. Although caregivers, young people and a key informant indicated that FGM/C now took place secretly, others such as a health worker said changing attitudes meant that FGM/C was considered optional.

Young women (FGD, 20–24 years, Kajiado West) shared that the practice, carried out during school holidays, included a cut treated afterwards with paraffin, sugar or cooking fat. According to one young woman (FGD, 15–19 years, Kajiado West), circumcisers sometimes used gloves, scalpels and injections to numb the pain. Of those young women who reported being circumcised, 30% stated they had received a clitoredectomy[3] while 28% reported to have undergone excision. Participants cited different ages of circumcision ranging from 8 to 18 years. According to one young woman (FGD, 15–19 years, Kajiado West), if a woman had an older sibling (male or female), they would likely be cut at the same time. There were a few accounts of uncircumcised women being cut at the time of their marriage and one account of being cut at the time of birth. Elderly women acted as circumcisers. A key informant and several young people were concerned about the health risks due to the limited training of

circumcisers. A young man (FGD, 20–24 years, Kajiado West) revealed that at times, doctors were also complicit and would conduct FGM/C for a fee at the hospital in secret, or at home.

> 'They are not taken to hospital because we all know that the government is against FGM/C, and so they are circumcised at home and celebrations are done later so as not to attract the attention of the government officials.' – Female caregiver, FGD, Kajiado West

In the past, FGM/C was accompanied by a celebration involving the family and community, often planned by older women without the girl's knowledge. While some boys were taken to hospital to be circumcised, girls were cut at home. According to one young man (FGD, 15–19 years, Kajiado West), if a celebration took place, it did so a few months later under the pretext of celebrating a male circumcision or another event to allay suspicion.

Reasons for FGM/C

Participants including youth and community stakeholders shared that girls were considered women once they had been circumcised. This meant that they were free to engage in sex and adult men could now approach these girls. A young woman (FGD, 15–19 years, Kajiado West) shared that 'To be regarded as a woman, you have to be cut'. Many young women and a parent reported that teenage pregnancies were common after FGM/C due to unprotected sex.

> 'The girl disassociates herself with young girls and joins mature people, and thus, practising all that a woman does. This leads to early pregnancy and then early marriage.' – Chief, FGD

A few young women and men, a male caregiver and a key informant mentioned marriageability as a reason for FGM/C in two ways. First, FGM/C enabled young women to find a good husband. Second, even if an uncircumcised woman found a potential partner, she would be cut prior to her wedding day. However, two key informants claimed that there were enough 'role model' uncircumcised women around who were happily married. Fifty-four percent (54%) of young people in the survey thought that FGM/C and child marriage were linked and 66% said FGM/C caused child marriage.

FGM/C was linked to pregnancy, cleanliness and having a good temperament by a few participants. Two young women (FGDs, 15–19 years, Kajiado West) shared that circumcised women would not have difficulty during childbirth, while a key informant, health worker and a male caregiver believed that FGM/C would cause difficulties during childbirth. Those who thought FGM/C brought no benefits were in a minority. Lower libido and sexual feeling as consequences of FGM/C were mentioned by a male caregiver and young woman (FGD, 20–24 years, Kajiado West) respectively.

Almost all participants were aware of the adverse health effects of FGM/C, particularly immediate effects such as excessive bleeding, difficulty in urinating and risk of infection due to the use of unsterilised razor blades. Fifty-six percent (56%) of young men did not prefer a circumcised partner in the future.

Decision-making

Many study participants shared that both parents decided on their daughter's circumcision, with some emphasising the role of the mother, and others the father. According to one key informant, fathers would become involved when girls refused to undergo FGM/C, whereas another key informant shared that fathers often agreed with the law and did not approve of FGM/C. In some cases, grandmothers would intervene to ensure FGM/C was carried out. If one parent did not agree with FGM/C, the other parent could organise it secretly. According to a young woman (FGD, 15–19 years, Kajiado West), parents' decision to circumcise also depended on their literacy levels. Of young people surveyed, 88% indicated that they would not circumcise their daughters, and educational status had no major influence of their response (see supplemental file 2).

According to a key informant, a few parents asked their daughter's opinion on FGM/C. Male caregivers, young women and a key informant shared that many young women chose to be circumcised because of the perceived social benefits. However, another key informant emphasised that many girls were too young to make informed choices and were often influenced by their mothers. In other cases, some girls were forced to be cut despite refusing. Survey findings indicate that young women had mixed feelings about being circumcised, with 56% feeling 'bad' about it while 32% felt 'good'. Among those who felt bad about it, 30% had had their FGM/C done secretly, while the latter said they volunteered to be cut due to peer pressure or to strengthen the bond with peers and the community.

Discussion

Different frames of FGM/C

In Indonesia, reasons for FGM/C are inter-connected at the nexus where religion, tradition and control over women's sexuality meet (Octavia 2014). Participants' interpretations of Islam frame women's sexuality as insatiable and therefore dangerous. Alongside this is the need for cleanliness and the removal of *najis*, making the practice a purification ritual (Newland 2006). The natural body at birth is considered impure and requires physical manipulation (Finke 2006) to become a 'pure body' – clean and with a limited sex drive.

Boyden, Pankhurst, and Tafere (2012) explain that for the Amhara and Tigray in Ethiopia, the 'cultural logics of circumcision are both related to subordination of women … and … control of reproductive capacity' (Boyden, Pankhurst, and Tafere 2012: 20). FGM/C is believed to promote sexual compatibility (Gebremariam, Assefa, and Weldegebreal 2016; Boyden, Pankhurst, and Tafere 2012) and prevent difficulty while giving birth (Boyden, Pankhurst, and Tafere 2012). FGM/C is used as a strategy to ensure wives' obedience evidenced by some cases where uncircumcised young women undergo FGM/C prior to marriage. Beliefs about the growth of an uncut clitoris, and difficulty penetrating an uncut woman further reinforce misconceptions about women's bodies. Hence, within this context FGM/C transforms the to-be woman into a 'tame' body, – tame with regard to sexual desire and obedience.

Among the Maasai, the cut symbolises a transition from girlhood to womanhood and readiness for marriage (Esho, Enzlin, and Van Wolputte 2013). Our findings indicate that womanhood does not imply marriage, but implies sexual activity. FGM/C results in an 'adult body' and subsequently young girls can behave like adult women. While FGM/C aims to reduce young women's sex drive among the Sundanese, Sasak and Amhara, it functions as a signal for young Maasai woman to become sexually active.

The cultured body

Although studies internationally have shown that FGM/C can cement a 'traditional' female identity, which can be in flux with values from Europe and North America (Public Policy Advisory Network on Female Genital Surgeries in Africa 2012), this study reveals a different picture. FGM/C drives certain ideals about what a woman should be like and their bodies become the medium through which these beliefs are exercised. Body markings such as the cutting of the clitoris are used to construct and shape specific social and gender identities as suggested by Esho, Enzlin, and Van Wolputte (2013) and Kwaak (1992). In its natural state, the body is 'unappealing' and must be made 'smooth, cleansed and refined' (Shweder 2000).

Navigating agency

The cultured body shuttles between being an active or passive agent in the act of FGM/C. If agency is understood as being possessed by a physical body, agency often lies with family members who are caretakers of the body. Parents, particularly mothers, have a crucial role to play in managing FGM/C (Bogale, Markos, and Kaso 2014; Gebremariam, Assefa, and Weldegebreal 2016; Esho, Enzlin, and Van Wolputte 2013; Budiharsana, Amaliah, and Utomo 2003). Future programmes and interventions should ensure that women continue to hold decision-making power while ensuring behaviour change (Public Policy Advisory Network on Female Genital Surgeries in Africa 2012), especially when involving fathers may be a protective strategy for reducing FGM/C (Mwendwa et al. 2020).

The high prevalence of FGM/C in Indonesia, its commonplace offering as part of traditional birth attendant 'birth packages', and the neutral attitudes expressed by circumcised women regarding their own FGM/C demonstrates the normalcy of the practice (Ida and Saud 2020). This could be linked to the early age of cutting and the 'light' version of FGM/C practised (Octavia 2014) and may explain why a majority of young women wished to circumcise their daughters in the future. In contrast, among the Amhara, where the age of cutting is also low, young women were aware of adverse consequences which could be because of the type of FGM/C practised and the implementation of numerous campaigns to end FGM/C. The latter was also true for the Maasai.

Since young Maasai women are older at the time of FGM/C, they potentially play a more active role – in either resisting, accepting or wanting to be circumcised. FGM/C offers women an opportunity, legitimacy and power to engage with their larger male-

dominated community (Njambi 2004; Shweder 2000; Gruenbaum 2001) and allows Maasai women to negotiate aspects of their gender, identity and sexuality that may otherwise be denied to them (Esho, Enzlin, and Van Wolputte 2013; Esho et al. 2010). However, we must be cautious in being too positive about women's agency in this context as many women felt 'bad' about being cut in a context where peer pressure to be cut was high.

Changing contexts and changing traditions

While study findings confirm that there are no major cuts or removal of flesh (Clarence-Smith 2008), the reasons for circumcision differ. Our study findings highlight how Islam, tradition, hygiene and a control of sexuality are related to the practice. While scholars argue that rising Islamic fundamentalism combined with government's drive for medicalisation for harm reduction (Leye et al. 2019) has resulted in 'real cutting' (Putranti 2008; Budiharsana, Amaliah, and Utomo 2003), our findings show health workers pushing back against FGM/C. Different types of circumcision carried out by traditional circumcisers and health workers co-existed in the same areas, with the latter performing FGM/C without any actual cuts (Putranti 2008). This could indicate the attempt of health workers to find common ground with religious perspectives by adopting a harm reduction approach (Duivenbode and Padela 2019).

Wide-reaching government campaigns may explain the high levels of awareness about FGM/C being illegal in Ethiopia. However, strong social norms have limited the impact of legal change in the Ethiopian context, through practices which Boyden, Pankhurst and Tafere (2012) frame as resistance and counter-reaction. The fear of retaliation and frustration about the slow progress in abandoning FGM/C have led to some district-level officials being indifferent to the issue among the Amhara (Presler-marshall et al. 2022). Criminalisation of the practice may have driven it underground, as a result the prevalence is unclear. Surveys indicate a decline in rates of FGM/C (Boyden, Pankhurst and Tafere 2012). To evade prosecution, cross-border practices have been documented, mostly between countries, but also within the country (Abebe et al. 2020; UNFPA 2019). Among the Maasai, our finding that FGM/C was not publicly celebrated due to its criminalisation was also reported by Esho, Wolputte and Enzlin (2011). Our findings also suggest that FGM/C may be occurring at a lower age compared to data from the Kenya DHS which suggests the practice occurs at 12-14 years of age. There are other data to indicate that age of FGM/C is falling (Shell-Duncan, Moore, and Njue 2017; KNBS 2015). This decline could be influenced by communities wanting to avoid detection due to criminalisation (Shell-Duncan, Naik and Feldman-Jacobs 2016; Hernlund 2000; 28TooMany 2016). Younger girls may also find it harder to resist and heal quicker (Njue 2004). In a context where circumcised girls engage in (unprotected) sex after FGM/C and often became pregnant, this decline in age is concerning. Although our findings do not allude to medicalisation of FGM/C among the Maasai, other studies have documented this and linked it to 'increased secrecy and invisibility of the practice' (Population Council 2019; Van Eekert et al. 2021).

Limitations

Like all research, this study has its limitations. These include the possibility of social desirability effects. Participants may have over-reported the prevalence of FGM/C in FGDs for social appearances in a group, while young people may have under-reported the prevalence of FGM/C in the survey in Ethiopia and Kenya as it is against the law. Translations from the local languages may not have captured all the nuances in key informant, IDI and FGD accounts. Likewise, sampling may have affected the survey variably across different contexts. In Indonesia, for example, the sample had received a relatively high level of formal education. This was not the case elsewhere.

Conclusions

A multiplicity of drivers are associated with FGM/C but most are rooted in gender norms that dictate how young women should embody specific characteristics and perform traditional roles to fulfil their femininity. The female body is the medium through which these norms are negotiated and its 'natural' form is transformed through FGM/C into a more 'cultured body'. The agency of parents warrants further exploration. In the Ethiopian and Kenyan settings, despite being illegal, our findings suggest that the cost of abandoning the practice may be too high for some and community-wide public pledges may make a difference in reducing FGM/C rates (Mackie 1996). In the Indonesian settings, future action might begin by carefully problematising FGM/C. Variations in the practice and multiplicity of drivers in each setting suggest that finely tuned context-specific interventions are needed. Although body marking is common in some communities, interventions promoting the medicalisation of FGM/C or symbolic forms of the practice remain motivated by notions of an ideal woman which can violate individual women's rights.

Notes

1. In this paper, we use the combined term FGM/C. Female circumcision was the term most commonly used by study participants in Indonesia. When citing the literature, we use the term used by the author(s).
2. https://www.kit.nl/project/yes-i-do/
3. Two types of clitoredectomy are practised by the Maasai. The survey did not differentiate between them.

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Data availability

The dataset used and analysed is available from the corresponding author upon reasonable request.

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