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Legal Pluralism and Muslim Family Authority in Sustaining Female Circumcision in Serang, Indonesia: A Critical Documentary Analysis

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Abstract

Women's circumcision in Serang, Banten, is in a space of legal pluralism that brings together religious, customary, family, health, and state regulatory norms. Previous research has generally examined these practices from the perspective of public health, gender, religion, anthropology, or law in isolation, so it has not explained how these various normative arrangements are mediated in family decision-making. This study aims to analyze the social reproductive mechanisms of female circumcision practices through the development of a Family-Mediated Socio-Legal Reproduction Model. The research uses a qualitative socio-legal approach with critical documentary analysis and thematic synthesis of academic literature, laws and regulations, government policies, public health reports, and religious publications relevant to the Indonesian context, especially Banten. The results of the study show three main findings. First, Muslim families reproduce female circumcision as a symbol of purification, honor, and femininity, even though it has no medical indications. Second, the distribution of authority in the family along with the symbolic position of the paraji shaman transforms religious and customary norms into ritual practices that gain social legitimacy. Third, regulatory fragmentation, differences in definitions of harm, and weak integration between legal and health approaches reduce the effectiveness of state interventions and biomedical evidence. This study also identifies paraji shamans as socio-legal actors who act as cultural intermediaries, holders of symbolic authority, and implementers of local health governance. The findings expand the study of legal pluralism by showing that the effectiveness of legal, medical, religious, and customary norms depends on the mediation process in the family and community. Therefore, prevention strategies require the integration of legal protection, family-based health education, the involvement of traditional practitioners, and the strengthening of religious narratives that place bodily dignity, child protection, and harm prevention as the main principles.

***Keywords**: Female Circumcision; Legal Pluralism; Socio-Legal; Family Authority; D'Shaman Paraji; Banten.*

Abstrak

Sunat perempuan di Serang, Banten, berada dalam ruang pluralisme hukum yang mempertemukan norma agama, adat, keluarga, kesehatan, dan regulasi negara.

Penelitian terdahulu umumnya mengkaji praktik ini dari perspektif kesehatan publik, gender, agama, antropologi, atau hukum secara terpisah, sehingga belum menjelaskan bagaimana berbagai tatanan normatif tersebut dimediasi dalam pengambilan keputusan keluarga. Penelitian ini bertujuan menganalisis mekanisme reproduksi sosial praktik sunat perempuan melalui pengembangan Model Reproduksi Sosio-Legal yang Dimediasi Keluarga. Penelitian menggunakan pendekatan sosio-legal kualitatif dengan analisis dokumenter kritis dan sintesis tematik terhadap literatur akademik, peraturan perundang-undangan, kebijakan pemerintah, laporan kesehatan publik, serta publikasi keagamaan yang relevan dengan konteks Indonesia, khususnya Banten. Hasil penelitian menunjukkan tiga temuan utama. Pertama, keluarga Muslim mereproduksi sunat perempuan sebagai simbol penyucian, kehormatan, dan feminitas, meskipun tidak memiliki indikasi medis. Kedua, distribusi otoritas dalam keluarga bersama kedudukan simbolik dukun paraji mentransformasikan norma agama dan adat menjadi praktik ritual yang memperoleh legitimasi sosial. Ketiga, fragmentasi regulasi, perbedaan definisi mengenai bahaya, dan lemahnya integrasi antara pendekatan hukum dan kesehatan mengurangi efektivitas intervensi negara maupun bukti biomedis. Penelitian ini juga mengidentifikasi dukun paraji sebagai aktor sosio-legal yang berperan sebagai perantara budaya, pemegang otoritas simbolik, dan pelaksana tata kelola kesehatan lokal. Temuan tersebut memperluas kajian pluralisme hukum dengan menunjukkan bahwa efektivitas norma hukum, medis, agama, dan adat bergantung pada proses mediasi dalam keluarga dan komunitas. Oleh karena itu, strategi pencegahan memerlukan integrasi perlindungan hukum, edukasi kesehatan berbasis keluarga, pelibatan praktisi tradisional, dan penguatan narasi keagamaan yang menempatkan martabat tubuh, perlindungan anak, dan pencegahan bahaya sebagai prinsip utama.
Kata Kunci: Sunat Perempuan; Pluralisme Hukum; Sosio-Legal; Otoritas Keluarga; Dukun Paraji; Banten.

INTRODUCTION

Female circumcision, commonly referred to in Indonesia as *sunat perempuan* or *khitan perempuan*, is situated at the intersection of bodily practices, family morality, religious interpretation, customary authority, and state regulation. The World Health Organization defines female genital mutilation/cutting (FGM/C) as any procedure involving the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons. The practice has no established health benefits and may cause immediate and long-term physical, psychological, sexual, and reproductive consequences.[1] Globally, more than 230 million girls and women are estimated to have undergone FGM/C, demonstrating that its elimination remains a major

[1] World Health Organization, "Female Genital Mutilation" (World Health Organization, 2024), https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation.

public-health and human-rights challenge.[2] Nevertheless, the forms and social meanings of the practice vary considerably across societies.

In Indonesia, female circumcision cannot be understood solely through the global category of genital mutilation. The term *sunat perempuan* carries religious and cultural familiarity and is not always perceived by local communities as equivalent to mutilation. Its practices range from symbolic cleansing and ritual gestures to scratching, pricking, or cutting genital tissue. Analysis of the 2013 Indonesian Basic Health Research data found that 51.2% of girls aged 0–11 in the surveyed population had reportedly undergone female circumcision.[3] Earlier Indonesian research also showed that the practice was embedded in family ceremonies, religiously framed expectations, and local understandings of purification and female propriety.[4] These findings indicate that female circumcision in Indonesia is not merely an isolated medical procedure, but a socially embedded practice sustained through family, religion, and local culture.

Indonesia's regulatory history illustrates the contested status of the practice. The Ministry of Health initially issued Regulation No. 1636/Menkes/Per/XII/2010, which provided procedural guidance for female circumcision. This regulation was subsequently revoked through Ministerial Regulation No. 6 of 2014, which stated that female circumcision is not a medical procedure, has no medical indication, and has not been proven to provide health benefits.[5] Although this revocation established the formal medical position of the state, it did not fully resolve the religious, customary, and familial legitimacy attached to the practice. State regulation and medical evidence therefore coexist with

[2] UNICEF, "Female Genital Mutilation: A Global Concern--2024 Update" (UNICEF Data, 2024), https://data.unicef.org/resources/female-genital-mutilation-a-global-concern-2024/.

[3] S Suparmi, I Saptarini, and N Amaliah, "Hubungan Faktor Sosio-Demografi Terhadap Sunat Perempuan Di Indonesia," *Jurnal Kesehatan Reproduksi* 7, no. 1 (2016): 1–10.

[4] Andree Feillard and Lies Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy," *Archipel* 56 (1998): 337–67, https://doi.org/10.3406/arch.1998.3495; Meiwita Budiharsana et al., "Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights" (Population Council, 2003).

[5] Ministry of Health of the Republic of Indonesia, "Regulation of the Minister of Health of the Republic of Indonesia Number 6 of 2014 Concerning the Revocation of Regulation of the Minister of Health Number 1636/Menkes/Per/XII/2010 Concerning Female Circumcision" (Ministry of Health of the Republic of Indonesia, 2014).

family and community norms that may continue to frame female circumcision as purification, protection, religious propriety, or preparation for respectable womanhood.

Serang and the broader Banten context provide a relevant setting for examining this normative tension. Research in Banten shows that female circumcision is connected to intergenerational tradition, the regulation of female sexuality, gendered morality, and the cultural authority exercised over women's bodies.[6] Local reports also indicate that the practice may be organized through parental decisions and performed by *dukun paraji*, whose authority derives from social trust, ritual experience, and their involvement in childbirth and infant care.[7] Within this arrangement, female circumcision is not necessarily regarded by families as an intentional form of harm. It may instead be interpreted as an expression of care, obedience, family responsibility, and cultural continuity. This interpretation helps explain why medical objections do not automatically eliminate the practice.

The Muslim family is particularly important because it constitutes the primary arena in which ideas of purity, modesty, obedience, sexuality, and family honor are transmitted. Decisions concerning girls' bodies may involve not only mothers and fathers, but also grandmothers, elder women, wider kinship networks, religious figures, and traditional practitioners. Family authority is therefore distributed across several actors who possess different forms of moral, religious, and customary legitimacy. In this context, the female body may become a symbolic site through which families demonstrate conformity to inherited notions of respectable womanhood. Female circumcision consequently operates not simply as a bodily intervention, but as a family-mediated mechanism for regulating gendered identity and social recognition.

Existing studies may be grouped into four principal strands. First, public-health studies emphasize the absence of medical benefits and the potential health consequences of female genital cutting.[8] Second, gender

[6] A P K Lutfi and S L Wahyuningroem, "Opresi Dan Kuasa Atas Tubuh Perempuan Dalam Tradisi Masyarakat Budaya: Studi Kasus Sunat Perempuan Di Banten," *Jurnal Perempuan* 28, no. 1 (2023): 37–47, https://doi.org/10.34309/jp.v28i1.808.

[7] KBR, "Perjuangan Ulama-Ulama Perempuan Banten Hapus Sunat Perempuan" (KBR, 2024), https://kbr.id/articles/ragam/perjuangan-ulama-ulama-perempuan-banten-hapus-sunat-perempuan.

[8] Organization, "Female Genital Mutilation"; UNICEF, "Female Genital Mutilation: A Global Concern-2024 Update."

and human-rights scholarship interprets the practice as a form of bodily control, gender discrimination, and violation of women's sexual and reproductive rights.[9] Third, anthropological studies explain its persistence through cultural meanings of purity, family honor, female propriety, and social belonging.[10] Fourth, religious scholarship questions the identification of female circumcision as an Islamic obligation and emphasizes that inherited custom should not be confused with binding religious doctrine.[11] Recent Indonesian scholarship further shows that the practice exists at a complex intersection of tradition, religion, medicalization, gender relations, and human rights.[12]

Recent scholarship on Qur'anic legal interpretation further demonstrates that gendered authority is produced through interpretive structures that may privilege inherited assumptions about male responsibility while marginalizing women's lived moral reasoning. This suggests that the regulation of women's bodies is inseparable from the question of who possesses the authority to define Islamic legal and ethical meaning.[13]

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[9] Yayasan Kesehatan Perempuan Indonesia, "Sunat Perempuan Di Indonesia: Praktik Kekerasan Berbasis Gender Yang Masih Mengancam" (YKP Indonesia, 2025), https://ykpindonesia.org/id/sunat-perempuan-di-indonesia-praktik-kekerasan-berbasis-gender-yang-masih-mengancam/.

[10] Feillard and Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy"; Budiharsana et al., "Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights"; Lutfi and Wahyuningroem, "Opresi Dan Kuasa Atas Tubuh Perempuan Dalam Tradisi Masyarakat Budaya: Studi Kasus Sunat Perempuan Di Banten."

[11] International Islamic Centre for Population Studies and Research and UNICEF, "Female Circumcision: Between the Incorrect Use of Science and the Misunderstood Doctrine" (Al-Azhar University and UNICEF, 2013); 28 Too Many, "Religion and FGM/C" (Orchid Project, 2022), https://www.fgmcri.org/media/uploads/Thematic Research and Resources/Religion/religion_factsheet_print-friendly_page_v2_%28april_2022%29.pdf.

[12] J Jaya, Y Kim, and M Kang, "Cutting through Complexity: An Intersectional Analysis of Female Genital Cutting in Indonesia," *Social Science & Medicine* 347 (2024): 116771; Irwan Martua Hidayana, "The Medicalization of Female Genital Cutting (FGC) in Indonesia: A Complex Intersection of Tradition, Religion, and Human Rights," *Current Sexual Health Reports* 16, no. 4 (2024): 217–20, https://doi.org/10.1007/s11930-024-00393-2.

[13] Rahmayati Koto, M. Farhan Hidayat, and Maisarah Siregar, "Gender, Authority, and Qur'anic Legal Interpretation: Reframing Contemporary Debates on Women's Interpretive Agency," *Journal of Qur'anic Legal Studies and Exegesis* 1, no. 1 (2026): 1–20, https://journal.bahsisfikr.or.id/index.php/JQLSE/article/view/8.

However, these studies generally discuss family, religion, culture, health, and regulation as parallel explanatory factors. They have not sufficiently explained the mechanism through which these competing normative claims are translated into concrete decisions concerning girls' bodies. The family is frequently presented as the social background of female circumcision, but it is rarely conceptualized as a normative institution that selects, combines, and prioritizes customary expectations, religious arguments, medical information, and state regulation. Similarly, legal pluralism has commonly been used to describe the coexistence of state, religious, and customary norms, but less attention has been given to the family-level processes through which one normative order becomes more socially persuasive than another.[14]

Unlike previous studies that examine the medical, religious, cultural, or legal dimensions of female circumcision as relatively separate domains, this article introduces a Family-Mediated Legal Pluralism Framework. This framework conceptualizes the Muslim family as a normative translator that mediates between family morality, religious legitimacy, customary authority, state regulation, medical evidence, and bodily-autonomy principles. It identifies three interconnected forms of authority. The first is norm-producing authority, through which families construct expectations regarding honor, purity, obedience, sexuality, and female respectability. The second is legitimating and operational authority, exercised through religious vocabulary, elder family members, inherited tradition, and the cultural position of *dukun paraji*. The third is counter-regulatory authority, derived from state regulation, medical evidence, Islamic arguments against harm, human-rights principles, and the protection of bodily integrity. The interaction among these forms of authority may result in the continuation, symbolic modification, contestation, or abandonment of female circumcision.

The framework moves beyond the general assertion that female circumcision occurs within legal pluralism. It explains how plural normative orders are filtered and mediated through family authority. Legal pluralism is therefore understood not as a consequence that

[14] John Griffiths, "What Is Legal Pluralism?," *Journal of Legal Pluralism and Unofficial Law* 18, no. 24 (1986): 1–55; Sally Engle Merry, "Legal Pluralism," *Law & Society Review* 22, no. 5 (1988): 869–96, https://doi.org/10.2307/3053638; Sally Falk Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study," *Law & Society Review* 7, no. 4 (1973): 719–46, https://doi.org/10.2307/3052967.

appears after female circumcision, but as the broader normative field within which decisions regarding the practice are produced.[15] Medical anthropology complements this socio-legal perspective by demonstrating that bodily interventions are not interpreted exclusively through biomedical knowledge. They may be culturally translated into purification, protection, moral preparation, or care, even when medical evidence identifies them as unnecessary and potentially harmful.[16]

Based on this framework, the article addresses three questions. First, how do legal, medical, religious, and empirical documents construct the role of Muslim family authority in sustaining or contesting female circumcision in Serang and the broader Banten context? Second, how do family norms, customary authority, religious legitimacy, state regulation, and medical discourse interact within this contested normative field? Third, what does the Family-Mediated Legal Pluralism Framework reveal about the protection of girls' bodily autonomy?

This study employs critical documentary analysis and thematic literature synthesis. It does not claim to present new ethnographic testimony from Muslim families, women who have undergone circumcision, or *dukun paraji* in Serang. Instead, it reconstructs the normative architecture through which female circumcision is justified, implemented, contested, and potentially transformed. The contribution of this article lies in developing a socio-legal framework and a typology of authority that connect Muslim family norms, religious and customary legitimacy, traditional practitioners, state regulation, medical evidence, and bodily autonomy. This framework offers a more precise explanation of why formal legal and medical objections may remain socially ineffective when family-based legitimacy continues to sustain the practice.

RESEARCH METHODS

This study employed a qualitative socio-legal research design based on critical documentary analysis and thematic synthesis. Documentary analysis was selected to examine how female circumcision is represented, justified, contested, and regulated in academic publications, legal instruments, public-health reports, religious documents, and previous empirical studies. The study did not involve

[15] Griffiths, "What Is Legal Pluralism?"; Merry, "Legal Pluralism."

[16] Arthur Kleinman, Leon Eisenberg, and Byron Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research," *Annals of Internal Medicine* 88, no. 2 (1978): 251–58; Margaret Lock and Vinh-Kim Nguyen, *An Anthropology of Biomedicine*, 2nd ed. (Wiley-Blackwell, 2018).

interviews, participant observation, surveys, or direct engagement with Muslim families, women who had undergone circumcision, religious figures, health workers, or *dukun paraji* in Serang. Accordingly, the findings do not constitute direct descriptions of current community practices but represent an analysis of how existing documents construct the relationships among Muslim family authority, customary norms, religious legitimacy, medical discourse, state regulation, and girls' bodily autonomy. This approach is appropriate for identifying institutional, legal, religious, and cultural meanings embedded in texts, policies, and scholarly debates.[17] The socio-legal perspective was applied because the reviewed literature presents female circumcision not merely as a medical procedure, but as a contested practice situated within overlapping normative orders, including state regulation, family morality, customary authority, religious discourse, medical ethics, and human-rights principles. To avoid presenting documentary findings as field observations, the analysis consistently uses formulations such as "previous studies indicate," "the reviewed documents suggest," and "the literature reports."

The initial document inventory consisted of 56 records, including peer-reviewed journal articles, scholarly books, Indonesian legal and policy documents, reports issued by national and international institutions, Islamic ethical publications, and selected contextual sources. The substantive literature primarily covered the period from 1998 to 2026, beginning with one of the principal studies on female circumcision in Indonesia.[18] Earlier publications were retained only when they provided foundational theoretical or methodological concepts concerning legal pluralism, symbolic authority, disciplinary power, medical anthropology, and documentary research.[19] Documents were identified using combinations of English and Indonesian keywords,

[17] Glenn A Bowen, "Document Analysis as a Qualitative Research Method," *Qualitative Research Journal* 9, no. 2 (2009): 27–40; Uwe Flick, *An Introduction to Qualitative Research* (Sage Publications, 2014).

[18] Feillard and Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy."

[19] Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study"; Michel Foucault, *The History of Sexuality, Volume 1: An Introduction*, ed. Robert Hurley (Pantheon Books, 1978); John. Griffiths, "Legal Pluralism.," in *" In International Encyclopedia of the Social & Behavioral Sciences: Second Edition*, 2015, 970–78, https://doi.org/10.1016/B978-0-08-097086-8.86073-0; Merry, "Legal Pluralism"; Pierre Bourdieu, *Language and Symbolic Power* (Harvard University Press, 1991).

including "female circumcision," "female genital mutilation," "female genital cutting," "*sunat perempuan*," "*khitan perempuan*," "Serang," "Banten," "Muslim family," "family authority," "*dukun paraji*," "legal pluralism," "medicalization," "religious legitimacy," "bodily autonomy," and "female reproductive health." Documents were included when they substantively examined female circumcision in Indonesia, Banten, or a relevant comparative context and addressed family decision-making, gender norms, religious legitimacy, customary authority, medical consequences, state regulation, legal pluralism, bodily autonomy, or abandonment strategies. Eligible sources included peer-reviewed publications, official legal and policy documents, reports from recognized institutions, and religious-ethical documents available in English or Indonesian. Duplicate, incidental, unverifiable, or substantively irrelevant publications were excluded, as were international studies that did not offer a relevant conceptual or comparative contribution. Following title, abstract, and full-text screening, **[**N] documents constituted the final analytical corpus. Purposive selection was applied to achieve conceptual and interpretive depth rather than statistical representativeness.[20]

A structured document-review matrix was used to record the author or issuing institution, publication year, geographical focus, document type, research method, principal findings, normative position, relevant actors, and contribution to the research questions. The matrix also documented how each source represented Muslim families, parents, grandmothers, religious authorities, health professionals, traditional birth attendants, and state institutions, as well as whether female circumcision was framed as a religious obligation, cultural tradition, purification ritual, family care, gendered control, medical harm, bodily violation, or contested socio-legal practice. The data were analyzed through deductive and inductive coding. Deductive codes were derived from the research questions and the Family-Mediated Legal Pluralism Framework, including family norms, female honor, purity, sexual control, family authority, religious legitimation, customary legitimacy, *dukun paraji* authority, state regulation, medical risk, bodily autonomy, symbolic modification, contestation, and abandonment. Inductive coding identified themes and contradictions emerging from the documents. The coding process involved descriptive coding to identify principal actors

[20] Michael Q Patton, *Qualitative Research & Evaluation Methods* (Sage Publications, 2015).

and normative claims, interpretive coding to examine relationships among honor, care, religion, gender discipline, health, and bodily integrity, and relational coding to assess how different normative orders reinforced, contradicted, or displaced one another. The resulting materials were organized into four analytical themes: the Muslim family as a site of normative transmission; honor, sexual control, and female respectability; *dukun paraji* and traditional authority; and medical risk, legal pluralism, and religious counter-discourse. This procedure is consistent with thematic analysis, which allows heterogeneous documentary evidence to be synthesized while retaining its contextual and disciplinary differences.[21]

The interpretation was guided by legal anthropology and medical anthropology. Legal anthropology and legal pluralism were used to explain how normative authority operates beyond formal state law through family expectations, customary obligations, religious vocabulary, kinship structures, and recognition of traditional actors.[22] Medical anthropology was employed to examine how bodily intervention, pain, purity, sexuality, reproductive risk, and care are interpreted differently across biomedical, familial, and customary discourses.[23] The Family-Mediated Legal Pluralism Framework differentiated three forms of authority: norm-producing authority based on family expectations concerning honor, purity, obedience, sexuality, and female respectability; legitimating and operational authority exercised through religious vocabulary, inherited custom, elder family members, and traditional practitioners; and counter-regulatory authority derived from state regulation, medical evidence, Islamic anti-harm reasoning, human-rights principles, child protection, and bodily autonomy. Analytical credibility was strengthened through triangulation across peer-reviewed empirical studies, legal and policy documents, public-health reports, religious publications, and socio-legal and anthropological scholarship. Greater evidentiary weight was assigned to peer-reviewed studies, official regulations, and reports from recognized

[21] Virginia Braun and Victoria Clarke, "Using Thematic Analysis in Psychology," *Qualitative Research in Psychology* 3, no. 2 (2006): 77–101.

[22] Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study"; Merry, "Legal Pluralism"; Griffiths, "What Is Legal Pluralism?"

[23] Kleinman, Eisenberg, and Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research"; Lock and Nguyen, *An Anthropology of Biomedicine*.

institutions, while media and advocacy sources were used primarily for contextual corroboration. Conflicting findings were retained as part of the analysis rather than resolved through unsupported assumptions.[24]

Nevertheless, the study does not generate new interview, observational, or prevalence data from Serang; therefore, its findings constitute a critical reconstruction of existing evidence rather than direct ethnographic testimony. Differences in geographical scope, methodology, terminology, and publication period also prevent national or comparative findings from being automatically generalized to Serang. Consequently, the study does not establish the current prevalence or precise form of female circumcision in the region, but explains how existing documents construct the normative relationships among family authority, religious and customary legitimacy, state regulation, medical discourse, and girls' bodily autonomy.

RESULTS AND DISCUSSION

The Muslim Family as the Primary Site of Normative Transmission

The analysis indicates that the Muslim family is represented in the reviewed documents not merely as the social background of female circumcision, but as the principal institution through which the practice acquires normative meaning. Across the Indonesian and Banten-related literature, female circumcision is repeatedly associated with ideas of purification, obedience, modesty, female respectability, religious propriety, and family honor.[25] The documentary evidence therefore suggests that the practice is sustained through a process of normative transformation: a non-therapeutic bodily intervention is reinterpreted within family discourse as care, moral preparation, cultural continuity, or the fulfillment of religiously framed parental responsibility. This transformation is central to explaining why medical warnings or formal regulatory objections may not immediately alter family decisions.

The synthesis identifies four interconnected mechanisms of normative transmission. The first is intergenerational narration, through which older family members transmit memories, customary expectations, and accounts of what a "proper" girl or Muslim family

[24] N K Denzin, *The Research Act: A Theoretical Introduction to Sociological Methods* (Routledge, 2017).

[25] Feillard and Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy"; Budiharsana et al., "Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights"; Lutfi and Wahyuningroem, "Opresi Dan Kuasa Atas Tubuh Perempuan Dalam Tradisi Masyarakat Budaya: Studi Kasus Sunat Perempuan Di Banten."

should be. The second is moral classification, through which female circumcision is linked to culturally valued categories such as purity, modesty, obedience, and respectability. The third is religious legitimation, in which customary expectations are expressed through Islamic terminology even when the religious basis of the practice remains contested. The fourth is ritual enactment, through which family decisions are implemented by a trusted practitioner, frequently a traditional birth attendant or *dukun paraji*. Previous Indonesian studies indicate that these mechanisms are mutually reinforcing because family obligation, religious vocabulary, and customary practice are rarely experienced as completely separate domains.[26]

The documents also demonstrate that decision-making is distributed rather than individual. Female circumcision is not adequately explained as a decision made exclusively by a mother or father. A systematic review of household decision-making found that mothers, fathers, grandmothers, elder women, and wider kinship networks may influence whether FGM/C is continued, delayed, modified, or abandoned.[27] The Indonesian literature similarly suggests that family decisions are shaped by collective expectations regarding religion, tradition, gender, and social acceptance.[28] The decision-making process may therefore be reconstructed as a sequence consisting of normative initiation, familial deliberation, moral authorization, practitioner selection, ritual implementation, and subsequent social reinforcement.

Within this sequence, the analysis does not identify a single actor who dominates every stage. Instead, authority is differentiated according to function. Grandmothers and elder women appear particularly influential in the transmission and defense of inherited norms because they are commonly positioned as custodians of family memory, female propriety, and reproductive knowledge. Comparative evidence confirms that programs aimed at changing FGM/C practices may be ineffective

[26] Feillard and Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy"; Budiharsana et al., "Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights"; Hidayana, "The Medicalization of Female Genital Cutting (FGC) in Indonesia: A Complex Intersection of Tradition, Religion, and Human Rights."

[27] Claudia Cappa, Carly Thomson, and Colleen Murray, "Decision-Making Process in Female Genital Mutilation: A Systematic Review," *International Journal of Environmental Research and Public Health* 17, no. 10 (2020): 3362, https://doi.org/10.3390/ijerph17103362.

[28] Jaya, Kim, and Kang, "Cutting through Complexity: An Intersectional Analysis of Female Genital Cutting in Indonesia."

when they overlook the authority of grandmothers in shaping gender norms and decisions concerning girls' bodies.[29] Mothers often occupy an operational role by arranging the procedure and communicating with practitioners, although their actions may reflect broader kinship pressure rather than complete individual autonomy. Fathers may function as gatekeepers whose approval, financial support, silence, or non-intervention provides implicit authorization. Religious figures may supply symbolic validation, while *dukun paraji* or other traditional practitioners operationalize the decision through ritual performance.

The dominant actor therefore depends on the stage of decision-making. At the stage of normative transmission, elder women and grandmothers are especially important. At the stage of household authorization, parents and senior kin members exercise greater influence. At the stage of religious legitimation, religious authorities or religiously knowledgeable relatives may become more prominent. At the stage of implementation, *dukun paraji* or another selected practitioner occupies the central role. This differentiated pattern may be described as distributed familial authority, in which no single actor independently controls the entire process, but each actor contributes a distinct form of authority to the continuation or modification of the practice.

The reviewed documents further suggest that this authority is reinforced through anticipated social consequences. Families may fear that abandoning an inherited practice will be interpreted as religious neglect, disrespect for elders, rejection of tradition, or failure to prepare a girl for respectable womanhood. Social-norms research shows that harmful practices persist when individuals believe that significant members of their community expect compliance, even when they privately question the practice.[30] In this configuration, the family does not simply transmit a ritual; it also produces expectations, sanctions, and classifications of acceptable femininity. A girl's body becomes the medium through which the family communicates conformity to a broader moral community.

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[29] Judi Aubel, "Grandmother-Inclusive Intergenerational Approaches: The Missing Piece of the Puzzle for Ending FGM/C by 2030?," *Frontiers in Sociology* 8 (2023): 1196068, https://doi.org/10.3389/fsoc.2023.1196068.

[30] UNFPA-UNICEF Joint Programme on the Elimination of Female Genital Mutilation, "Manual on Social Norms and Change" (United Nations Population Fund and United Nations Children's Fund, 2022), https://www.unfpa.org/publications/manual-social-norms-and-change-2022.

The documentary evidence concerning Banten must nevertheless be interpreted cautiously. The reviewed studies and contextual reports suggest that family obedience, local tradition, gendered morality, and traditional authority are relevant to the reproduction of female circumcision in the region.[31] However, because the present study is based on documentary analysis, these sources cannot be treated as direct observations generated by this research. The evidence supports an analytical reconstruction of how the practice has been represented in previous studies, but it does not establish the current prevalence, uniformity, or precise distribution of female circumcision across all Muslim families in Serang. The findings therefore concern documented normative patterns rather than a claim that every family follows the same decision-making process.

These patterns can be integrated through what this article terms the Family Normative Governance Model. The model explains the reproduction of female circumcision through four connected processes: norm production, authority distribution, bodily enactment, and social reinforcement. Norm production occurs when the family associates female respectability with purity, obedience, sexuality, and honor. Authority distribution occurs when different actors grandmothers, parents, religious figures, and traditional practitioners—exercise complementary forms of influence. Bodily enactment occurs when these normative expectations are translated into a ritual or physical intervention. Social reinforcement occurs when compliance is rewarded through recognition, acceptance, and the preservation of family legitimacy, while non-compliance is associated with anxiety, stigma, or cultural disobedience.

The Family Normative Governance Model brings together theoretical perspectives that are often applied separately. Legal anthropology and legal pluralism explain why family norms, customary authority, religious discourse, medical standards, and state regulation can coexist without producing a single authoritative rule.[32] Bourdieu's concept of symbolic power explains why elder women, religious figures, and *dukun paraji* can exercise authority even without formal legal or

[31] Lutfi and Wahyuningroem, "Opresi Dan Kuasa Atas Tubuh Perempuan Dalam Tradisi Masyarakat Budaya: Studi Kasus Sunat Perempuan Di Banten"; KBR, "Perjuangan Ulama-Ulama Perempuan Banten Hapus Sunat Perempuan."

[32] Griffiths, "What Is Legal Pluralism?"; Merry, "Legal Pluralism"; Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study."

medical credentials; their influence arises from recognition, reputation, age, ritual knowledge, and accumulated social trust.[33] Foucault's account of disciplinary power explains how expectations concerning sexuality and respectability are inscribed on the female body through intimate institutions rather than only through formal law.[34] Medical anthropology explains how a bodily intervention rejected by biomedical discourse may be culturally reclassified as protection, purification, or care.[35]

Integrating these perspectives reveals that family authority does not operate outside legal pluralism; it is one of the principal mechanisms through which legal pluralism becomes socially effective. State regulation may deny the medical legitimacy of female circumcision, while biomedical evidence identifies its risks. However, family norms may continue to authorize the practice when elder authority, religious language, customary obligation, and cultural understandings of care remain mutually reinforcing. The persistence of the practice is therefore not caused simply by insufficient medical knowledge. It is produced by a normative hierarchy in which family-based and culturally recognized authority may be more immediate and persuasive than state law or public-health discourse.

The analysis consequently shifts the central question from why individual parents choose female circumcision to how families collectively produce the conditions under which the practice appears morally appropriate or socially necessary. This shift has practical implications. Interventions directed only at mothers risk overlooking the distributed structure of decision-making. Family-based prevention must engage fathers, grandmothers, elder women, religious educators, and traditional practitioners because each actor controls a different stage of normative transmission and implementation. The documentary synthesis therefore identifies the Muslim family as the primary site of normative governance, while also showing that the family can become a site of transformation when its understanding of honor, care, and religious responsibility is redirected toward bodily dignity and child protection.

Honor, Sexual Control, and the Socio-Legal Reproduction of Female Respectability

[33] Bourdieu, *Language and Symbolic Power*.

[34] Foucault, *The History of Sexuality, Volume 1: An Introduction*.

[35] Kleinman, Eisenberg, and Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research"; Lock and Nguyen, *An Anthropology of Biomedicine*.

The analysis indicates that honor is not merely a cultural value surrounding female circumcision but a regulatory mechanism through which the female body is classified, disciplined, and made socially intelligible. Across the reviewed Indonesian and Banten-focused documents, female circumcision is associated with purification, modesty, sexual restraint, family dignity, and preparation for socially acceptable womanhood.[36] Rather than directly demonstrating the current beliefs of all Muslim families in Serang, the documentary evidence reveals a recurrent representational pattern: female sexuality is constructed as a potential moral risk, the management of that risk is assigned to the family, and genital intervention is subsequently reframed as purification, protection, or responsible upbringing. The practice thereby acquires legitimacy not from demonstrated medical benefit, but from its association with an idealized model of respectable femininity.

The synthesis identifies four stages through which this construction occurs. First, normative coding associates the female body with purity, modesty, sexual restraint, and future marital respectability. Second, moral problematization represents uncontrolled female sexuality as a possible threat to personal virtue and family reputation. Third, ritual correction presents female circumcision as an appropriate response to that imagined risk. Fourth, social validation transforms compliance with the ritual into evidence of family responsibility and female propriety. Earlier Indonesian studies support this reconstruction by showing that female circumcision has often been justified through religious propriety, bodily cleanliness, and preparation for adulthood rather than through biomedical reasoning.[37] Comparative studies similarly demonstrate that FGM/C may be sustained through expectations concerning chastity, purification, marriageability, and sexual control.[38] These comparative findings are used here to clarify the

[36] Feillard and Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy"; Budiharsana et al., "Female Circumcision in Indonesia: Extent, Implications and Possible Interventions to Uphold Women's Health Rights"; Lutfi and Wahyuningroem, "Opresi Dan Kuasa Atas Tubuh Perempuan Dalam Tradisi Masyarakat Budaya: Studi Kasus Sunat Perempuan Di Banten."

[37] Feillard and Marcoes, "Female Circumcision in Indonesia: To 'Islamize' in Ceremony or Secrecy."

[38] Katherine Brown, David Beecham, and Hazel Barrett, "The Applicability of Behaviour Change in Intervention Programmes Targeted at Ending Female Genital Mutilation in the EU: Integrating Social Cognitive and Community Level Approaches," *Obstetrics and Gynecology International* 2013 (2013): 324362, https://doi.org/10.1155/2013/324362; Omaima El-Gibaly et al., "The Decline of

mechanism identified in the documents, not as direct evidence of present practices in Serang.

Judith Butler's concept of gender performativity helps explain why these meanings are repeatedly reproduced. Gender, in this perspective, is not simply a pre-existing identity expressed through social conduct; it is constituted through repeated norms, language, rituals, and embodied acts that establish what counts as intelligible masculinity or femininity.[39] Applied to the reviewed evidence, female circumcision does not merely reflect an already established notion of respectable womanhood. It functions as one of the ritual practices through which respectable femininity is symbolically produced and reaffirmed. The repeated association of the circumcised body with purity, discipline, and moral completeness makes these qualities appear natural, although they are socially constructed through family and community expectations. Because the procedure is commonly performed during childhood, the girl does not freely enact this gender performance; rather, the family and community inscribe their preferred gender norm upon her body.

Connell's theory of the gender order extends this analysis beyond individual families. Expectations concerning female purity and sexual restraint are not isolated household beliefs but elements of a wider institutional arrangement that distributes authority, respectability, and bodily freedom unequally between men and women.[40] The documents suggest that the family operates as a localized gender regime in which ideas drawn from kinship, religion, custom, and marriage are combined to regulate girls' bodies. Within this regime, female sexuality is treated as requiring preventive discipline, while family members are granted authority to determine the conditions of bodily propriety. Female circumcision can therefore be interpreted as part of the social

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Female Circumcision in Egypt: Evidence and Interpretation," *Social Science & Medicine* 54, no. 2 (2002): 205–20, https://doi.org/10.1016/S0277-9536(01)00020-X; Mohammed A Tag-Eldin et al., "Prevalence of Female Genital Cutting among Egyptian Girls," *Bulletin of the World Health Organization* 86, no. 4 (2008): 269–74, https://doi.org/10.2471/BLT.07.042093; R A Almeer et al., "Female Genital Mutilation in Saudi Arabia: A Systematic Review," *International Journal of Environmental Research and Public Health* 18, no. 22 (2021): 11950, https://doi.org/10.3390/ijerph182211950.

[39] J Butler, *Gender Trouble: Feminism and the Subversion of Identity* (London & New York: Routledge, 1990).

[40] Raewyn Connell, *Gender: In World Perspective*, 2nd ed. (Cambridge: Polity, 2009).

reproduction of a gender order in which responsibility for family honor is disproportionately attached to women's bodies.

The involvement of mothers, grandmothers, and elder women requires a more nuanced interpretation than a simple opposition between male perpetrators and female victims. Kandiyoti's concept of the patriarchal bargain explains how women may reproduce gendered norms as a strategic response to the constraints and rewards of an existing social order.[41] Within the documentary pattern examined here, older women may support female circumcision because conformity is believed to protect a girl from stigma, preserve her social acceptance, strengthen her marital prospects, or affirm the family's religious and cultural standing. Their participation does not necessarily indicate unrestricted agreement with patriarchal norms. It may reflect an attempt to secure protection and recognition for younger women within a system whose standards they did not independently create. This interpretation is consistent with evidence that grandmothers and senior women often exercise considerable influence over decisions concerning girls' bodies and the intergenerational transmission of gender norms.[42] The concept of patriarchal bargaining therefore explains how gender hierarchy may be reproduced through women's agency without reducing those women either to passive victims or autonomous perpetrators.

Bourdieu's concept of symbolic violence and Foucault's account of disciplinary power further clarify how this gender order becomes durable. Symbolic violence operates when unequal relations are misrecognized as legitimate care, virtue, or moral necessity rather than perceived as domination.[43] In the reviewed documents, female circumcision is commonly represented not as punishment but as purification, protection, or preparation. This benevolent framing conceals the asymmetry between the family members who authorize the intervention and the girl whose bodily integrity is affected. Foucault's concept of disciplinary power explains how this authority operates through intimate institutions and routine practices rather than only through explicit legal coercion.[44] The body becomes the site upon which expectations concerning sexuality, obedience, and femininity are

[41] Deniz Kandiyoti, "Women, Islam, and the State," in *Political Islam: Essays from Middle East Report*, 2023, https://doi.org/10.2307/3012623.

[42] Aubel, "Grandmother-Inclusive Intergenerational Approaches: The Missing Piece of the Puzzle for Ending FGM/C by 2030?"

[43] Bourdieu, *Language and Symbolic Power*.

[44] Foucault, *The History of Sexuality, Volume 1: An Introduction*.

materialized before the girl is able to participate meaningfully in the decision.

Legal anthropology and medical anthropology connect these gender processes to the broader socio-legal structure. Legal pluralism explains how family norms, customary authority, religious discourse, state regulation, and medical ethics coexist as competing sources of legitimacy.[45] The reviewed literature suggests that state and medical objections may remain socially weak when family honor and religiously inflected custom are considered more immediate and authoritative. Medical anthropology, meanwhile, explains how the same bodily intervention may be defined as harmful within biomedical discourse but interpreted as purification or care within family and customary discourse.[46] These perspectives demonstrate that the disagreement is not simply about medical facts; it concerns which normative authority has the power to define harm, care, respectability, and legitimate control over the female body.

The relationship among these theoretical perspectives can be integrated into what this article terms the Socio-Legal Reproduction Model of Female Respectability. The model consists of six connected mechanisms:

Gender order → normative coding of the female body → familial and patriarchal bargaining → religious and customary legitimation → ritualized bodily discipline → social recognition and intergenerational reproduction.

Connell explains the broader gender order within which female sexuality is unequally regulated. Butler explains how respectable femininity is constituted through repeated discourse and ritual. Kandiyoti explains why women may strategically participate in reproducing norms that constrain them. Bourdieu explains how domination is misrecognized as care and moral obligation. Foucault explains how normative expectations are inscribed through bodily discipline. Legal pluralism explains why family and customary authority may prevail despite competing state and medical norms, while medical anthropology

[45] Griffiths, "What Is Legal Pluralism?"; Merry, "Legal Pluralism"; Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study."

[46] Kleinman, Eisenberg, and Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research"; Lock and Nguyen, *An Anthropology of Biomedicine*.

explains how bodily harm is culturally translated into purification, protection, or care.

The documentary evidence also demonstrates that the relationship between honor and female circumcision cannot be reduced to an opposition between Islam and culture. The practice may be expressed through Islamic vocabulary, but its meanings and distribution vary across Muslim communities, indicating that local history, kinship relations, gender hierarchy, and customary authority remain decisive.[47] Indonesian research likewise suggests that the meaning of female circumcision is negotiated through interacting religious and socio-cultural interpretations rather than derived from a single, uncontested theological position.[48] Religious language therefore functions not only as doctrine but also as a legitimating idiom through which inherited gender expectations are presented as morally authoritative.

The analysis consequently identifies honor as the normative engine of female respectability. It connects family reputation to the regulation of female sexuality, converts bodily intervention into an expression of responsible care, and rewards compliance through social recognition. Even when physical cutting is reduced or replaced by a symbolic ritual, the underlying gender message may persist if the ritual continues to imply that a girl's body requires purification, correction, or control before she can be recognized as socially complete. The critical distinction is therefore not only between invasive and symbolic forms, but between practices that preserve the gendered logic of bodily correction and those that affirm girls' bodily autonomy without requiring ritual modification.

These findings refine the Family Normative Governance Model developed in the preceding section. The family governs not only through decision-making authority but also through the production of gendered meanings. Accordingly, interventions limited to medical-risk information may fail because they do not challenge the moral grammar that connects circumcision with honor and proper femininity. Effective

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[47] Sami A Aldeeb Abu-Sahlieh, *Male and Female Circumcision among Jews, Christians and Muslims: Religious, Medical, Social and Legal Debate* (Shangri-La Publications, 2006); Ibrahim Lethome Asmani and Maryam Sheikh Abdi, "De-Linking Female Genital Mutilation/Cutting from Islam" (Frontiers in Reproductive Health Program, Population Council, 2008).

[48] G Nurdiana and E Susanti, "Negotiating the Meaning of Female Genital Mutilation and Cutting: A Symbolic Interactionist Approach among Religious University Students," *Islamic Communication Journal* 10, no. 1 (2025).

transformation requires a redefinition of respectability itself: family honor must be detached from control over female sexuality and reconstructed around bodily dignity, child protection, informed consent, and freedom from non-medically indicated intervention. Because the present analysis is documentary, this conclusion identifies a recurring normative structure within the reviewed literature rather than claiming that all families in Serang currently understand or practise female circumcision in an identical manner.

Dukun Paraji, Cultural Brokerage, and Indigenous Health Governance

The analysis indicates that the significance of *dukun paraji* in the documentary corpus extends beyond their role as traditional practitioners who perform female circumcision. The reviewed documents construct *paraji* as actors situated at the intersection of family morality, customary authority, religiously inflected tradition, and local understandings of health care. Their legitimacy does not primarily derive from formal medical qualifications or state authorization, but from accumulated trust, familiarity, age, ritual knowledge, repeated involvement in childbirth and infant care, and recognition within local kinship networks. Indonesian studies on traditional birth attendants show that families may continue to rely on them because they provide culturally familiar assistance, emotional proximity, flexible services, and ritual reassurance that formal health institutions do not always offer.[49] Research in Pandeglang, Banten, similarly suggests that *paraji* remain socially relevant because maternal and infant-care decisions are shaped not only by the availability of biomedical services, but also by locality, family influence, cultural familiarity, and community trust.[50]

The documentary evidence demonstrates that the authority of *dukun paraji* operates through four interconnected functions: symbolic authority, cultural brokerage, informal legal authority, and indigenous health governance. These functions explain why their role cannot be reduced either to technical performance or to a simple lack of biomedical

[49] Christiana R Titaley et al., "Why Do Some Women Still Prefer Traditional Birth Attendants and Home Delivery? A Qualitative Study on Delivery Care Services in West Java Province, Indonesia," *BMC Pregnancy and Childbirth* 10 (2010): 43, https://doi.org/10.1186/1471-2393-10-43.

[50] S Handayani et al., "Relevansi, Efektivitas Dan Sustainabilitas Model Pemberdayaan Paraji Dan Kokolot Dalam Upaya Meningkatkan Persalinan Di Fasilitas Kesehatan," *Health Science Journal of Indonesia / Buletin Penelitian Sistem Kesehatan* 24, no. 1 (2021), https://doi.org/10.22435/hsr.v24i1.3406.

knowledge. They occupy a mediating position between the family's moral expectations and the bodily intervention through which those expectations are enacted. In this position, *paraji* do not merely carry out a previously settled family decision. Their recognition as trusted practitioners may also confirm that the decision is culturally legitimate, morally acceptable, and consistent with inherited understandings of care.

First, *dukun paraji* exercise symbolic authority. Bourdieu's concept of symbolic capital helps explain how their influence is accumulated through social recognition rather than through formal credentials. Age, experience, reputation, ancestral knowledge, repeated service to families, and participation in important reproductive transitions generate a form of authority that is socially acknowledged as legitimate.[51] Within the reviewed documents, this symbolic capital allows the *paraji* to occupy a position that may be more persuasive to families than an impersonal medical warning or an abstract government regulation. The authority to touch, treat, cleanse, or perform rituals on a child's body is therefore granted not solely because of technical competence, but because the practitioner has been incorporated into the community's moral memory.

This finding distinguishes social legitimacy from medical competence. The documentary evidence does not establish that traditional recognition provides the clinical knowledge required to perform procedures involving female genitalia safely. Rather, it shows how cultural trust can obscure the distinction between socially recognized care and medically justified treatment. When a bodily intervention is performed by a trusted elder who has assisted several generations of the same family, the act may be interpreted as protection, purification, or moral completion rather than as a medically unnecessary intervention. Symbolic authority thus contributes to what Bourdieu describes as misrecognition: unequal or potentially harmful practices are accepted as natural, virtuous, or benevolent because the authority sustaining them is culturally respected.[52]

Second, the analysis identifies *dukun paraji* as cultural brokers. They mediate between different systems of meaning by translating family expectations, customary practices, religious vocabulary, and bodily procedures into a culturally coherent act. In medical anthropology, bodies are never understood solely through biological

[51] Bourdieu, *Language and Symbolic Power*.
[52] Bourdieu.

categories; they are interpreted through local histories, moral expectations, social relationships, and culturally specific understandings of illness and care.[53] The *paraji* occupies precisely this intermediary position. She connects the biological body of the girl with the social body of the family and community by giving the procedure a meaning that biomedical discourse does not recognize.

As a cultural broker, the *paraji* can transform a bodily intervention into a ritual of purification, family obedience, social belonging, or preparation for proper womanhood. This process involves more than semantic labeling. It changes how the family evaluates the act. A procedure classified by medical authorities as lacking indication may be classified within customary discourse as care. Potential harm may be minimized when the act is embedded in familiar rituals, carried out by a trusted practitioner, and supported by elder relatives. The central issue is therefore not simply whether families possess medical information, but how that information is interpreted within an existing moral framework. Biomedical knowledge competes with a culturally mediated understanding of care rather than entering a normatively neutral decision-making process.

The cultural-broker role also explains why replacing traditional practitioners with medical personnel would not necessarily eliminate the practice. Evidence from Egypt shows that the movement of FGM/C from traditional practitioners to health professionals may strengthen rather than weaken the practice by giving it an appearance of clinical safety and professional legitimacy.[54] Studies conducted after criminalization similarly indicate that medicalization may persist when families and providers continue to negotiate among legal prohibition, custom, religious claims, modesty, and social pressure.[55] Comparative research on medicalized FGM/C further warns that transferring a culturally demanded procedure to health professionals can reduce certain

[53] Kleinman, Eisenberg, and Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research"; Lock and Nguyen, *An Anthropology of Biomedicine*.

[54] O El-Gibaly et al., "Health Care Providers' and Mothers' Perceptions about the Medicalization of Female Genital Mutilation or Cutting in Egypt: A Cross-Sectional Qualitative Study," *BMC International Health and Human Rights* 19 (2019): 26, https://doi.org/10.1186/s12914-019-0202-x.

[55] D Alkhalaileh et al., "Prevalence and Attitudes on Female Genital Mutilation/Cutting in Egypt since Criminalisation in 2008," *Culture, Health & Sexuality* 20, no. 2 (2018): 173–82, https://doi.org/10.1080/13691058.2017.1337927.

immediate risks while simultaneously normalizing the underlying practice.[56] These comparative cases do not provide direct evidence concerning present practices in Serang, but they clarify a mechanism relevant to the Indonesian documentary evidence: changing the practitioner does not automatically change the normative demand.

Third, *dukun paraji* may be interpreted as informal legal actors. Legal anthropology demonstrates that socially effective norms are not produced only by legislatures, courts, or formal administrative institutions. Rules and obligations may also emerge from semi-autonomous social fields such as families, kinship networks, religious communities, and customary institutions.[57] Within such fields, actors who possess recognized authority may interpret norms, authorize conduct, settle uncertainty, and determine whether an action is socially proper. The *paraji* therefore functions not simply as a service provider but as an actor whose participation can validate the family's interpretation of customary and religious obligation.

This does not mean that *dukun paraji* formally create law. Rather, their authority operates within legal pluralism, where state regulation, customary norms, family morality, religious interpretations, and medical standards coexist and compete.[58] Ministerial Regulation No. 6 of 2014 states that female circumcision is not a medically indicated procedure and has not been demonstrated to provide health benefits.[59] Nevertheless, the reviewed literature suggests that formal medical and regulatory positions may remain socially weak when local actors continue to define the practice as culturally appropriate. The participation of a respected *paraji* can provide an informal form of authorization, even where no formal legal authorization exists.

The informal legal role of the *paraji* is especially important because it connects normative interpretation with practical implementation. Elder family members may transmit the expectation, religious vocabulary may provide moral justification, and parents may

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[56] Samuel Kimani and Bettina Shell-Duncan, "Medicalized Female Genital Mutilation/Cutting: Contentious Practices and Persistent Debates," *Current Sexual Health Reports* 10, no. 1 (2018): 25–34, https://doi.org/10.1007/s11930-018-0140-y.

[57] Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study."

[58] Griffiths, "What Is Legal Pluralism?"; Merry, "Legal Pluralism."

[59] Indonesia, "Regulation of the Minister of Health of the Republic of Indonesia Number 6 of 2014 Concerning the Revocation of Regulation of the Minister of Health Number 1636/Menkes/Per/XII/2010 Concerning Female Circumcision."

approve the decision, but the *paraji* converts these normative claims into embodied action. She stands at the point where family obligation becomes bodily practice. In Foucauldian terms, power operates here not primarily through centralized legal coercion, but through intimate and dispersed practices that discipline bodies in everyday social settings.[60] The *paraji* becomes part of a capillary structure of power through which expectations concerning gender, sexuality, cleanliness, and female respectability are materialized on the body.

Fourth, the analysis positions *dukun paraji* within indigenous health governance. This concept refers to locally recognized systems through which communities define appropriate care, identify trusted practitioners, regulate access to reproductive knowledge, and negotiate relationships with formal health institutions. The reviewed documents suggest that the authority of traditional birth attendants persists because health decisions are embedded in social relations rather than determined exclusively by biomedical evidence. Families may evaluate practitioners according to accessibility, familiarity, emotional support, cultural competence, ritual knowledge, and respect for community expectations.[61] Indigenous health governance therefore explains why formal health systems do not automatically displace customary actors.

Within this system, *paraji* may perform a dual function. They may sustain practices that biomedical and human-rights frameworks classify as harmful, but they may also become strategic agents of transformation. Their proximity to families, familiarity with local moral language, and symbolic authority provide them with capacities that external health campaigns often lack. The same practitioner who once facilitated a bodily intervention may potentially reinterpret care through non-injurious rituals, explain the absence of medical benefit, refer families to health services, or support the abandonment of genital cutting. The relevant question is therefore not only how *paraji* reproduce female circumcision, but under what conditions their authority can be redirected toward bodily protection.

These four roles can be integrated into what this article terms the Paraji-Mediated Indigenous Health Governance Model. The model

[60] Foucault, *The History of Sexuality, Volume 1: An Introduction*.

[61] Titaley et al., "Why Do Some Women Still Prefer Traditional Birth Attendants and Home Delivery? A Qualitative Study on Delivery Care Services in West Java Province, Indonesia"; Handayani et al., "Relevansi, Efektivitas Dan Sustainabilitas Model Pemberdayaan Paraji Dan Kokolot Dalam Upaya Meningkatkan Persalinan Di Fasilitas Kesehatan."

explains how traditional authority mediates the transition from family expectation to bodily intervention through the following sequence:

Family moral demand → symbolic authorization → cultural translation → informal normative validation → bodily enactment → social reinforcement or normative transformation.

Family moral demand originates in expectations concerning purity, honor, obedience, sexuality, and female respectability. Symbolic authorization occurs when the trusted status of the *paraji* confirms that the practice is socially legitimate. Cultural translation reframes a non-medical intervention as purification, protection, care, or moral preparation. Informal normative validation occurs when customary and religious meanings are treated as sufficient grounds for action despite the absence of medical indication. Bodily enactment translates these meanings into ritual or physical practice. The final stage may produce social reinforcement when the family's compliance is recognized, or normative transformation when the *paraji* redirects her authority toward non-harmful alternatives and abandonment.

The model brings together theories that previously appeared separately in the discussion. Bourdieu explains the symbolic capital that makes the *paraji* socially authoritative.[62] Foucault explains how this authority becomes part of an intimate disciplinary structure that regulates the female body.[63] Legal pluralism explains how customary and family-based authority can remain effective despite competing state and medical norms.[64] Medical anthropology explains how bodily harm may be culturally translated into care and how trust shapes evaluations of appropriate treatment.[65] Integrated through indigenous health governance, these perspectives show that the *paraji* is simultaneously a cultural, normative, and health-related actor.

This synthesis also refines the Family Normative Governance Model developed in the preceding sections. The family produces and distributes expectations, but the *paraji* mediates their passage from discourse to embodied practice. She is not external to family governance;

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[62] Bourdieu, *Language and Symbolic Power*.

[63] Foucault, *The History of Sexuality, Volume 1: An Introduction*.

[64] Griffiths, "What Is Legal Pluralism?"; Merry, "Legal Pluralism"; Moore, "Law and Social Change: The Semi-Autonomous Social Field as an Appropriate Subject of Study."

[65] Kleinman, Eisenberg, and Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research"; Lock and Nguyen, *An Anthropology of Biomedicine*.

she is incorporated into it as a trusted implementer and validator. At the same time, she connects the family to wider customary and reproductive-health networks. The *paraji* therefore occupies a bridging position between domestic authority and community governance, making her one of the most consequential actors in the reproduction or transformation of female circumcision.

The documentary evidence consequently challenges two reductive interpretations. The first depicts *dukun paraji* solely as dangerous traditional actors whose authority should simply be eliminated. This approach overlooks the relational foundations of their legitimacy and may alienate families who continue to trust them. The second romanticizes them as custodians of cultural heritage without adequately addressing the implications of non-medically indicated genital intervention. A socio-legal analysis must avoid both positions. Cultural authority deserves analytical recognition, but it cannot be treated as a justification for violating bodily integrity or child protection principles.

The practical implication is that abandonment strategies should engage *dukun paraji* as potential agents of normative change while establishing a clear boundary that genital injury cannot be redefined as legitimate care. Interventions should not be limited to biomedical instruction; they must address the cultural meanings through which care, purification, family responsibility, and respectability are constructed. Training and dialogue could reposition *paraji* from ritual executors to community educators, referral actors, advocates of non-injurious rites, and local mediators of bodily protection. Such transformation would not merely replace one practitioner with another. It would change the normative content of indigenous health governance.

Because this study is based on documentary analysis, the proposed model should be understood as an analytical reconstruction rather than a direct description of every *dukun paraji* or Muslim family in Serang. The available literature does not establish the current prevalence, uniformity, or exact form of *paraji* involvement across the region. Nevertheless, the documentary synthesis reveals a consistent conceptual pattern: traditional authority becomes socially effective when trust, ritual competence, family memory, cultural meaning, and bodily practice converge. The novelty of this analysis lies in identifying the *dukun paraji* not merely as the performer of female circumcision, but as a symbolic authority, cultural broker, informal legal actor, and participant in indigenous health governance. This multidimensional position explains

why the same authority can sustain the practice or become a powerful channel for its abandonment.

Medical Risk, Legal Pluralism, and the Need for Religious Counter-Discourse

The analysis indicates that the central conflict surrounding female circumcision is not simply between medical knowledge and cultural ignorance. The documentary evidence demonstrates a deeper competition among biomedical evidence, state regulation, child-protection principles, religious interpretation, customary authority, and family morality. Within this contested normative field, medical risk may be acknowledged but subordinated to culturally persuasive ideas of purification, propriety, family honor, and religious responsibility. Such an approach is consistent with a layered conception of hadith authority in which transmission, rational deliberation, and normative moral reasoning including non-harm, mercy, proportionality, and public welfare must operate together in responsible Islamic ethical judgment.[66] The persistence of the practice is therefore best explained not by the complete absence of information, but by a hierarchy of normative authority in which family, customary, and religiously framed claims may be treated as more socially binding than medical advice or formal regulation.

The reviewed medical literature consistently rejects the assumption that female genital intervention provides therapeutic benefits. The WHO collaborative prospective study involving 28,393 women in six African countries identified an association between FGM and increased obstetric complications, including caesarean delivery, postpartum haemorrhage, prolonged maternal hospitalization, infant resuscitation, stillbirth, and early neonatal death, with the level of risk increasing according to the severity of cutting.[67] These findings cannot be directly generalized to every form of female circumcision reported in Indonesia because the anatomical extent, instruments, practitioners, and social contexts may differ. Nevertheless, the distinction between

[66] Isnayanti Isnayanti, Muhammad Ghifary Ramadani Mallo, and Muhammad Nabil Ardhani, "Hadith Authority in Late Modern Islamic Ethics: Reframing Transmission, Rational Deliberation, and Normative Moral Reasoning," *Dialogues in Qur'anic and Hadith Studies* 1, no. 1 (2026): 77–101, https://journal.bahsisfikr.or.id/index.php/DQHS/article/view/15

[67] E Banks et al., "Female Genital Mutilation and Obstetric Outcome: WHO Collaborative Prospective Study in Six African Countries," *The Lancet* 367, no. 9525 (2006): 1835–41, https://doi.org/10.1016/S0140-6736(06)68805-3.

extensive excision and supposedly "minor" or "symbolic" procedures does not resolve the ethical and legal problem when genital tissue is injured without medical indication and without the meaningful consent of the child.

The documentary synthesis identifies what may be termed an asymmetrical legal architecture. Indonesian health regulation increasingly provides an explicit policy direction against female circumcision, but the criminal-law consequences remain indirect and distributed across several statutes. Historically, Ministerial Regulation No. 6 of 2014 revoked the earlier procedural regulation and affirmed that female circumcision was not a medically indicated procedure and had not been demonstrated to provide health benefits.[68] This position has subsequently been strengthened by Law No. 17 of 2023 on Health. Articles 54-57 place reproductive health within the protection of reproductive systems and functions, recognize the right to a healthy and safe reproductive and sexual life free from discrimination, coercion, and violence, and require reproductive-health services to be safe and of appropriate quality. More explicitly, Article 102(a) of Government Regulation No. 28 of 2024 identifies the elimination of female circumcision as part of reproductive-health efforts for infants, toddlers, and preschool children.[69]

This regulatory development changes the legal framing of the practice. Female circumcision can no longer be treated merely as an unregulated cultural procedure existing outside health policy. Government Regulation No. 28 of 2024 places its elimination within the state's reproductive-health obligations. However, the provision primarily establishes a preventive and administrative direction; it does not independently formulate a specific criminal offence called "female circumcision." The documentary analysis therefore reveals a gap between explicit health-policy rejection and indirect criminal accountability. This gap may contribute to uncertainty among families, practitioners, health workers, and law-enforcement institutions regarding when a customary ritual becomes legally actionable bodily violence.

The Child Protection Law provides a more direct protective framework. Law No. 35 of 2014 defines violence against children as

[68] Indonesia, "Regulation of the Minister of Health of the Republic of Indonesia Number 6 of 2014 Concerning the Revocation of Regulation of the Minister of Health Number 1636/Menkes/Per/XII/2010 Concerning Female Circumcision."

[69] Supreme Court of the Republic of Indonesia, "Annual Report of the Supreme Court 2023" (Jakarta: Mahkamah Agung Republik Indonesia, 2023).

conduct resulting in physical, psychological, or sexual suffering, including coercion. Article 76C prohibits any person from placing, allowing, committing, ordering, or participating in violence against a child, while Article 80 provides criminal sanctions and increases the penalty when the perpetrator is the child's parent.[70] From a child-protection perspective, a non-therapeutic genital intervention that causes physical pain or injury may therefore be examined as violence against a child. Its customary or familial motivation does not automatically remove the child's entitlement to bodily protection.

Nevertheless, the application of the Child Protection Law requires careful factual and legal assessment. Not every ritual described locally as *sunat perempuan* involves the same physical act, and documentary labels such as "symbolic," "pricking," "scratching," or "cutting" may refer to materially different procedures. A legally credible analysis must therefore establish what was done, whether physical contact or injury occurred, who authorized and performed the act, what consequences resulted, and whether the conduct meets the statutory definition of violence. The law should not assume that all local practices are anatomically identical, but neither should the language of symbolism be allowed to conceal actual injury.

Law No. 12 of 2022 on Sexual Violence Crimes provides an additional but more complex legal pathway. Article 4 recognizes several forms of sexual violence, including physical sexual harassment and sexual torture, while Article 6 criminalizes specified physical sexual acts directed at the body, sexual desire, or reproductive organs when accompanied by the legally required purpose of degrading dignity or placing another person under unlawful control.[71] Female circumcision is not expressly named as a distinct offence in the statute. Its classification under the Sexual Violence Crimes Law would therefore depend on whether the particular conduct satisfies all statutory elements, including the physical act, its direction toward reproductive organs, the relevant intent, and the absence of a more serious applicable offence.

This limitation is analytically important. The practice may objectively involve a child's genital or reproductive organs, but the family or practitioner may claim a purpose of purification, tradition, or religious duty rather than an intention to degrade the victim. Such claims

[70] Ministry of Religious Affairs Republic of Indonesia, "Pedoman Bimbingan Perkawinan," 2020.

[71] Indonesia.

do not necessarily justify the act, but they may complicate the proof of the specific intent required by Article 6. Consequently, the Sexual Violence Crimes Law has conceptual relevance because female circumcision concerns bodily and reproductive integrity, yet its application is not automatic. The absence of an explicit provision on female genital cutting leaves interpretive uncertainty and reinforces the need to coordinate the Sexual Violence Crimes Law with child-protection, health, and general criminal-law provisions.

The new Indonesian Criminal Code, enacted through Law No. 1 of 2023, further strengthens the general protection of bodily integrity. Article 155 includes damage to reproductive function within the definition of serious injury, while Article 156 defines violence broadly as conduct causing danger to the body or life, physical, sexual, or psychological suffering, or deprivation of liberty. Articles 466–469 regulate ordinary, premeditated, serious, and premeditated serious assault, including conduct that damages health.[72] These provisions may provide a possible basis for assessing female circumcision as assault when physical injury, damage to health, or impairment of reproductive function can be established. However, such application remains dependent on the facts, the degree of injury, causation, the actor's responsibility, and judicial interpretation.

Parental approval should not be treated as automatically legitimizing a non-medically indicated intervention on a child's genital organs. Parents possess authority and responsibility for care, but that authority is constrained by the best interests, health, safety, dignity, and bodily rights of the child. The documentary evidence therefore reveals a fundamental tension between sociological family authority and juridical parental responsibility. Within the family's moral order, approval may be interpreted as responsible care. Within child-protection and criminal-law frameworks, the same approval may become relevant to participation in, authorization of, or failure to prevent physical violence. This tension illustrates how legal pluralism operates not merely as the coexistence of different rules, but as a conflict over which authority may legitimately determine what happens to a child's body.

Indonesia's international obligations further strengthen the protective interpretation. Indonesia ratified the Convention on the Elimination of All Forms of Discrimination against Women through Law No. 7 of 1984. CEDAW requires states to eliminate discriminatory

[72] Indonesia, "Annual Report of the Supreme Court 2023."

practices and transform social and cultural patterns based on stereotyped gender roles, while its health provisions require the elimination of discrimination in access to health care. CEDAW General Recommendation No. 14 specifically addresses female circumcision, and the later joint CEDAW-CRC recommendation classifies harmful practices as gender-based practices that states must prevent and eliminate.[73]

Indonesia also ratified the Convention on the Rights of the Child through Presidential Decree No. 36 of 1990. Article 19 requires protection of children from physical or mental violence, injury, and abuse, while Article 24(3) requires states to take effective measures to abolish traditional practices prejudicial to children's health. These provisions are particularly relevant because they reject the assumption that cultural continuity can by itself justify practices harmful to children. The CRC does not deny the importance of family and cultural values, but it places those values within the overriding requirements of child health, protection, dignity, and best interests.[74]

The interaction of these instruments reveals that Indonesia does not lack legal principles relevant to female circumcision. The more precise problem is fragmentation. The Health Law and its implementing regulation establish reproductive-health protection and an explicit policy of elimination. The Child Protection Law prohibits violence against children. The Sexual Violence Crimes Law protects bodily and reproductive integrity but does not expressly name female circumcision. The Criminal Code provides general assault provisions and recognizes reproductive-function damage as serious injury. CEDAW and the CRC require the elimination of gender-discriminatory and harmful traditional practices. Yet these norms have not been consolidated into a single operational framework specifying definitions, reporting duties, practitioner liability, parental responsibility, evidentiary standards,

[73] Indonesia, "Regulation of the Minister of Health of the Republic of Indonesia Number 6 of 2014 Concerning the Revocation of Regulation of the Minister of Health Number 1636/Menkes/Per/XII/2010 Concerning Female Circumcision"; L Tønnessen, "Between Sharia and CEDAW in Sudan: Islamist Women Negotiating Gender Equity," in *Gender Justice and Legal Pluralities: Latin American and African Perspectives*, 2013, 133–55, https://doi.org/10.4324/9780203084434-11.

[74] Republic of Indonesia, "Presidential Instruction of the Republic of Indonesia Number 1 of 1991 Concerning the Dissemination of the Compilation of Islamic Law," Compilation of Islamic Law in Indonesia § (1991); United Nations, "International Covenant on Civil and Political Rights," 1966.

preventive intervention, and culturally appropriate abandonment procedures.

Legal pluralism explains why the presence of multiple protective norms does not automatically produce abandonment. State law is only one component of the normative environment in which families act. Family expectations, customary authority, religious language, and the symbolic status of elder women or *dukun paraji* may exercise greater practical influence over everyday decisions. The central issue is therefore not merely whether protective law exists, but whether its meaning can enter the intimate moral field of the family and displace the customary legitimacy of the practice.

Medical anthropology explains the second dimension of this regulatory failure. Biomedical institutions classify female genital injury according to anatomy, risk, clinical indication, consent, and measurable health outcomes. Families and customary practitioners may instead interpret the same act through concepts of cleanliness, purification, modesty, protection, moral preparation, and social belonging.[75] The conflict is thus partly epistemological: biomedical evidence defines the act as unnecessary and potentially harmful, while customary discourse may redefine it as responsible care. Medical facts do not enter an empty cultural space; they are filtered through existing moral classifications.

Bourdieu and Foucault clarify how these competing classifications become unequal in social practice. Bourdieu's theory of symbolic power explains how family elders, religious figures, and traditional practitioners can make customary interpretations appear legitimate, natural, and benevolent.[76] Foucault's account of disciplinary power explains how these interpretations become materialized through intimate control over the female body, particularly when norms of sexuality, purity, and obedience are imposed before the child can participate meaningfully in the decision.[77] Legal pluralism identifies the competing normative orders, medical anthropology explains the divergent meanings of harm and care, Bourdieu explains why customary authority is recognized, and Foucault explains how that authority is inscribed on the body.

[75] Lock and Nguyen, *An Anthropology of Biomedicine*; Kleinman, Eisenberg, and Good, "Culture, Illness, and Care: Clinical Lessons from Anthropologic and Cross-Cultural Research."

[76] Bourdieu, *Language and Symbolic Power*.

[77] Foucault, *The History of Sexuality, Volume 1: An Introduction*.

The analysis therefore demonstrates that religious counter-discourse is not an optional supplement to legal and medical intervention. It is a necessary mechanism of normative translation. A general assertion that female circumcision "is not Islamic" may be insufficient when families do not rely on formal doctrine alone but on inherited religious vocabulary, elder authority, communal expectations, and ideas of purification. A more credible counter-discourse must demonstrate from within Islamic ethical reasoning that preventing harm, protecting children, preserving bodily dignity, and refusing non-therapeutic injury are themselves religious responsibilities. Islamic and humanitarian publications have challenged the treatment of female circumcision as a religious obligation and emphasized that inherited customs should not be transformed into binding doctrine without a valid religious basis.[78]

Religious counter-discourse performs three interrelated functions. First, it removes the assumption that abandoning female circumcision constitutes disobedience to Islam. Second, it translates medical and legal concerns into a moral vocabulary that families and religious communities recognize. Third, it redefines honor from control over the girl's body to responsibility for her safety, dignity, and bodily integrity. Comparative evidence also indicates that awareness of physical and sexual consequences does not necessarily produce abandonment when patriarchal expectations and social pressures remain intact.[79] Religious reinterpretation must therefore be combined with changes in family authority and collective expectations rather than delivered only as individual health information.

The effectiveness of religious counter-discourse also depends on how it is communicated and circulated. Contemporary fatwa authority is increasingly mediated through institutional websites, social media, searchable digital archives, and networked Muslim publics, where religious guidance acquires visibility and legitimacy through institutional credibility, media formats, and audience participation. Religious counter-discourse on female circumcision should therefore be

[78] Research and UNICEF, "Female Circumcision: Between the Incorrect Use of Science and the Misunderstood Doctrine"; Many, "Religion and FGM/C"; Asmani and Abdi, "De-Linking Female Genital Mutilation/Cutting from Islam."

[79] F A Ali, B A Alhaffar, and N Howard, "Women's Perspectives on Female Genital Mutilation/Cutting Abandonment in Somalia: A Qualitative Study," *PLOS Global Public Health* 5, no. 5 (2025): e0004571, https://doi.org/10.1371/journal.pgph.0004571.

disseminated not only through face-to-face religious instruction, but also through credible digital fatwa platforms and public-education networks capable of reaching parents, religious educators, health workers, and younger Muslim audiences.[80]

The findings from this and the preceding sections can be consolidated into a Family-Mediated Socio-Legal Reproduction Model. The model explains persistence through the following sequence: Gendered expectations of honor → family normative authorization → religious and customary legitimation → cultural brokerage by trusted actors → bodily enactment → social reinforcement.

It also explains abandonment through a reverse process: Medical recognition of harm → explicit legal protection → Islamic ethical reinterpretation → engagement of family and community authorities → withdrawal of normative legitimacy → abandonment or replacement with non-injurious practices.

Within this model, the decisive issue is not only the existence of competing rules but the ordering of normative authority. Female circumcision persists when family honor, customary legitimacy, and religious symbolism are ranked above bodily autonomy, medical evidence, and state protection. Transformation becomes possible when protective law and biomedical evidence are translated by credible religious, familial, and customary actors into a socially persuasive definition of care. The objective is therefore not simply to add more prohibitions, but to reorder the hierarchy through which families determine what is moral, religious, healthy, and legally acceptable.

The documentary evidence ultimately demonstrates that female circumcision should be understood as a problem of fragmented legal protection and contested normative governance. Indonesia's health regulations now articulate an explicit commitment to eliminating the practice, while child-protection, sexual-violence, criminal-law, CEDAW, and CRC frameworks provide overlapping protections for bodily integrity. However, the lack of a consolidated legal classification and implementation mechanism may weaken practical enforcement. Effective prevention consequently requires legal clarity, medical education, child-protection procedures, family-level intervention, engagement with *dukun paraji*, and religious counter-discourse. The

[80] Marhamah Annazah Tambunan and Maulida Fitria, "Digital Fatwas and the Transformation of Religious Authority in Contemporary Muslim Societies," *Islamicate Futures: Knowledge, Ethics, and Muslim Societies* 1, no. 1 (2026): 96–123, https://journal.bahsisfikr.or.id/index.php/IFKEMS/article/view/41

struggle over female circumcision is therefore not only a dispute about medical risk; it is a contest over which institutions possess the legitimate authority to define care, honor, religion, violence, and the boundaries of parental power.

CONCLUSION

This study concludes that the sustainability of women's circumcision practices in Serang, Banten, is not solely influenced by religious factors or limited medical knowledge, but is the result of complex interactions between family authorities, customary legitimacy, symbols of women's honor, religious discourse, and cultural constructions regarding body care. The Muslim family serves as a key arena that mediates, prioritizes, and legitimizes various legal, religious, customary, and health norms before translating them into social practices. In that context, paraji shamans function not only as ritual implementers, but also as symbolic authorities, cultural intermediaries, informal legal actors, and part of local health governance that reinforce the reproduction of the practice.

Theoretically, this research offers novelty through the development of the Family-Mediated Socio-Legal Reproduction Model, which explains that the effectiveness of legal, medical, religious, and customary norms is determined by the mediation process in the family and community, not by the existence of the norm itself. This model expands the study of legal pluralism by integrating the perspectives of legal anthropology, medical anthropology, symbolic power, disciplinary power, and gender theory into a single analytical framework to explain how the practice of female circumcision is maintained or potentially abandoned in Muslim societies.

The implications of the study show that efforts to abolish female circumcision require an integrated socio-legal approach, going beyond legal prohibitions and health education alone. Policy effectiveness depends on the harmonization of legal protection, strengthening family-based health education, involving religious leaders, health workers, parents, and paraji shamans as agents of social change, as well as the development of a religious counter-narrative that affirms the principles of harm prevention, bodily dignity, and protection of children's rights. This research is still limited to documentary analysis, so further research based on ethnography and socio-legal field studies is needed to test the validity of the developed model and evaluate the dynamics of its implementation in various social and cultural contexts.

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