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Original Research Article

Health Communication Barriers in the Eradication of Female Genital Mutilation: The Role of Social Copying and Inadequate Education

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ABSTRACT

This study explored the persistence of Female Genital Mutilation/Cutting (FGM/C) in Indonesia, focusing on the role of health communication barriers and social copying in sustaining the practice. Despite being recognized globally as a violation of human rights, FGM/C remains prevalent as a culturally normative practice in West Java, where it is intertwined with notions of purity, religion, and social acceptance. Using a qualitative case study with an ethnographic communication approach in Purwakarta Regency, this research involved in-depth interviews with 10 participants, consisting of two traditional birth attendants (paraji), three healthcare workers (doctors and midwives), two adult women, and 2 adolescents to understand how cultural meanings and weak health communication perpetuate the practice. The findings revealed that FGM/C was endured not because of religious obligation but through intergenerational social imitation and the absence of culturally sensitive health education. Ambiguous regulations and passive attitudes among healthcare providers further reinforce public reliance on traditional actors. Consequently, formal health messages fail to challenge deeply rooted social norms. The study concludes that effective eradication of FGM/C requires culturally grounded and integrated health communication strategies.

Keywords: Cultural Norms; Female Genital Mutilation; Health Communication; Social Copying

INTRODUCTION

Since 1997, FGM/C has been globally recognized as a violation of human rights and a form of gender-based violence that harms women's reproductive health and bodily integrity (WHO et al., 2008). Despite contradicting the targets of the 3rd and 5th Sustainable Development Goals (SDGs), this practice persists as a collective norm passed down across generations. Its impact is not only physical but also long-term psycho-social, including trauma, decreased self-esteem, and the risk of post-traumatic stress disorder (PTSD) (Keles et al., 2025; Newton & Glover, 2022).

In Indonesia, this phenomenon shows a unique complexity. Indonesian Basic Health Research data have shown that FGM/C practices are not influenced by economic or educational levels, but rather by the power of habitus and social structures internalized within families (Rosyidah & Jamilah, 2022). This situation is complicated by policies in Indonesia that have undergone extreme shifts. In 2010, the government issued Minister of Health Regulation No. 1636/2010, which attempted to "medicalize" the practice by providing guidelines for medical personnel. However, this regulation was revoked and replaced by a policy that explicitly prohibited all health workers from performing female circumcision in any form, as it was deemed to have no medical indication. Ironically, this total ban on medical personnel was not accompanied by a decline in demand among the community; as a result, the practice

shifted back to traditional practitioners such as *paraji* (traditional birth attendants). This phenomenon has created a riskier underground market and proves that formal, *top-down* policy interventions are often powerless against the pressure of deeply rooted social norms and religious identities.

Qualitative studies have shown that FGM has significant psychosocial consequences. Women who undergo circumcision in childhood often carry traumatic memories into adulthood. This trauma can make them feel a loss of control over their bodies, lower their self-confidence, and cause feelings of worthlessness. In the long term, this condition can also affect the quality of their relationships with their partners, including the emergence of fear, pain, or awkwardness in married life (Newton & Glover, 2022). Furthermore, recent research has linked FGM to a higher risk of PTSD and depression, especially when the practice is performed without consent or at a very young age (Keles et al., 2025). This finding underscores that FGM is not merely a medical issue but has far-reaching impacts on women's social and psychological well-being.

As the island with the largest population in Indonesia, West Java remains an area where female circumcision continues to be practiced. This practice is inseparable from the strong Sundanese culture that upholds the values of tradition and ancestral heritage. Female circumcision is often seen as a legacy of the elders and is considered necessary to maintain the religious identity and "purity" of girls. The term circumcision comes from the Javanese language, while in Sundanese it is called *sudat.* In polite language, the term *disepitan,* which means cleaned, is often used. The root word, *sebitan*, refers to a small cut or the act of tearing something. traditional practitioners, or *paraji,* often refer to the practice as *'sunat istri'*, describing it as a symbolic 'scratch' intended to moderate future desires and ensure the child's spiritual well-being, rather than an invasive surgical procedure. This linguistic framing can give female circumcision a positive connotation because the community sees it as a religious obligation, while others emphasize the aspect of family tradition. This practice persists because it is passed down through intergenerational communication, especially between mothers and grandmothers, who emphasize that *disepitan* is part of the process of cleansing oneself, maintaining honor, and ensuring that girls are accepted into the community (Setiati et al., 2023).

Various social practices that persist across generations are not always maintained because of reflective individual beliefs, but rather because of their existence as social norms that are collectively reproduced. In studies of harmful *practices*, such as FGM, these practices persist not primarily because of formal coercion, but because they operate as social norms that regulate reciprocal expectations among community members. In this context, individuals adjust their actions to what is done and expected by their social environment in order to maintain acceptance and social status (Mackie & LeJeune, 2009). This gap is further explained by Goel and Arora (2025), who argue that health outcomes are not only determined by economic or physical access to care, but are deeply constrained by a lack of 'social and cultural independence.' In communities where women's autonomy is low, their health decisions including the practice of female circumcision are dictated by the need to conform to communal social norms rather than individual health considerations.

This study used a symbolic interaction perspective to understand how female circumcision practices are maintained through social interaction and the meanings attached to these actions. Symbolic interaction explains that humans interact with others, interpret actions, and give meaning to objects or events through mutually agreed symbols (Littlejohn & Foss, 2009). Human actions are based on the meanings they possess, which are obtained from

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social interactions and are dynamic through communication (Soeprapto, 2002). Thus, identity, social relationships, and social structures are constructed through symbols, especially language, which are used to interpret one's own actions and those of others (Poerana et al., 2023). This approach helps research explain how traditions are passed down and reproduced through cross-generational social interactions.

The practice of FGM/C persists through a mechanism *of social copying*, whereby individuals imitate dominant behaviors within their community as a manifestation of concrete social norms in order to maintain collective identity and group affiliation (McAdams, 1997). This mechanism bridges abstract moral norms, such as the obligation to maintain family honor, into specific actions that are considered "normal" and "should be done" because they have been essentialistically constructed as part of a tradition inherent to group identity (Mackie & LeJeune, 2009). As a result, these culturally normative practices are faithfully replicated across generations without the need for a deep understanding of the reasons behind them, making them a collective habit that is difficult to shake by individual reflective thinking.

The persistence of this phenomenon of social imitation is exacerbated by the low effectiveness of health education in Indonesia, which still faces structural obstacles, such as limited geographical access and a lack of culturally sensitive education (Yatni et al., 2025). When health information is inconsistent and fails to provide credible counterarguments, people tend to turn to the symbolic authority of traditional or religious leaders and social references in their environment as a basis for decision-making. Although global literature has recognized FGM as a social convention, to date there have been no studies in Indonesia that specifically combine the perspective *of* social copying with an analysis of the weakness of health communication as a factor that allows the practice to continue. Therefore, this study aimed to fill this gap by exploring how the failure of medical information transmission reinforces cultural imitation mechanisms in perpetuating FGM/C practices in society.

METHODS

Research Design

This study used a qualitative approach with a case study design that employs communication ethnography to understand the socio-cultural reality of female circumcision practices. The research location was in Purwakarta Regency, West Java, Fieldwork was conducted over a period of four months, from November to February 2026, which was chosen because it has a diverse range of community characteristics, from modern urban areas to rural areas such as Wanayasa, which are still steeped in tradition. The difference in location aimed to see how the practice of female circumcision persists in different social environments through the mechanism of social imitation. Because the practice of female circumcision is maintained through meanings formed in social interactions and passed down across generations, this study used a constructivist paradigm to understand how people construct, interpret, and perpetuate this tradition. Constructivism as a paradigm is rooted in the belief that individuals seek understanding of the world in which they live and work. They develop subjective meanings from their experiences and meanings directed at specific objects or things (Creswell & Poth, 2018).

Population and Sample

Research informants were selected *purposively* to represent communities from urban and rural areas in Purwakarta. The informant group consisted of: health workers (doctors or

midwives) who faced dilemmas regarding community demands; and traditional practitioners who were still actively practicing their traditions. In addition, this study involved ten participants, consisting of three healthcare workers (doctors and midwives), two traditional birth attendants (*paraji),* three adult women to explore their traumatic experiences or cultural meanings, and two adolescents as recipients of values to see the potential for a shift in views on the practice of *disepitan.* Primary data was collected through in-depth interviews and observation of social interactions, while secondary data was obtained from policy documents and health education materials.

Data Analysis

Data analysis was conducted thematically using NVivo to identify patterns of social copying, social norms, and barriers in health communication. Ethical approval was granted by the Health Research Ethics Committee of Universitas Padjadjaran (No. 6/UN.KEC/EC/2026). Before data collection, informed consent was obtained from all participants after a full disclosure of the study's purpose and their right to unconditional withdrawal. To ensure confidentiality, all personal identifiers were removed through de-identification, and participants are referred to by pseudonyms throughout the report.

To ensure trustworthiness, the study employed triangulation of sources and methods, alongside the researcher's reflective notes. To mitigate interpretive bias, the analysis included coder discussions to refine thematic nodes and peer debriefing with academic colleagues. The results are presented descriptively to explain the communication dynamics perpetuating female circumcision in Purwakarta.

RESULTS AND DISCUSSION

The initial step of this analysis focused on identifying where the community actually obtained their main information about female circumcision. Through *Word Cloud* visualization in NVivo, the emerging pattern was very contrasting: terms such as "Health," "Tradition," "Religion," and "Clean" were the words most frequently mentioned by the informants. The dominance of these terms reflects overlapping constructions of meaning, in which the labels "health" and "cleanliness" are actually used by the community to justify practices rooted in cultural heritage and social conformity. In fact, medically speaking, female genitalia have a natural cleansing mechanism that does not require surgical intervention, so hygiene is often merely a sociocultural excuse to promote certain beauty standards that actually risk damaging the body's original functions (WHO, 2025).

The dominance of traditional and religious narratives in this practice shows that the procedure is viewed more as a moral and cultural obligation than merely a medical act. This finding has proven that in the collective view of the community, female circumcision is not a clinical procedure in itself, but rather a sacred identity ritual. As a result, the medical narrative of doctors or midwives is often less popular than the voices of family members and local figures who are considered to have more credibility in traditional matters.

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Figure 1. Word cloud visualization of the perceived meanings and cultural significance of *disepitan* (female circumcision) in Purwakarta.

The dominance of these terms can be further analysed through the lens of Symbolic Interactionism, particularly as articulated by Herbert Blumer. According to this perspective, individuals act toward things based on the meanings those things have for them, meanings which are derived from social interaction. In this context, terms like "Health" and "Clean" undergo a symbolic redefinition; they are no longer objective clinical descriptors, but rather social symbols representing moral and spiritual purity. Through continuous interaction within the kinship network, the community constructs a shared reality where the uncircumcised body is symbolized as "impure" or "incomplete." The effectiveness of this symbolic construction is driven by what Bermúdez-González et al. (2026) describe as 'symbolic leadership,' where traditional figures act as authentic sources of meaning. Their influence ensures that cultural symbols (like 'purity') generate a sense of 'pride of belonging' and 'identification' within the group, effectively overshadowing the health-based narratives provided by external medical authorities.

Thus, the practice persists because the meaning of the ritual is constantly reinforced through social dialogue, prioritizing the preservation of the "social self" and communal identity over medical facts. Furthermore, findings from in-depth interviews revealed that the persistence of this practice is driven by three intertwined factors, namely Female circumcision in this community is practiced as an automatic tradition that is rarely questioned, the mechanism of social copying is the most dominant factor in the continuation of the practice, and the lack of health education further reinforces the continuation of these practices, which form the core of the community's social logic:

Female Circumcision in This Community Is Practiced as An Automatic Tradition That Is Rarely Questioned

Female circumcision is performed not because of medical considerations or strong religious beliefs, but mainly because the practice is considered part of the birth cycle in the village. Indonesia is undergoing a process of modernization and globalization that brings together deep-rooted traditions with modern practices, including technological developments and social media (Alauddin et al., 2025). However, in the context of this research community,

the tide of modernization does not automatically displace traditional practices, as local social interaction patterns remain the primary reference in the formation of meaning and action. This resilience is often observed in migrant communities where female circumcision remains a deeply embedded cultural marker; even when individuals migrate to Western countries with different legal and social frameworks, the practice is frequently maintained as a way to preserve cultural identity and connection to their roots (Pastor-Bravo et al., 2021).

Paraji explained that in traditional communities, there has been no change from the past to the present. The decision to circumcise girls is the same as in other regions is performed when the baby is 40 days old and is carried out without any family discussion (Setiati et al., 2023; Sander & Sunantri, 2020). This belief is emphasized by one of the traditional birth attendants in a rural area who stated that circumcising all girls is a necessity to maintain their "purity." In this local view, a woman is not considered ritually valid in performing acts of worship such as prayer or reciting the Quran if she has not undergone circumcision. This understanding is what keeps the practice alive as a final spiritual obligation, the urgency of which is rarely questioned by the surrounding community.

This statement presents the norm that the community carries out this practice as if there were no other choice. In this situation, the *paraji* plays a role in various aspects of maternal and infant care, so the community's trust in her is very high. The *paraji* occupies a central position as a trusted figure in the community, so the community consistently entrusts the practice of female circumcision to her. The practice is perceived as a minor and harmless act, as it is not associated with bleeding or injury but rather interpreted as a process of purification and cleansing. Although the relationship between *paraji* and midwives is harmonious, there is a clear division of roles: health workers handle childbirth, while practices interpreted as cultural rites are entirely within the domain of *paraji.* In addition to social roles, community trust is reinforced by the persona of *paraji*, who are gentle, attentive, and wise in their interactions, thereby building symbolic legitimacy in the eyes of the community.

This finding reinforces the perspective that symbolic interactionism places the interaction between people and their negotiation of meaning at the center. In this context, meanings develop in and through people's defining interactions with one another , allowing them to use symbols to understand each other and define their actions (Hasim et al., 2023). In this context, the *paraji* functions as a social object that is interpreted as a safe and authoritative figure, so that the practice of female circumcision is maintained as an act that is considered normal and socially acceptable.

However, when this traditional meaning conflicts with formal medical regulations, people tend to look for loopholes so that the tradition can continue. This finding is reflected in the experience of a pediatrician who has been practicing for about two decades in Purwakarta, who said that female circumcision is understood by some parents not as a questionable medical procedure, but as a practice that is understood as part of social customs and religious beliefs. During his practice in Purwakarta, the doctor explained that the peak demand for female circumcision occurred around 2018, then declined as information about health regulations became more widespread. However, this practice did not completely stop, but continued in a symbolic form, and because the regulations were not strict, the community tended to do it through traditional midwives, which was riskier because it did not meet medical standards.

Based on interviews with doctors, parents generally interpret female circumcision as part of religious teachings that are similar in context to male circumcision, with the aim of

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maintaining the cleanliness and purity of children. He said that female circumcision among some communities is considered "something that should be done" and is rarely questioned by families, because it is seen as a religious matter with the aim of keeping children clean and pure. This perspective shows that female circumcision is carried out as an automatic tradition that has been symbolically legitimized, rather than as an act that requires careful health considerations.

The Mechanism of Social Copying Is the Most Dominant Factor in The Continuation of The Practice

The mechanism *of social copying* or social imitation emerged as the most dominant factor in the continuation of female circumcision practices. Field findings showed that individuals did not make decisions based on rational considerations or health knowledge, but rather by imitating behaviors that have been consistently observed since childhood. Repeated exposure to this practice in the immediate environment has internalized it as a social norm that is accepted without question. The persistence of female circumcision is driven by a deep-seated mechanism of social copying, where individuals replicate traditional practices with high fidelity to 'communicate likeness' and ensure group affiliation, often internalizing these cultural biases and normative behaviors from a very young age (Over & Carpenter, 2012; Torres, 2022)

Many human behaviors are not solely driven by individual rational considerations, but rather by an orientation toward the social norms that prevail in their environment. Individuals tend to adjust their behavior to what is done and approved by their social references, in order to ensure that their actions are considered appropriate and socially acceptable (Geber et al., 2021). In an interview with a pediatrician in Purwakarta, he explained that parents with a strong religious background believe that female circumcision will help shape their children into pious individuals. Parents with a good understanding of religion tend to see this practice as part of an effort to instill religious values from an early age.

This dominance of social copying is further reinforced by the use of specific linguistic frames. Whittle et al. (2023) suggest that language provides the cognitive schemas that guide action. The term *disepitan*, which is deeply embedded in the local vocabulary, acts as a linguistic frame that triggers a sense of cultural obligation, making the practice appear as an 'automatic' choice within the social structure. In this context, the decision to perform female circumcision does not arise from individual considerations, but rather from conformity to prevailing social norms and expectations, so that the practice is reproduced through mechanisms of social copying across generations. Social imitation functions not only as a learning process, but also as a mechanism for adjusting to community norms. One informant from the younger generation, for example, admitted to having known about this practice since childhood without ever thinking to question its urgency.

This awareness grew purely from the informant's observation of their environment, as expressed by a young mother who saw that all of her neighbors were doing the same thing. Interestingly, even though she s realized that in big cities like Bandung this practice was beginning to be abandoned, she felt that this rule did not apply in her village, which still considered circumcision to be an obligation. This phenomenon shows that information does not come from formal health education, but rather from the example set by the people around them. The social pressure that has been created has ultimately transformed the act of circumcision from a personal preference into a "social obligation" that is difficult to avoid.

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Unlike rural communities, the continuation of female circumcision in urban areas shows more complex dynamics. Although some values and beliefs are still rooted in rural traditions, urban communities tend to be more reflective and critical of the practice. They are beginning to question the purpose and benefits of female circumcision, and prefer health workers over traditional birth attendants to perform the procedure, in the hope that it will be carried out in a safer and more hygienic manner.

However, the shift from traditional birth attendants to health workers has not been accompanied by any substantial change in the meaning or purpose of the practice. Female circumcision is still understood as a tradition with moral or religious value, rather than a medical procedure with a scientific basis. The policy prohibiting health workers from performing female circumcision has actually caused confusion among the community, as it was not accompanied by a clear explanation of the medical, ethical, or social reasons behind the policy. Consequently, urban residents who were unable to access the procedure through formal healthcare facilities sought alternatives by privately summoning traditional birth attendants (paraji) to their homes. Unlike the elaborate traditional ceremonies often held in rural areas, such as those integrated with *marhabaan* rituals, these urban practices were conducted discreetly and solely focused on the physical procedure of circumcision to bypass formal prohibitions. As a result, the practice has not actually stopped, but has shifted to a more hidden and ambiguous space where the community questions the legitimacy of the practice, but the belief in its value and obligation remains.

This condition shows that individual decisions to perform female circumcision are not based on rational considerations between regions or health aspects, but rather on conformity to the social norms that apply in their environment. Information about changes in practice in urban areas does not necessarily influence behavior, because social pressure and limited choices at the local level mean that this practice continues to be seen as something normal and almost inevitable. Thus, the continuation of female circumcision is not solely maintained by religious beliefs or tradition, but also by social forces that normalize the practice in everyday life.

The Lack of Health Education Further Reinforces the Continuation of These Practices

The limitations of contextual and participatory health education create space for social copying mechanisms to play a more dominant role in shaping public health behavior. When formal health information is scarce, difficult to understand, or considered irrelevant, individuals tend to rely on what they observe in their immediate social environment as a reference for action. Practices that are carried out collectively and passed down across generations become the main source of learning, as they are considered to be socially "proven" and in line with community identity. In situations like this, changing health behaviors is difficult to achieve through conventional education approaches alone, because social norms reproduced through social imitation have a stronger influence than educational messages that come from outside the community.

Several studies have noted that communities tend to trust knowledge that has been passed down from generation to generation or conveyed by traditional and religious leaders more than they trust formal health workers (Reskiaddin et al., 2020). In this context, health education that does not involve local actors and does not adapt to the cultural framework of the community tends to lose its social legitimacy. As a result, health messages are not

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internalized as behavioral guidelines, but rather positioned as external knowledge that is separate from daily practices.

Findings in the field reveal that one of the main reasons for the persistence of this tradition is the lack of specific education for pregnant women about the risks to female genital mutilation. The community has practically never received any counter-information from health authorities that could shake their beliefs. This lack of socialization is reflected in the statement of one informant, a mother who said she would be willing to follow the rules if there was a strict ban from the government; however, she admitted that she had never received any information about this at the local health center. This reality shows that the tradition of female circumcision persists not solely because of rigid ideology, but also because of the absence of alternative information that

could shift existing social norms. As a result, both traditional birth attendants and the younger generation continue to believe that the practice is completely safe, simply because they have never witnessed or received reports of medical complications firsthand.

This situation is exacerbated by regulatory ambiguity that causes confusion, especially among millennial parents in the Purwakarta City area. Although they are more exposed to information, there is uncertainty about the underlying reasons behind the medical ban. One informant expressed concern about the double standards they perceived; they questioned why a procedure that they believed was intended for hygiene was prohibited by health workers. This confusion ultimately led the community to return to relying on traditional birth attendants as a solution. For them, as long as the government does not provide a clear and logical explanation regarding the link between the ban and health aspects, the community will continue to find ways to keep the tradition alive, even if it has to be done outside the formal medical system.

This phenomenon of "cat-and-mouse" with the regulations shows that regulations without transparent education actually risk increasing unsafe circumcision practices in the hands of traditional practitioners. The phenomenon of people switching to traditional birth attendants *(paraji)* due to ambiguous information is openly acknowledged by health practitioners. This phenomenon is reinforced by the perspective of pediatricians who were informants in this study, who highlighted that simply imposing a ban without clear communication of the policy risks is backfiring. According to him, when the public is not given a logical understanding of the medical reasons behind the ban, tightening regulations for health workers does not necessarily stop the practice, but instead encourages parents to return to traditional methods that have minimal safety standards. The doctor explained that with the spread of information about the ban among the medical community, the public tends to seek alternatives through *paraji*, which are clinically much riskier.

Furthermore, there is an interesting reality regarding the role of health workers in the field, who tend to be passive and ambivalent. Instead of being agents of change who provide counter-education, health workers prefer not to actively prohibit or encourage these practices to patients. In his admission, the doctor informant stated that he tended to just go with the flow of parents' requests; he was willing to perform circumcision procedures if requested by families, but never tried to influence or educate them to change their decisions. Although formal regulations prohibit medical personnel from performing female circumcision, there was a notable absence of strict sanctions or enforcement from the government or health associations at the local level. This lack of professional consequences, coupled with intense social pressure from families, led some health workers to continue performing the procedure discreetly; thus,

while this attitude cannot be generalized as representative of all health workers in Purwakarta, these findings indicated a dilemma in which medical personnel preferred to accommodate the social needs of the community rather than strictly enforcing regulations, which ultimately perpetuated the practice of female circumcision in the region.

The passive attitude of medical personnel confirms that without systematic educational instruction, the community loses its only source of valid information that can dispel the myth of "cleanliness." As a result, female circumcision practices remain prevalent amid modernization, because there is no education strong enough to challenge old customs. This situation is based on differences in perception regarding the definition of "danger" between the government and the community. From a local perspective, circumcision practices are often only minor cuts or symbolic acts that are not considered to pose fatal risks as described in global prohibitions. The absence of any noticeable physical impact causes the community to question the label of "dangerous" given by the government. As a result, the regulation is considered inconsistent with the reality on the ground, and the practice continues to be considered normal as a hygiene procedure, rather than a form of violence. Although often considered a symbolic act or merely a light prick without tissue cutting, any form of injury to female genital organs for non-medical reasons is still categorized as a mutilation practice because it provides no health benefits whatsoever and actually damages the integrity of healthy body tissue (WHO, 2025).

Despite these insights, this study has several limitations. First, the small number of informants (ten participants) means that the findings cannot be generalized to the entire population of West Java or Indonesia. Second, because this research focused specifically on the socio-cultural dynamics in Purwakarta, the results may reflect local characteristics that differ from other regions with different cultural or religious backgrounds. Finally, as this study relied on self-reported experiences and interviews, there is a potential for social desirability bias, where informants might have withheld certain information regarding sensitive or prohibited practices. Future research should involve a broader demographic and a longitudinal approach to observe potential shifts in views among the younger generation more comprehensively

CONCLUSION

The practice of female circumcision in Purwakarta Regency shows that the continuation of this practice is not solely due to religious beliefs, but rather to social forces that shape behavior through social copying mechanisms amid weak health communication. The results of this study reveal that the failure to convey contextual and culturally sensitive medical information has led the community to place more trust in social references such as traditional birth attendants, religious leaders, and family traditions than in formal messages from health workers. Female circumcision is maintained not because of reflective awareness, but because it has been internalized as a social norm and symbol of purity that has been passed down from generation to generation. This condition is exacerbated by policy ambiguity and the passive attitude of health workers who do not actively educate, thus creating a gray area where the practice continues in a more hidden form. Thus, barriers to health communication play a central role in perpetuating FGM/C practices because they are unable to shake the deep-rooted cultural legitimacy. This study emphasizes the importance of health communication interventions that are based on local participation and cultural sensitivity, involving traditional birth attendants, religious leaders, and women as agents of change. Further research should be directed toward formulating intercultural communication strategies that not only bridge

medical and traditional perspectives but also challenge the social constructs that normalize this practice, so that the transformation toward ending female circumcision can be rooted in collective community awareness, not merely in formal policies.

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