# BRIEFING PAPER: Female genital mutilation

## Northern Ireland Human Rights Commission

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**31 March 2016**

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[2] FGM is [illegible] 

## Contents

## What is Female Genital Mutilation?

Female Genital Mutilation (FGM)[2] comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons[3]. *Eliminating female genital mutilation*, an interagency statement developed by the World Health Organization (WHO) in 1995 and updated in 2008 provides the accepted international anatomical typology of FGM:

Type I: Clitoridectomy. Partial or total removal of the clitoris and/or prepuce. Many FGM-practising communities refer to type I as *sunna*, which is Arabic for 'tradition' or 'duty'[4].

Type II: Excision. Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.

Type III: Infibulation. Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris. The seal of the labia results in near complete covering of the urethra and the vaginal orifice, which must be reopened for sexual intercourse and childbirth, a procedure known as deinfibulation.[5] In some cases, the seal is later closed again to recreate an infibulation, usually after childbirth when deinfibulation is necessary. This procedure is referred to as reinfibulation. FGM-performing community usually refer to Type III FGM as

[2] FGM is known by a number of names, particularly at the community level, including 'female genital cutting' or 'female circumcision'. Female circumcision gives a misleading analogy to male circumcision. FGM is used at an international level to indicate the gravity of the procedure and that it is a human rights abuse. See: HM Government. (2014). *Multi-agency Practice Guidelines: Female Genital Mutilation*. HM Government. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/380125/MultiAgencyPracticeGuidelinesNov14.pdf Page 11.

[3] World Health Organization. (2008). *Eliminating female genital mutilation: an interagency statement-OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM, WHO*. Geneva: World Health Organisation. Available at: http://apps.who.int/iris/bitstream/10665/43839/1/9789241596442_eng.pdf

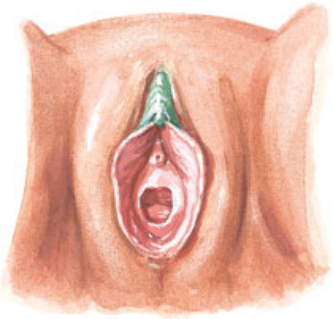
[4] UNICEF. (2013). *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*. New York: UNICEF. Available at: http://www.unicef.org/media/files/UNICEF_FGM_report_July_2013_Hi_res.pdf Page 7.

[5] *Ibid*.

Pharonic circumcision or Pharonic infibulation[6]. It is thought Pharonic refers to the origins of the practice in ancient Egypt[7].

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example: pricking, piercing, incising, scraping and cauterization. Type IV is a broad category that includes all other harmful practices performed on the genitalia. The reasons, contents, consequences and risks of the various practices subsumed under type IV vary considerably[8]. The introduction of pricking has even been suggested as a replacement of more invasive procedures as a form of harm-reduction[9].

Type I



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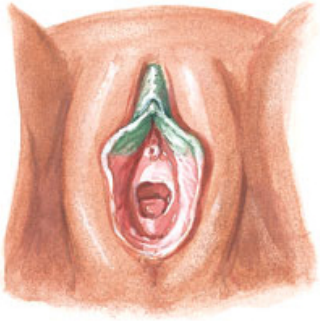

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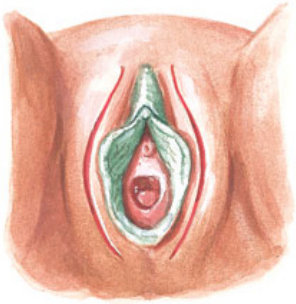
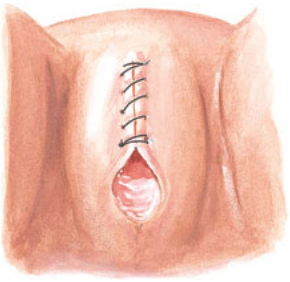
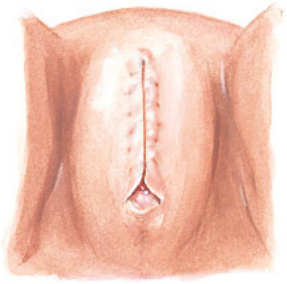






[6] Momoh, C. (2005). *Female genital mutilation*. Radcliffe publishing.

[7] Dorkenoo, E. (1994). *Cutting the rose: female genital mutilation: the practice and its prevention*. Minority Rights Group. Page 33.

[8] Some practices, such as female genital cosmetic surgery and hymen repair, which are legally accepted in many countries, and not generally considered to constitute FGM, actually fall under the definition used here. A broad definition of FGM is used to avoid loopholes that might allow the practice to continue. See, World Health Organisation, Op Cit, p28.

[9] World Health Organisation, *op. cit.*, page 26.

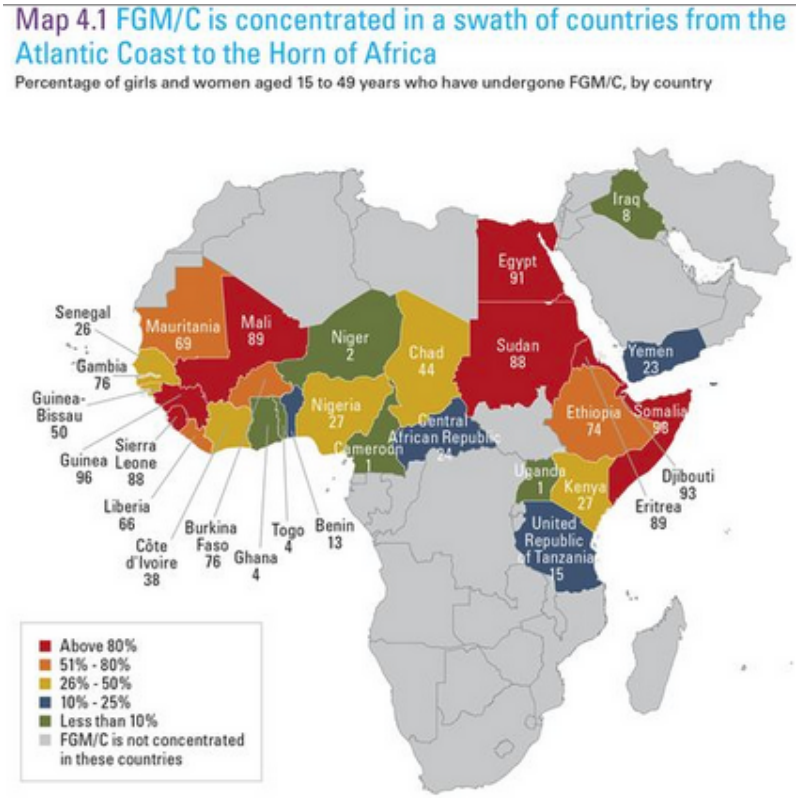
*Source:* Daughters of Eve, an anti-FGM campaign group based in the UK: http://www.dofeve.org/types-of-fgm.html

**How widespread is FGM?**

Due to a lack of data collection about FGM worldwide, the exact numbers of women and girls who have undergone FGM is not known. A report by UNICEF in 2016, 'Female Genital Mutilation/Cutting: A Global Concern', notes that at least 200 million girls and women alive today have undergone FGM in 30 countries across Africa and the Middle East[10]. The report states that half of the girls and women who have been cut live in three countries – Egypt, Ethiopia and Indonesia. According to the data, girls 14 and younger represent 44 million of those who have been cut.

While the practice is nearly universal in Somalia, Guinea, Djibouti and Egypt, FGM affects only 1 per cent of girls and women in Cameroon and Uganda[11]. The report also states that FGM can be found in Latin America, India, Pakistan, Malaysia and Indonesia. However, there are no reliable estimates about FGM prevalence rates in these countries. The prevalence rates and the type of FGM performed vary according to ethnic group within each country[12]. It is possible to detect trends in the types of FGM that are performed in various countries. In Somalia, Eritrea, Niger, Djibouti and Senegal, more than one in five girls have undergone type III, the most physically invasive type of FGM[13].

[10] Available at: http://www.unicef.org/media/files/FGMC_2016_brochure_final_UNICEF_SPREAD.pdf
[11] UNICEF, *op. cit.,* page 113.
[12] Momoh, *op. cit.*
[13] UNICEF, *op. cit.,* page 114.




*Source:* UNICEF, *op. cit.*, page 26.

In the UK and some European countries, FGM tends to occur amongst migrant communities, including refugees and asylum seekers from FGM-practising countries[14]. Communities at the highest risk of FGM include: Kenyan, Somali, Sudanese, Sierra Leonean, Egyptian, Nigerian and Eritrean. Non-African communities that practise FGM include Yemeni, Afghani, Kurdish, Indonesian and Pakistani groups.

A recent study estimates that approximately 60,000 girls aged 0-14 were born in England and Wales to mothers who had undergone FGM, and 137,000 women and girls born in countries where FGM is practised were permanently resident in England and Wales in 2011[15]. Northern Ireland and Scotland were excluded from the study. There have been no systematic estimates of the prevalence of FGM in Northern Ireland. Since September 2014, the Health and Social Care Information Centre began collecting data on FGM within England on behalf of the

[14] Momoh, *op. cit.*

[15] Macfarlene, A, and Dorkenoo, E. (2015). *Prevalence of Female Genital Mutilation in England and Wales: National and local estimates*. London: City University and Equality Now.

Department of Health and NHS England to improve the NHS response to FGM and help commission services to support women and girls[16].

FGM is mostly carried out on girls between the ages of 0 and 15 years, although adult and married women are occasionally subjected to the procedure[17]. The age when FGM is performed on victims varies with local traditions and customs but is believed to be decreasing in some countries[18]. This may be a response to increasing legal prohibition and authority vigilance: FGM is a dynamic social practice. The rationale is that younger children are less likely to understand what is happening to them or speak out. In the UK, girls are most likely subjected to FGM between five and ten[19]. However, as the campaign against FGM intensifies, parents are possibly cutting children younger to prevent detection[20]. Girls may be cut alone or with a group of family members or peers from their community[21].

FGM is usually performed by a traditional practitioner, often an older woman, who typically originates from a family in which generations of women were traditional practitioners[22]. The arrangements for the procedure usually include the child being held down on the floor by several women with the procedure performed without medical expertise or sterilized medical instruments[23]. Traditional excisors perform FGM either in the UK, or in their countries of origin. There is an increasing trend of medical practitioners performing procedures in hospitals[24] due to the 'medicalisation' of the practice overseas (see Egypt) or on the black market in the UK[25]. Girls of school age who are subjected to FGM overseas are taken abroad at the start of the school holidays, typically in the summer, in order for them to recover before returning to school[26]. This is commonly known as the 'cutting season'.

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[16] Between April 2015 and June 2015, there were 1,036 newly recorded cases of FGM reported. The highest incidence of FGM was type II at 37.6 per cent. Available at: http://www.hscic.gov.uk/article/2021/Website-Search?productid=18864&q=fgm&sort=Most+recent&size=10&page=1&area=both#top

[17] World Health Organisation, *op. cit.*, page 4.

[18] *Ibid.*

[19] Dorkenoo, *op. cit.*

[20] *Ibid.*, page 131.

[21] Rahman, A., and Toubia, N. (2000). *Female genital mutilation: A practical guide to worldwide laws & policies*. Zed Books. Page 3.

[22] *Ibid.*, page 3.

[23] HM Government *op. cit.*, page 13.

[24] *Ibid.*

[25] Dorkenoo, *op. cit.*, page 131.

[26] HM Government *op. cit.*, page 12.

**What are the main motivations for FGM?**

The reasons for FGM are complex, interrelated, and based on a belief system rather than any single factor. Motivations vary within each FGM-performing community. They include women's sexuality, custom and tradition, social pressure, and religion.

*Women's sexuality*

The most significant reason for FGM is to control a woman's sexuality. The meanings that are attached to women's sexuality depend on the community performing the practice. In patriarchal communities, a family or clan's honour depends on a girl and woman's virginity and chastity[27]. FGM is performed to prevent premarital sex, preserve virginity and curtail infidelity in marriage. It is thought that cutting a woman's genitalia will reduce her sexual desire; certain procedures such as restricting the available aperture are believed to enhance the man's sexual pleasure.

In some communities, the clitoris is believed to represent a masculine feature of a woman, and is thus removed to enhance her femininity. It is also removed due to a belief that excising the clitoris will cleanse a girl and improve hygiene. Other reasons include fear of the clitoris, due to mythical beliefs that coming into contact with it during intercourse or labour could be fatal to anyone who touched the genitalia. Women play an important role in socialising girls to undergo FGM, thus continuing the cycle of sexual subordination, mainly because failure to comply could result in social sanctions such as ostracisation from the community. FGM is often seen as a natural and beneficial practice carried out by a loving family who believe that it is in the best interests of the victim[28]. As a result, girls are less likely to come forward and discuss the issue with frontline professionals, such as teachers, social workers or medical practitioners.

*Custom and tradition*

In some communities, FGM is performed as a rite of passage from childhood to adulthood[29]. FGM symbolises that a girl is now a woman, and she is ready to fulfill her role as wife and begin reproduction. It can also show a girl's ability to withstand pain in preparation for

[27] Rahman and Toubia *op. cit.*
[28] HM Government *op. cit.*, page 11.
[29] *Ibid.*

childbirth. The notion that FGM is a prerequisite for a girl to become a woman ensures the practice is maintained, because FGM is believed to be central for a girl to perform the roles expected of her as a wife and mother. FGM is an act of socialising girls to accept cultural values that can be passed onto the next generation. It can also be a way for migrant groups to indicate their difference from the dominant Western culture.

*Social pressure*

In communities where most women are cut, family, peers, and community members create an environment in which the practice is normalised and acceptable. In these circumstances, non-conformity could carry significant social consequences. From the fear of family and community isolation, to the prospect of living a life unmarried, all contribute to pressure that ensures the persistence of the practice.

*Religion*

Community members often cite religion as a reason for performing FGM. While Jews, Christians, Muslims and indigenous religious groups in Africa practise FGM[30] there is no religious basis for the procedure. FGM predates Christianity, Islam, and Judaism, and key religious texts do not prescribe FGM[31]. Consequently, FGM is best understood as a cultural rather than religious practice. Therefore appeals to religious authority or duty are ill-founded.

**What are the health consequences of FGM?**

Risks generally increase with the increasing severity of the type of FGM. As there is limited data on type IV FGM, health information usually excludes this type. The health consequences of the practice vary depending on multiple factors such as the medical experience of the excisor, and the medicalised or non-medicalised context in which FGM is performed. Health complications of types I, II and III include severe pain, shock, excessive bleeding, difficulty in passing urine, menstrual problems, infections (sepsis), HIV, psychological consequences such as post-traumatic stress, repeated FGM,[32] birth complications, pain during sexual intercourse, and infertility and in rare cases, death[33].

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[30] Toubia, N. (1995a). Female Genital Mutilation. In J. Peters & A. Wolper (Eds.), *Women's rights, human rights: International feminist perspectives*. Psychology Press. Page 225.
[31] HM Government *op. cit.,* page 12.
[32] A significant minority of females are mutilated more than once.
[33] World Health Organisation, *op. cit.*, page 33-35.

**Identifying FGM**

Professionals in all frontline and regulated agencies need to be alert to the possibility of a girl or woman being at risk of the practice or having already undergone FGM. There are several indicators that could suggest the practice is imminent or has already taken place.

There is a range of potential indicators that a girl or woman is at risk of being cut:

- Community or family are less integrated into Western society.
- A girl is born to a woman subjected to FGM.
- A girl's sister is believed to have already undergone FGM.
- Female family elders are visiting from an FGM-prevalent country.
- A girl may speak about a special ceremony or 'becoming a woman'.
- A girl may be taken overseas for a prolonged period of time to a country where FGM is prevalent.
- Parents seeking to withdraw their children from learning about FGM at school.
- A girl may disclose her concerns that she could be cut to a teacher or school friend.

Indicators that a girl or woman has been cut include:

- Difficulty walking, sitting or standing comfortably.
- Spending longer in the toilet than usual due to difficulties urinating.
- Frequent bladder or menstrual problems.
- Prolonged or repeated absence from school.
- Noticeable change in behaviour, i.e. withdrawn or depressed.
- Reluctance to undergo normal medical examinations.
- A girl may confide in a professional or friend.

## UK Legal framework

FGM is illegal in the UK. In England, Wales and Northern Ireland, the practice is illegal under the Female Genital Mutilation Act 2003 (2003 Act)[34]. In Scotland it is illegal under the Prohibition of Female Genital Mutilation (Scotland) Act 2005[35].

### FGM in England, Wales and Northern Ireland

Under the 2003 Act, a person is guilty of an offence if they excise, infibulate or otherwise mutilate the whole or any part of a girl's or woman's labia majora, labia minora or clitoris, except for necessary operations performed by a registered medical practitioner on physical and mental health grounds; or an operation performed by a registered medical practitioner or midwife; or a person undergoing training with a view to becoming a medical practitioner or midwife – on a girl who is in labour or has just given birth for purposes connected with the labour or birth (these exceptions are set out in section 1(2) and (3) of the 2003 Act).

Other than in the excepted circumstances, it is an offence for any person (regardless of their nationality or residence status) to:

- Perform FGM in England, Wales or Northern Ireland (section 1 of the Act);
- Assist a girl to carry out FGM on herself in England, Wales or Northern Ireland (section 2 of the Act); and
- Assist (from England, Wales or Northern Ireland) a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident or UK habitual resident (section 3 of the Act).
- The nationality or residence status of the victim is irrelevant, provided that FGM takes place in England, Wales or Northern Ireland,

### FGM taking place overseas

It is also an offence for a UK national or permanent UK resident or other person habitually resident in the UK to:

- Perform FGM abroad (sections 4 and 1 of the Act);

[34] Available at: http://www.legislation.gov.uk/ukpga/2003/31/contents
[35] Available at: http://www.legislation.gov.uk/asp/2005/8/contents

- Assist a girl to perform FGM on herself outside the UK (sections 4 and 2 of the Act); and
- Assist (from outside the UK) a non-UK person to carry out FGM outside the UK on a UK national or permanent UK resident or habitual UK resident (sections 4 and 3 of the Act).

A person found guilty of an offence under the 2003 Act is liable to a maximum penalty of 14 years imprisonment or a fine, or both.

**Legislative changes in England, Wales and Northern Ireland: Serious Crime Act 2015**

Despite criminalising FGM in 1985[36], there has not been one conviction for the practice[37]. As a result, a House of Commons Home Affairs Committee report into FGM published 25 June 2014 recommended a national action plan, which would involve "strengthening the law on FGM, principally to ensure the safeguarding of at-risk girls, but also to increase the likelihood of achieving successful prosecutions"[38]. As a result of the recommendations proposed by the House of Commons Home Affairs Committee, the government introduced five legislative changes in the Serious Crime Act 2015[39].

1. *Offence of FGM: extra-territorial acts*

The Female Genital Mutilation Act 2003 (2003 Act) was originally concerned with acts done by UK nationals or permanent UK residents to girls or women who are UK nationals or permanent UK residents. Perpetrators and victims who were habitually resident in the UK (but not UK nationals or permanent UK residents) were not covered by the legislation. The Bar Human Rights Committee of England and Wales (BHRC) noted in its report on FGM that

[36] The Government introduced the Prohibition of Female Circumcision Act 1985.

[37] Dr Dhanuson Dharmasena from Whittington hospital, North London, was charged with reinfibulating a patient after she gave birth, and Hasan Mohamed, the complainant's husband was charged with intentionally encouraging an offence of FGM, and aiding, abetting, counselling or procuring Dr Dharmasena to commit an offence. The case was unusual in that the victim gave evidence on behalf of the defence rather than for the prosecution. On 4 February 2015 the jury found them not guilty.

[38] House of Commons Home Affairs Select Committee. (2014). *Female genital mutilation: the case for a national action plan*. House of Commons. http://www.publications.parliament.uk/pa/cm201415/cmselect/cmhaff/201/201.pdf Paragraph 22.

[39] Information taken from Ekaney QC, N. and Proudman, C. (2014). *FGM and the Serious Crime Act 2015*. Family Law Week. http://www.familylawweek.co.uk/site.aspx?i=ed145848

"the UK's legal obligations extend to all children within its jurisdictions – therefore UK organisers of such mutilations should face prosecution, irrespective of the child's status"[40].

The Serious Crime Act amends sections 1 to 3 of the 2003 Act so that it applies to UK nationals and habitual residents rather than only to UK nationals and permanent UK residents. A person is deemed habitually resident in the UK contingent upon a number of factors, including length of presence in UK, reason for coming, intended duration of stay, whether working, family and communities ties to the UK and other life features (educational ties, possession of property et cetera.).

The Act does not, however, address those who have a temporary stay in the UK. No provision is made, for instance, for the situation in which a woman travels to the UK for a short period, visits an NHS doctor who discovers that the woman has been subjected to FGM, and intends that her daughter(s) should also be subjected to the procedure.

2. *Anonymity for victims of FGM*

A new section 4A and Schedule 1 have been inserted into the 2003 Act and provide for injunctions prohibiting the publication of any matter that could lead the public to identify the alleged victim of an offence under the Act. The prohibition lasts for the lifetime of the alleged victim. The power to waive the restrictions is limited to the circumstances necessary to allow a court to ensure that a defendant receives a fair trial (Article 6 ECHR) or to safeguard freedom of expression (Article 10 ECHR). The rationale is that anonymisation will encourage women and girls to report FGM offences committed against them, and increase the number of prosecutions. This was also specifically recommended by the Bar Human Rights Committee based upon the use of such 'special measures' to assist complainants come forward in the criminal courts.

3. *Offence of failing to protect a girl from risk of genital mutilation*

A new Section 3A offence of failing to protect a girl under the age of 16 from risk of FGM is introduced into the 2003 Act. A person is liable for the offence if they are responsible for a

[40] Bar Human Rights Committee England and Wales. (2014). *Report of the Bar Human Rights Committee England and Wales to the Parliamentary Inquiry into Female Genital Mutilation*. https://barhumanrights.org.uk/sites/default/files/documents/news/bhrc_fgm_submission_12_feb_2014.pdf Page 3.

girl at the time when an offence is committed against her and when FGM has actually occurred.

The term ‘responsible’ covers two classes of person: first, a person who has 'parental responsibility' for the girl and has 'frequent contact' with her, and, second, any adult who has assumed responsibility for caring for the girl in the manner of a parent, for example, grandparents who might be caring for the girl during the school holidays.

There are two possible defences. The first is that the defendant did not think that there was a significant risk of the girl being subjected to FGM and could not reasonably have been expected to be aware that there was any such risk. The second defence is that the defendant took reasonable steps to protect the girl from being the victim of FGM.

*4. Female genital mutilation protection orders*

Section 5A is inserted into the 2003 Act which introduces the new Schedule 2 into the 2003 Act. The schedule provides for FGM Protection Orders[41], one of the principal BHRC recommendations and one which has been already been used extensively in the High Court to protect at-risk young women and girls. An order can be made to protect either a girl or woman at risk of FGM[42]. FGM protection orders are modelled on forced marriage protection orders introduced by the Forced Marriage (Civil Protection) Act 2007. The terms of such an order can be broad and flexible and enable the court to include whatever terms it considers necessary and appropriate to protect the girl. These include, for example, provisions requiring a person to surrender his or her passport. While civil orders, breach of the order is a criminal offence since it would amount to a contemptuous breach of the order of the court.

[41] There were 28 applications and 18 orders made for FGMPOs in July to September 2015, following their introduction on 17 July 2015. Available at: http://www.familylaw.co.uk/news_and_comment/fgmpo-figures-published-for-first-time-in-family-court-statistics#.Vvp5AMdBDdk

[42] *Re E (Children) (Female Genital Mutilation Protection Orders)* [2015] EWHC 2275 (Fam), Holman J on 24 July 2015 ordered an ex parte FGM Protection Order after a Nigerian mother applied for protection of her three daughters then aged 12, 9, 6 from being subjected to FGM by their father in Nigeria. Available at: http://www.familylaw.co.uk/news_and_comment/re-e-children-female-genital-mutilation-protection-orders-2015-ewhc-2275-fam#.Vvp52MdBDdk

5. *Section 74: Duty to notify police of FGM*

A new section 5B of the 2003 Act (when the section is implemented) places a duty on persons who work in a 'regulated profession' in England and Wales, namely healthcare professionals, teachers and social care workers, to notify the police when, in the course of their work, they discover that an act of FGM appears to have been carried out on a girl who is under 18. The term 'discover' would refer to circumstances where the victim discloses to the professional that she has been subject to FGM, or where the professional observes the physical signs of FGM. The section does not apply to girls or women who might be at risk of FGM or cases where professionals discover a woman who is 18 or over and has been subjected to FGM.

This provision could be deficient in a number of respects:

- First, there appears to be a contradiction in legislation in that FGM is a criminal offence according to the 2003 Act for adults and minors and consent is not a defence, and yet, professionals do not have to report adults who have had FGM.
- Second, vulnerable women of at least 18-years of age who could be at risk of FGM, or indeed sisters who could be at risk of FGM, might not receive appropriate support because professionals have no duty to report cases involving adult women to the police.
- Third, if there was a duty to notify police of FGM even when the woman is an adult, this could lead to a conviction of 'failing to protect a girl from risk of FGM'. For example, if a healthcare professional discovers that a UK-born woman of 18 years or more has been subjected to FGM, her parents could be guilty of an offence of failing to protect her from FGM; however, according to the new section 5B offence, the healthcare professional has no duty to report the offence, thus leading to no prosecution.

**No convictions for FGM**

There are a number of reasons that no convictions for FGM have been obtained in spite of the prevalent nature of the practice, including[43]:

[43] Dias QC, D; Gerry QC, F; Burrage, H. (2014). *10 reasons why our FGM law has failed and 10 ways to improve it*. The Guardian. Available at: http://www.theguardian.com/commentisfree/2014/feb/07/fgm-female-genital-mutilation-prosecutions-law-failed

- There are rarely complaints from survivors, who are typically young girls with little knowledge of the law and perhaps no knowledge that FGM will be performed; often the practice is undertaken without warning. Children may be related to the cutters, and may believe that their parent's actions were in their best interests. Thus they are unlikely to give evidence against loved ones for fear of them going to prison.
- Witnesses are unlikely to come forward as they are often family or friends and are part of a community, which sanctions the practice, and would ostracise anyone who refused to submit to FGM.
- Professionals are rarely trained about FGM. A failure to understand the law can lead to misguided beliefs that the practice is culturally acceptable, thus professionals fear interfering with a traditional practice due to concerns about being branded racist.
- Parents who engage in FGM usually have no history of offending, thus they go under the radar of police officers responsible for investigating and prosecuting offenders. Apart from performing FGM, parents are often loving and caring towards their families.

## International Human Rights Law

FGM is recognised as a harmful practice and violation of the human rights of girls and women[44]. The UK is formally committed to a range of international human rights instruments in addition to the European Convention on Human Rights (ECHR). The Northern Ireland Act 1998 makes provision to ensure that Northern Ireland public authorities act compatibly with the UK's international obligations and with ECHR rights and European Community law in particular[45]. Human Rights are codified in several international and regional treaties that are relevant to the UK. The legal regime is complemented by a series of political consensus documents, such as those resulting from United Nations world conferences and summits, which reaffirm human rights and call upon governments to strive for their full respect, protection and fulfillment[46].

| **International treaties** | **Signature** | **Ratification** |
|---|---|---|
| Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment | 15 March 1985 | 8 December 1988 |
| Covenant on Civil and Political Rights | 16 September 1968 | 20 May 1976 |
| Covenant on Economic, Social and Cultural Rights | 16 September 1968 | 20 May 1976 |
| Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) | 22 July 1981 | 7 April 1986 |
| Convention on the Rights of the Child (CRC) | 19 April 1990 | 16 December 1991 |
| Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees | 28 July 1951 | 11 March 1954 |
| **Regional treaties** | **Signature** | **Ratification** |
| European Convention for the Protection of Human Rights and Fundamental Freedoms | 4 November 1950 | 8 March 1951 |
| European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment | 26 November 1987 | 24 June 1988 |
| **Consensus documents** | | |
| Beijing Declaration and Platform for Action of the Fourth World Conference on Women | | |
| General Assembly Declaration on the Elimination of Violence against Women | | |
| Programme of Action of the International Conference on Population and Development (ICPD) | | |
| UNESCO Universal Declaration on Cultural Diversity | | |

[44] World Health Organisation, *op. cit.*, page 8.
[45] Northern Ireland Act 1998, ss.24, 26. Available at: http://www.legislation.gov.uk/ukpga/1998/47/contents.
[46] World Health Organisation, *op. cit.*, page 8.

United Nations Economic and Social Council (ECOSOC), Commission on the Status of Women. Resolution on Ending Female Genital Mutilation. E/CN.6/2007/L.3/Rev.1.

By ratifying the Convention on the Elimination of all Forms of Discrimination against Women 1979 (CEDAW), the UK committed itself to *eliminating* discrimination against women and to intervening to modify social and cultural patterns of behaviour that result in discrimination against women (Article 5). FGM unambiguously constitutes one of the most abhorrent forms of discrimination against young women and girls[47]. Further, by virtue of the Convention on the Rights of the Child 1989 (CRC), the UK has *positive* obligations in international law to *ensure* that children are not subjected to cruel, inhuman or degrading treatment (Article 37)[48]. FGM constitutes an irreparable violation of the child's bodily integrity and endangers the child's physical and psychological health[49]. In addition, the UK has a legal duty pursuant to CRC 1989 to ensure that mechanisms are adequately resourced to the maximum extent of resources available (Article 4)[50]. In a United Nations General Resolution in 2007, the UN emphasized that custom, tradition or religious beliefs cannot be used as excuses for avoiding the obligation to eliminate violence against women and girls[51].

Typically, the implementation of a treaty is overseen by a UN Committee. Many of the United Nations human rights treaty committees have addressed FGM in their concluding observations on how states are meeting their treaty obligations[52]. For instance, the Committee on the Elimination of All Forms of Discrimination against Women, the Committee on the Rights of the Child and the Human Rights Committee have condemned the practice and recommended measures to combat it, including the criminalisation of the practice[53].

These legal obligations among others place a requirement on states to respond to FGM in an effective way. Passing legislation that is ineffectively implemented is not enough. Legislation must be combined with other measures such as mandatory training for frontline professionals about FGM. Indeed, the Bar Human Rights Committee England and Wales report on FGM in 2014 found that "the UK has been in breach of its international law obligations to protect young women and girls from mutilation" which is a "serious breach of the state's duty of

[47] Bar Human Rights Committee England and Wales, *op. cit.*, paragraph 11.
[48] *Ibid.*, paragraph 12.
[49] *Ibid.*
[50] *Ibid.*, paragraph 20.
[51] See: http://www.un.org/ga/search/view_doc.asp?symbol=A/RES/61/143&Lang=E
[52] World Health Organisation, *op. cit.*, page 8.
[53] *Ibid.*

care"[54]. The UK lacked a sufficiently tailored or a targeted legal power to assist in intervening in cases where FGM is suspected. The law alone was not sufficient to eliminate the practice[55].

[54] Bar Human Rights Committee England and Wales, *op. cit.*, paragraph 29.
[55] *Ibid.*, paragraph 32.

## Commonwealth Legal Responses

The prevalence rates and legal responses to FGM are outlined in each Commonwealth member country by region where the practice is performed.

### Africa

| Country | Prevalence of FGM | Legal status |
|---|---|---|
| **Botswana** | FGM reportedly does not exist in Botswana [56]. However, there are newspaper reports of type IV, labia elongation being carried out on girls in some tribes, such as the Kalanga in the Northern East region and Shakawe in the North West region[57]. | No information on the existence of specific legislation could be found. |
| **Cameroon** | Population 22.8 million[58]. One per cent of girls and women aged 15 to 49 years have undergone FGM[59]. | No national legislation criminalising FGM[60]. |
| **Ghana** | Population 26.4 million[61]. Four per cent of girls and women aged 15 to 49 years have undergone FGM[62]. | The Criminal Code criminalises FGM. Minimum imprisonment is five years and maximum imprisonment is 10 years. Excisors have been imprisoned[63]. |

[56] Available at: http://www.unicef.org/infobycountry/botswana_statistics.html and http://www.genderindex.org/country/botswana

[57] Available at: http://www.sundaystandard.info/when-culture-harms-girls-case-female-genital-mutilation and http://www.pitlanemagazine.com/cultures/misleading-superstitions.html

[58] Available at: http://data.un.org/CountryProfile.aspx?crName=cameroon

[59] Data UNICEF. (2013). *Cameroon statistical profile on female genital mutilation/cutting*. UNICEF. http://data.unicef.org/corecode/uploads/document6/uploaded_country_profiles/corecode/222/Countries/FGMC_CMR.pdf Page 3.

[60] Data UNICEF, *op cit*., page 1.

[61] Available at: http://data.un.org/CountryProfile.aspx?crName=ghana

[62] UNICEF, *op cit*.

[63] United Nations. (2009). *Legislation to address the issue of female genital mutilation (FGM)*. United Nations. http://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Expert%20Paper%20EGMGPLHP%20_Berhane%20Ras-Work%20revised_.pdf Page 9-10.

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|---|---|---|
| **Kenya** | Population 45.5 million[64]. 27 per cent of girls and women aged 15 to 49 years have undergone FGM[65]. | The Prohibition of Female Genital Mutilation Act 2011 criminalises the practice in similar terms to the UK[66]. It is also an offence to use derogatory or abusive language against a woman who has not undergone FGM (section 25). |
| **Lesotho** | FGM reportedly does not exist in Lesotho[67]. | No information on the existence of specific legislation could be found. |
| **Malawi** | No information on the prevalence rate could be found. | No information on the existence of specific legislation could be found. |
| **Mauritius** | FGM reportedly does not exist in Mauritius[68]. | No information on the existence of specific legislation could be found. |
| **Mozambique** | No information on the prevalence rate could be found. | No information on the existence of specific legislation could be found. |
| **Namibia** | FGM reportedly does not exist in Namibia[69]. | No information on the existence of specific legislation could be found. |
| **Nigeria** | Population 178.5 million[70]. 27 per cent of girls and women aged 15 to 49 years have undergone FGM[71]. | FGM was criminalised on 5 May 2015. |
| **Rwanda** | Population 12.1 million[72]. Type IV FGM, labia elongation, is performed[73]. However, prevalence rates are unknown. | No information on the existence of specific legislation could be found. |
| **Seychelles** | FGM reportedly does not exist in Seychelles. | No information on the existence of specific legislation could be found. |

[64] Available at: http://data.un.org/CountryProfile.aspx?crName=kenya
[65] UNICEF, *op cit*.
[66] Prohibition of Female Genital Mutilation Act 2011 available at: http://kenyalaw.org/kl/fileadmin/pdfdownloads/Acts/ProhibitionofFemaleGenitalMutilationAct_No32of2011.pdf
[67] Available at: http://www.genderindex.org/country/lesotho
[68] Available at: http://www.ipu.org/wmn-e/fgm-prov-m.htm
[69] Available at: http://www.ipu.org/wmn-e/fgm-prov-n.htm
[70] Available at: http://data.un.org/CountryProfile.aspx?crName=NIGERIA
[71] UNICEF, *op cit*.
[72] Available at: http://data.un.org/CountryProfile.aspx?crName=RWANDA
[73] Koster, M., & Price, L. L. (2008). Rwandan female genital modification: Elongation of the labia minora and the use of local botanical species. *Culture, Health & Sexuality*, *10*(2), 191-204.

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|---|---|---|
| **Sierra Leone** | Population 6.2 million[74]. 88 per cent of girls and women aged 15 to 49 years have undergone FGM[75]. | There is no law in Sierra Leone that specifically prohibits FGM, although the Child Rights Act states that girls must be of 18 before they can consent to being cut[76]. |
| **South Africa** | FGM reportedly does not exist in South Africa. | There is no specific legislation prohibiting FGM[77]. |
| **Swaziland** | FGM reportedly does not exist in Swaziland. | No information on the existence of specific legislation could be found. |
| **Uganda** | Population 38.8 million[78]. 1 per cent of girls and women aged 15 to 49 years have undergone FGM[79]. | FGM is a criminal offence pursuant to the Prohibiting of Female Genital Mutilation Act 2010 [80]. The maximum penalty is life imprisonment, with a typical sentence of 10 years. The law has been enforced against perpetrators of FGM[81]. |
| **United Republic of Tanzania** | Population 50.7 million[82]. 15 per cent of girls and women aged 15 to 49 years have undergone FGM[83]. | FGM is prohibited for girls under the age of 18[84]. There is no minimum sentence and the maximum sentence is five years imprisonment and/or a fine of 300,000 Tanzanian shillings (US $185) [85]. The CEDAW Committee expressed concerns with the legality of the practice upon women aged 18 years of age[86]. |

[74] Available at: http://data.un.org/CountryProfile.aspx?crName=sierra leone
[75] UNICEF, *op cit*.
[76] 28 too many. (2014). *Country Profile: FGM in Sierra Leone*. 28 too many. http://www.28toomany.org/media/uploads/sierra_leone_(june_2014).pdf Page 10.
[77] Available at: http://www.ipu.org/wmn-e/fgm-prov-p.htm
[78] Available at: http://data.un.org/CountryProfile.aspx?crName=uganda
[79] UNICEF, *op cit*.
[80] 28 too many. (2013). *Country Profile: FGM in Uganda*. 28 too many. http://www.28toomany.org/media/uploads/UgandaFinal.pdf Page 47
[81] *Ibid*.
[82] See: http://data.un.org/CountryProfile.aspx?crName=United%20Republic%20of%20Tanzania
[83] UNICEF, *op cit*.
[84] 28 too many. (2013). *Country Profile: FGM in Tanzania*. 28 too many. http://www.28toomany.org/media/uploads/tanzania_final_final_final.pdf Page 55.
[85] *Ibid*.
[86] *Ibid*.

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|---|---|---|
| **Zambia** | FGM reportedly does not exist in Zambia[87]. | No information on the existence of specific legislation could be found.[88]. |

**Asia**

| Country | Prevalence of FGM | Legal status |
|---|---|---|
| Bangladesh | FGM reportedly does not exist in Bangladesh[89]. | No information on the existence of specific legislation could be found.[90]. |
| Brunei Darussalam | FGM reportedly does not exist in Brunei.[91] | No information on the existence of specific legislation could be found.[92]. |
| India | The practice has been documented among the Daudi Bohra Muslims in India[93]. | No information on the existence of specific legislation could be found. |
| Malaysia | Evidence suggests FGM is being performed amongst Muslim women[94]. | No information on the existence of specific legislation could be found. |
| Maldives | Evidence suggests FGM is being performed amongst Muslim women[95]. | There is no law prohibiting the practice. |
| Pakistan | The practice is believed to be performed on 90 per cent of the 100,000 Daudi Bohra Muslim population in Pakistan[96]. | There is no law prohibiting the practice. |
| Singapore | The prevalence rate is unknown, although it is assumed the practice is performed on up to 100 per cent of the 650,000 Malay population in Singapore[97]. | There is no law prohibiting the practice, although FGM is medicalised in Singapore. |

[87] Available at: http://www.ipu.org/wmn-e/fgm-prov-t.htm
[88] *Ibid*.
[89] Available at: http://www.unicef.org/infobycountry/bangladesh_bangladesh_statistics.html
[90] *Ibid*.
[91] Available at: http://www.unicef.org/infobycountry/bruneidarussalam.html
[92] *Ibid*.
[93] Rahman and Toubia *op. cit.*, page 7.
[94] UNICEF, *op cit.*, page 23.
[95] Available at: http://orchidproject.org/wp-content/uploads/2015/06/The-Maldives-Final.pdf
[96] The Institute for Social Justice Pakistan. (2014). *The Practice of Female Genital Mutilation (FGM) in Pakistan. Submission to the Women Human Rights and Gender Section The Office of the High Commissioner for Human Rights*. http://www.ohchr.org/Documents/Issues/Women/WRGS/FGM/NGOs/InstituteSocialJusticesPakistan.docx.
[97] http://orchidproject.org/wp-content/uploads/2015/06/Singapore-Final.pdf

| | | |
|---|---|---|
| Sri Lanka | The practice is documented amongst a few Muslim ethnic groups in Sri Lanka[98]. However, there are no prevalence rates. | No information on the existence of specific legislation could be found. |

**Americas**

| Country | Prevalence of FGM | Legal status |
|---|---|---|
| Canada | FGM is documented amongst immigrant populations [99]. However, there are no prevalence rates. | FGM is explicitly prohibited under the Criminal Code[100]. |

**Europe**

| Country | Prevalence of FGM | Legal status |
|---|---|---|
| Cyprus | FGM is documented amongst immigrant populations. However, there are no prevalence rates. | In 2003, a specific criminal law provision on FGM was adopted: Article 233A of the Penal Code prohibits FGM[101]. |
| Malta | FGM is documented amongst immigrant populations. However, there are no prevalence rates. | General criminal law is applicable to FGM, in particular Article 214 of the Penal Code, which consists of the crime of bodily injury[102]. Physical mutilation, as referred to in Article 54d (b), is punishable if it causes death or seriously endangers health[103]. There is no specific criminal law provision on FGM[104]. |

**Pacific**

[98] Rahman and Toubia *op. cit.*, page 7.
[99] Rahman and Toubia *op. cit.*, page 120-121.
[100] *Ibid.*
[101] Available at: http://eige.europa.eu/sites/default/files/documents/current_situation_and_trends_of_female_genital_mutilation_in_cyprus_en.pdf
[102] Available at: http://eige.europa.eu/sites/default/files/documents/current_situation_and_trends_of_female_genital_mutilation_in_malta_en.pdf
[103] *Ibid.*
[104] *Ibid.*

| Country | Prevalence of FGM | Legal status |
|---|---|---|
| Australia | FGM is documented amongst immigrant populations. However, there are no prevalence rates. | All States and Territories have passed criminal legislation prohibiting female genital mutilation in Australia[105]. |
| New Zealand | FGM is documented amongst immigrant populations. However, there are no prevalence rates. | FGM is a criminal offence in New Zealand under the Crimes Act, punishable for a maximum of seven years imprisonment[106]. |

[105] Available at: https://www.ag.gov.au/publications/documents/reviewofaustraliasfemalegenitalmutilationlegalframework/review%20of%20australias%20female%20genital%20mutilation%20legal%20framework.pdf Page 3.

[106] Available at: https://www.newzealandnow.govt.nz/living-in-nz/safety/keeping-safe-security

## Conclusion and recommendations

### England, Wales and Northern Ireland

Over the last few years there has been a significant political willingness to address FGM in the UK through redesigning legislation. Despite the recent introduction of legislative changes, there has not been one conviction for the practice. While further time is required to ascertain the impact of the law, it is clear that legislation cannot unilaterally eradicate the practice. Women are living with the effects of having been cut, and every year girls are at risk of being subjected to FGM. International human rights law demands that legislation is combined with other measures to ensure the law is effectively implemented, and ultimately, FGM is *eliminated*. Recommendations to further the eradication of FGM include:

*Examine legislative loopholes regarding female genital cosmetic surgery*

An investigation is required to examine whether section 1(2)(a) of the Female Genital Mutilation act 2003 provides a loophole for FGM to be performed under the guise of female genital cosmetic surgery on the basis that the surgery is 'necessary for physical or mental health' reasons. There appears to be a loophole in law that allows medical practitioners in the private sector to conduct FGM with impunity[107]. Royal College of Obstetricians and Gynaecologists and the British Society for Paediatric and Adolescent Gynaecology, recommended that female genital cosmetic surgery should not be carried out on girls under the age of 18[108].

There has been a fivefold increase in the number of female genital cosmetic procedures in the last 10 years performed in the private sector; over 2000 operations were performed in 2010 on women and girls[109]. It is thought the procedures are similar to Type I and II FGM, and can result in comparable health consequences, such as reduced sensation, infection and bleeding[110]. FGM-performing communities perceive there is a "double standard" whereby there is a focus on black and ethnic minority communities, while the dominant community

[107] House of Commons Home Affairs Select Committee. *Op cit*., paragraph 32.
[108] Royal College of Obstetricians and Gynaecologists Ethics Committee. (2013). *Ethics opinion papers. Ethical considerations in relation to female genital cosmetic surgery (FGCS)*. https://www.rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf
[109] House of Commons Home Affairs Select Committee. *Op cit*., paragraph 89.
[110] *Ibid*.

undergo female genital cosmetic surgery without criminal repercussions[111]. In this way, communities use female genital cosmetic surgery as a justification for continuing the practice of FGM.

*Mandatory safeguarding training for frontline professionals*

At present, frontline professionals in regulated professions are under a duty to notify the police if a girl has been subjected to FGM, and yet there is no legal requirement to train professionals about the practice. As a result professionals lack awareness of FGM, and knowledge of the law, which leaves girls and women at risk of the practice.

*Fund community-level projects*

Invest public finance in working with grass-root level communities to increase community awareness projects to change attitudes and beliefs regarding the practice. It should be emphasised that many community-level projects are charities or NGOs and operate on very limited resources. This is an impediment to effective community engagement.

*Introduce FGM and violence against women and girls teaching into the National Curriculum*

School pupils and teachers need to be taught about FGM, and the legislation enacted to deal with the practice. This could deter FGM, and save girls from being subjected to it.

*Mandatory health screenings*

Mandatory health screenings at school could be introduced for boys and girls under the age of 18. Health screenings could check for a range of medical problems not *only* FGM. In contrast to other European countries, France has achieved more than 40 prosecutions since 1979, resulting in the punishment of more than 100 parents and cutters[112]. A key feature of the French system is the use of regular medical screenings on children up to the age of six, which includes examination of the genitals[113]. The system is not mandatory, though receipt of social security is dependent on participation[114]. Girls who are identified as being at risk of FGM are

[111] *Ibid*.
[112] House of Commons Home Affairs Select Committee. *Op cit*., paragraph 32.
[113] *Ibid*., paragraph 33.
[114] *Ibid*.

required to have medical examinations every year, and whenever they return from abroad[115]. The House of Commons Home Affairs Select Committee into FGM stated that "this approach has proven effective both in protecting girls in France from FGM, but also providing the evidence to mount a prosecution where FGM has taken place."[116]

*Further research on type IV FGM*

There is scant research available on Type IV FGM in the UK and overseas. Research is required to ascertain prevalence rates, where Type IV is performed, the purpose of the practice, for example, is Type IV performed because it is difficult to detect, and thus parents and excisors are able to avoid prosecution[117], and the health consequences of the practice.

**Commonwealth member countries**

There is limited research available on the prevalence rates and legal response to FGM in many Commonwealth member countries. As a result the following international course of action is recommended across Commonwealth member countries:

- Conduct research on the prevalence rates of the practice, and the Types of FGM performed.
- Undertake research on the legal responses to FGM and the number of prosecutions and convictions for FGM.
- Ensure the practice is criminalised in each Commonwealth member country to uphold a consistent legal approach towards FGM, and comply with international human rights law. It is concerning that the practice is medicalised in some Commonwealth member countries, such as Singapore. This offers a haven for FGM to be performed with impunity, particularly on British girls who are taken abroad and subjected to FGM in hospitals.

[115] *Ibid*.
[116] *Ibid*.
[117] FGM-performing communities suspect type IV FGM is being performed as opposed to type I, II and III because it is difficult for professionals to detect type IV, thus parents and excisors are able to avoid prosecution. In the matter of *B and G (Children) (No 2)* [2015] EWFC 3, the court found on the balance of probabilities the girl had not been subjected to type IV FGM. See: Proudman, C. 2015). *Case analysis of B and G (Children) (No 2)* [2015] EWFC 3. Family Law Week. http://www.familylawweek.co.uk/site.aspx?i=ed142550