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Promising Practices on Female Genital Mutilation in the UK

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Female Genital Mutilation/Cutting[1]

Female genital mutilation/cutting (hereafter referred to as FGM/C) is an ancient tradition dating to as early as 200 BC, and is thought to have come into practice during the Pharaonic era of Ancient Egypt. The practice has its origins in cultural rather than religious values and traditions, although it is widely acknowledged that the primary causes of FGM/C vary across regions and cultures. However, while statistical data indicate no clear relationship between FGM/C and any specific religion this does not mean that religion has no influence. As anthropologist Gruenbaum (2001: 3) argues, "People have different and multiple reasons [for FGM/C] … For some it is a rite of passage. For others it is not. Some consider it aesthetically pleasing. For others, it is mostly related to morality or sexuality." Most studies speak of 'justifications' and 'rationalisations' rather than 'causes', in order to avoid pointing the finger at Islamic rules relating to women and sexual morality, given that the Quran does not require FGM/C (though many perpetrators invoke Islam to justify their acts) (Fourcroy, 2006). Indeed, FGM/C is practiced by Muslims, Christians, and Jews, and is not restricted to any particular ethnic or religious sect. Although often associated with Islam, FGM/C is not practised in a large number of Islamic countries, including Morocco, Algeria, Afghanistan, and Saudi Arabia and so it should be considered a cultural practice and not as a fundamentally or inherently religious one (Banks et al, 2006).

Beliefs associated with the practice of FGM/C usually centre on traditions concerning the rite of passage into womanhood (Gallo, 1985). In some cultures, FGM/C is seen to ensure social acceptance and marriageability through preserving a woman's virginity and thereby protecting her family's honour (Gill, 2014). As a result, FGM/C largely defines a woman's future as a wife and mother. Accordingly, it is performed so that women can conform to longstanding social and cultural norms. Not circumcising a daughter is equivalent to condemning her to a life of isolation as it shames her and her entire family. Here it is also useful to understand why women, particularly older women in practicing communities, tend to be the most vocal supporters of FGM/C[2] - particularly where the honour of families is intrinsically linked to the sexual purity of their female members and of the in-marrying women under its

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[1] The term 'female genital mutilation' (FGM), also referred to as 'female genital cutting' (FGC), 'female circumcision' (FC), and 'female genital mutilation/cutting' (FGM/C), concerns all procedures involving partial or total removal of the external female genitalia or other damage to the female genital organs for non-medical reasons.

[2] Elderly women mostly perform FGM without any medical knowledge. Increasingly, mutilation is done in many countries by doctors or midwives.

protection (Gill, 2014). In these communities, proof of virginity is regarded as prerequisite of marriage and infibulation taken as an index to both physical and social virginity. This fact is evidenced, for instance, by the practice of reinfibulating women after childbirth or upon later marriages in some parts of Somalia (Moxey and Jones, 2016). If not properly channelled, female sexuality is considered to be the greatest possible source of shame to the elders in the family – especially those who are female. As a consequence, women infibulated their daughters to protect them from their supposedly inherent sexual desires which they believe if left uncontrolled, could lead to rape, social disgrace, illegitimate children and even retributive death. In such a context this practice, carried out by women on women, can be interpreted as pragmatic response to the pressures of conforming to particular gender-related social norms necessary for surviving everyday life as a woman in these communities and maintaining one's social status in its kinship hierarchy.

Eighty-five percent of cases of FGM/C fall under Type I/II, which entails partial or total removal of the clitoris, prepuce, labia minora and/or labia majora. Fifteen percent fall under Type III/infibulation, which involves narrowing the vaginal orifice with a covering created by cutting and apposition the labia minora and/or the labia majora, with or without excision of the clitoris (Gallo, 1985; UNICEF, 2005; WHO, 2008) Type IV unclassified, involves all other harmful procedures performed on female genitalia for non-medical purposes (e.g. pricking, piercing, incising, scraping, and/or cauterisation) (Abdulcadir, Rodriguez and Say, 2014). FGM/C is associated with a variety of health risks, including severe pain, bleeding, shock, infection, and difficulty in passing urine and faeces. There are also associated birth risks, such as delivering the baby through a caesarean section, blood loss, and increased perinatal mortality. Women who have been subjected to FGM/C are more likely to experience pain during sexual intercourse, reduction in sexual satisfaction and reduction in sexual desire compared with women who have not been subjected to FGM/C (UNICEF, 2013).

There has been a considerable decline in the prevalence of female genital mutilation (FGM) over the last 25 years due to worldwide educational campaigns and the fact that FGM has increasingly been the subject of legislative developments at domestic and international levels (Macfarlane and Dorkenoo, 2014). Nevertheless, approximately 200 million women and girls worldwide have undergone some form of FGM (World Bank, 2015). In Africa alone, the figure is in the region of 91.5 million with 3 million girls at risk each year (World Bank, 2011). FGM has been documented in 28 countries in sub-Saharan Africa, as well as in a number of countries in Southeast Asia and the Middle East (UNICEF, 2005; 2013). FGM increasingly affects permanent residents of England and Wales. In 2011, the number of women in England and Wales born in countries where FGM/Cutting (C) is regularly practised and estimated to have been subjected to the practice or at risk of having been was 103,000 for the 15-49 age group and 24,000 for the over 50 age group, while a further 10,000 girls in the 0-14 age group had undergone the practice or were at risk, meaning that in 2011 up to 127,000 women who had undergone FGM and 10,000 girls below the age of 14 who had undergone or were at risk of FGM were permanent residents in England and Wales, compared to an estimated 66,000 in 2001 (Farlane and Dorkenoo, 2014).

Is FGM/C Islamic?

In some Muslim countries where FGM/C is prevalent, it is often erroneously stated that this practice is primarily motivated by religion. FGM/C has no religious basis whatsoever. It has been condemned by Al-Azhar[3] based on several verses in the Quran that relate explicitly or implicitly to female circumcision. The use of the gendered term 'sunnah circumcision' is nothing but a form of deceit used to misguide people and give the impression that this act is an Islamic practice. As for the traditions attributed to Prophet Mohammad, scholars have agreed that none of these traditions are authentic and it is therefore inappropriate to attribute support for this act to the prophet (Serour, 2013). Proponents base their support for FGM/C on views of the four schools of thought, each of which hold their own different perspective of this practice based on their understanding and interpretation of the same unauthentic or inapplicable ahadith:

- The Hanafiya view it as sunnah (optional) whereby those who observe it are rewarded while those who do not have not sinned;
- Malikiya hold that it is wajib (obligatory) for men and sunnah (optional) for women;
- Shafiiya say it is wajib (obligatory) for both men and women;
- Hambaliya have two opinions: it is wajib (obligatory) for both men and women; it is wajib (obligatory) for men and makrumah (honourable) for women.

It should be noted that FGM/C cannot be compared with male circumcision. Whereas male circumcision has a strong basis in shariah and is therefore a religious requirement, female circumcision has no such basis and cannot, thus, be considered a religious practice. Furthermore, there is a difference in what is cut: in males it is the foreskin, and in females, functional organs. Male circumcision, consequently, has both religious and medical benefits, whereas FGM/C is damaging, both medically and in a religious sense (Serour, 2010).

Anthropologists speak of genital mutilation as an active institution determining basic relations and exchanges within the social organisation of the communities in which it is practiced (Talle, 2010). In patriarchal societies like these, the tradition of female genital mutilation ensures control over female sexuality, chastity (essential for marriage), and the honour of the community. Additionally, it represents a deeply-rooted social convention which confers social status both on the child and her family. Non-conformity with this practice leads to stigma, exclusion, and shame. According to these traditions, mutilation is performed in order to allow the child to become a woman; the rite ensures, in this regard, honour, value, identity, pride, and a sense of belonging to the cultural and social group. It is thought to protect virginity and chastity by shielding women from their sexual drives, and it guarantees marriage (Gele et al, 2012). Furthermore, infibulation is associated with beauty; centuries of genital modification have changed the aesthetic perception in these communities so that even if external genitalia are hidden, being soft, without hair, and emitting secretions and odour, the genitalia are considered sexually attractive (Abubakar, 2013).

The beliefs associated with FGM/C are not singular but manifold, and some of them are uniquely specific to certain countries. In some practicing countries it is an initiation rite where the child becomes an adult. Depending on the type of community

[3] The world's leading institution of Sunni Islam.

and its traditions, FGM/C is performed at different ages (during the first weeks of life, childhood, adolescence, or before pregnancy). In some regions, after each delivery, a woman will be re-infibulated if the scar has been previously opened in order to give birth (Abubakar, 2013).

The prevalence of reinfibulation[4] differs markedly between countries. Reinfibulation is most prevalent in countries where type III FGM/C prevails, such as Somalia (98–100 %), Sudan (82 %), Djibouti (50 %), and Eritrea (34 %). Reinfibulation is less prevalent in other countries where infibulation is rarely performed, such as Egypt (9 %), Chad, Ethiopia, Kenya, and Nigeria, where infibulation is only performed in certain regions. It is less prevalent in Burkina Faso, Central African Republic, Ivory Coast, Guinea, Liberia, Senegal, Sierra Leone, Cameroon, Democratic Republic of Congo, Guinea-Bissau, Mauritania, and Uganda where type I and type II FGM are performed (Shell-Duncan, 2001). Reinfibulation is occasionally practiced among immigrants in Europe and North America even though FGM/C is prohibited in these countries (Serour, 2010).

An ethical conflict may arise wherein some women may feel more comfortable with their fused labia and may request to have their scar re-approximated (reinfibulated) to varying degrees after delivery to restore their sense of beauty, normalcy, and genital self-image. There may also be socio-cultural pressures within a woman's family and/or community that drive her decision-making (Serour, 2010; Johnsdotter and Essén, 2010; Balogun, Hirayama, Wariki, Koyanagi, and Mori, 2013).

Reasons for the practice of FGM/C

The practice of FGM/C is rooted in socio-cultural and societal beliefs linked to psycho-sexual and social forms of reasoning, such as those revolving around the control of women's sexuality and family honour as enforced by community mechanisms (WHO, 1999). While reasons for the practice vary across cultural groups, they may typically include FGM/C as a ritualised act for initiating girls into womanhood and for the maintenance of social cohesion. Socio-economic reasons include beliefs that FGM/C is a prerequisite for marriage or an economic necessity in cases where women are largely dependent on men. Religious reasons rest on the belief that it is a doctrinal requirement. Hygienic and aesthetic reasons for FGM/C encompass the belief that the female genitalia are dirty and unsightly while health reasons are associated with beliefs that FGM/C enhances fertility and child survival. FGM/C may also be an important source of income for circumcisers (UNFPA, 2007).

Social consequences

FGM/C is a deeply entrenched social convention among some ethnic groups, and as such, carries consequences both when it is practiced and when it is not. When girls and families conform to the practice, they acquire social status and respect. For girls, undergoing FGM/C promotes their honour and full acceptance in the community, and also imparts a sense of pride and coming of age. In some societies, the link between FGM/C and value is explicit: girls who undergo FGM/C often

[4] Re-infibulation refers to the resuturing (usually after childbirth) of the incised scar tissue in a woman with FGM type 2 or 3. Previously there was uncertainty as to whether re-infibulation was covered by the FGM Acts in the UK. However, it is now accepted that re-infibulation is illegal and should not be performed in any circumstances (Royal College of Midwives, 2013).

receive rewards in the form of celebrations and gifts, and the bride price for a girl who has been cut is much higher than for one who has not (Wheeler, 2003). For families, fulfilling the cultural expectation that girls should be cut confers upon them status and community membership. Conversely, failure to conform leads to difficulty in finding a husband for the girl, shame, and stigmatisation, as well as loss of social status, honour, and protection, resulting in the family's social exclusion from the community.

The fact that women may be more vulnerable to coercion or violence within particular cultural groups does not mean that coercion and violence are 'cultural practices'. Politicians now commonly make the point that culture is no excuse (Díaz, 2012). Culture is paramount to one's identity, subjective orientation for comprehending the world and sense of purpose. When understood in this light, individuals generally feel negatively about being judged as "backward" due to their cultural practices. Utz-Billing (2008) notes that FGM/C is a very delicate topic that is deeply rooted in the tradition and culture of a society. In many regions, FGM/C is regarded as an initiation ritual to integrate young people into the community. Questioning this ritual is often construed as interference in tradition and as a dictate of a 'Western lifestyle'. But culture is not an explanation, at least not if taken in the deterministic sense that represents all men in a particular group as violent, or all women as victims. It has to be possible to address abuses of women without promoting stereotypes of culture in the process. To think about culture is to address the whole spectrum of experiences and modes of thinking, feeling, and behaving – as well as the values, customs, and traditions – of relevant social formations. Migrants, thus, do not carry culture like baggage. Rather, the traces of their cultures of origin are brought into negotiation with the cultures they encounter in their country of destination.

Female Genital Mutilation Prevalence in the UK

Article 11 of the Istanbul Convention highlights the need for parties to the Convention to collect reliable data on a regular basis to measure the prevalence of all forms of violence against women and girls. Collecting evidence on the extent and nature of FGM can assist policy makers and NGOs in their efforts to address the practice. In the UK female genital mutilation is seen in some ethnic groups that have migrated to this country. The majority are refugees, with the main groups coming from Egypt, Eritrea, Ethiopia, the Gambia, Iraq, Kenya, Kurdistan, Liberia, Mali, Nigeria, Northern Sudan, Sierra Leone and Somalia (UNICEF, 2013). Precise figures for the number of girls and women who have undergone, or who are at risk of, genital mutilation in the UK are hard to establish due to the secrecy surrounding the practice. However, a Department of Health funded study found that in England and Wales:

- In 2001, 65,790 women had undergone genital mutilation, with the highest numbers being in women from Kenya and Somalia. The study noted that "their numbers are likely to have increased since then".
- In 2004, there were 9,032 pregnant women, and women who had just had a baby, with genital mutilation.
- In 2005, over 21,000 girls under the age of 15, in England and Wales, were at high risk of genital mutilation.

However, government guidance notes that "it is possible that, due to population growth and immigration from practising countries…FGM is significantly more prevalent than these figures suggest" (Ministry of Justice, 2015).

In July 2015, City University London published a report entitled The Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates which offers support to this suggestion of wider prevalence of FGM. The report states that the overall number of women aged 15-49 who were permanently resident in England and Wales, but born in FGM-practising countries, increased from 182,000 in 2001 to 283,000 in 2011. The report estimates that in 2011 there were 137,000 women and girls (across all age ranges, 103,000 in the 15-49 range) with FGM ─ of those born in countries where it is practised ─ permanently resident in England and Wales. The estimated rates per 1,000 population varied considerably by region (ranging from 21.0 per 1,000 in London to below one per 1,000 in some rural areas). The report estimates that, in 2011, approximately 60,000 girls aged 0-14 were resident in England and Wales who were born in England and Wales to mothers with FGM.

There is also anecdotal evidence that girls are taken from the UK to their country of origin to undergo FGM and that FGM takes place in the UK (House of Commons, 2014). In order to capture data about numbers of women with FGM receiving care from the National Health Service in England, the Department of Health implemented an FGM data set in 2014. In April 2015, an enhanced data set was introduced, requiring all acute trusts, general practices and mental health trusts to record FGM data and return patient-identifiable data to the Health and Social Care Information Centre (HSCIC).

In England and Wales, FGM is recorded as a crime under the Female Genital Mutilation Act 2003. However, figures specifically on the numbers of FGM cases are not available; they are instead aggregated into larger crime categories (FGM crimes are counted in the category 'assault with injury', for example).

National Legislation

In England, Wales and Northern Ireland all forms of FGM are illegal under the Female Genital Mutilation Act 2003[5]. In Scotland it is illegal under the Prohibition of FGM (Scotland) Act 2005[6]. A person is guilty of an offence if he/she, excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris except for operations performed on specific physical and mental health grounds by registered medical or nursing practitioners (Kaplan, Forbes, Bonhoure, Utzet, Martín, Manneh, 2013). It is also an offence to assist a girl to mutilate her own genitalia.

[5] The prevalence of FGM remains a significant concern in the UK. The statutory framework governing the criminalisation of FGM continues to expand and develop in an attempt, it seems, to address this lacuna. The Serious Crime Act 2015 strengthened the laws around female genital mutilation (FGM) which were introduced in the Prohibition of Female Circumcision Act 1985 and the Female Genital Mutilation Act 2003.

[6] In Scotland, FGM legislation is contained in the Prohibition of Female Genital Mutilation (Scotland) Act 2005. The Female Genital Mutilation Act 2003 was amended by sections 70-75 of the Serious Crime Act 2015. Under section 1 of the act, a person is guilty of an FGM 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.

FGM is an offence which extends to acts performed outside of the UK and to any person who advises, helps or forces a girl to inflict FGM on herself. Any person found guilty of an offence under the Female Genital Mutilation Act 2003 will be liable to a fine or imprisonment of up to 14 years, or both. FGM is considered to be a form of child abuse as it is illegal and is performed on a child who is unable to resist or give informed consent. Under the Children Act 1989, local authorities can apply to the courts for various orders to prevent a child being taken abroad for FGM. Despite the legislation, and despite difficulties in determining the number of cases involving FGM, it is possible to say that there have been no convictions for FGM in the UK to date. This is a situation that criminal justice agencies are working hard to address at both national and local level. It should, however, be noted here that in February 2015 the UK's first prosecution of a medical professional for undertaking a female genital mutilation (FGM) procedure collapsed amid accusations against the Crown Prosecution Service for staging a "show trial" in response to political pressure. On 4 February 2015, Dr Dhanuson Dharmasena (together with another defendant) was found not guilty of performing FGM on a patient at the Whittington Hospital in North London. Dr Dharmasena, an obstetrics and gynaecology registrar, was alleged to have performed reinfibulation on a woman after she had given birth. Dr Dharmasena said that he had never before treated a woman who had previously undergone FGM, nor had he received any relevant training. He performed a single suture to stop postpartum bleeding. The woman herself made no request for Dr Dharmasena to be prosecuted (McCartney, 2015). Against the background of apparent inaction in view of the original 1985 legislation, the case represented something of a milestone and the Crown Prosecution Service at the time reported that it had a number of other potential cases under review (Jefferson, 2015).

International Legislation

Three international conventions contain articles that can be applied to FGM. They place an obligation on signatory states, including the UK to take legal action in relation to FGM:

- The United Nations Convention on the Rights of the Child;
- The United Nations Convention on the Elimination of all forms of Discrimination Against Women; and
- The Istanbul Convention on Preventing and Combating Violence against Women and Domestic Violence. This Convention (signed but not yet ratified by the UK) sets out obligations relating to data collection and research, training of professionals, education and other matters, in respect of violence against women generally and FGM specifically.

Offences of FGM

Sections 1-3 or the Female Genital Mutilation Act 2003 make it an offence for any person (regardless of their nationality or residence status) to:

- perform FGM in England and Wales (section 1 of the act);
- assist a girl to carry out FGM on herself in England and Wales (section 2 of the act);
- assist (from England or Wales) a non-UK person to carry out FGM outside the UK on a UK national or UK resident (section 3 of the act).

If the mutilation takes place in England or Wales, the nationality or residence status of the victim is irrelevant.

In addition to the specific offences enacted in each of these sections, the following further categories of offence are created.

Failing to protect a girl from risk of FGM

If an offence under sections 1, 2 or 3 of the act is committed against a girl under the age of 16, each person who is responsible for the girl at the time the FGM occurred could be guilty of an offence under section 3A of the act.

FGM taking place abroad

Section 4 of the act extends the provisions of sections 1-3 to create offences where a UK national or UK resident is connected to FGM abroad (even in countries where FGM is not an offence), specifically where they:

- perform FGM outside the UK (sections 4 and 1 of the act);
- assist a girl to carry out FGM on herself outside the UK (sections 4 and 2 of the act);
- assist (from outside the UK) a non-UK person to carry out FGM outside the UK on a UK national or UK resident (sections 4 and 3 of the act).

An offence of failing to protect a girl from the risk of FGM can be committed wholly or partly outside the UK by a person who is a UK national or UK resident. The extra-territorial offences of FGM are intended to include taking a girl abroad to be subjected to FGM.

Any person found guilty of an offence under sections 1, 2, 3 of the act faces up to 14 years' imprisonment, a fine, or both. Any person found guilty of an offence under section 3A of the act, faces up to 7 years' imprisonment, a fine, or both.

Under general provisions of the law which apply to all criminal offences, it is also an offence to:

- aid, abet, counsel or procure a person to commit an FGM offence;
- encourage or assist a person to commit an FGM offence;
- attempt to commit an FGM offence;
- conspire to commit an FGM offence.

Any person found guilty of such an offence faces the same maximum penalty as these offences carry under the act.

FGM Protection Orders

FGM Protection Orders under s.73 of the Serious Crime Act 2015[7] came into force in July 2015; an FGM Protection Order (FGMPO) is a civil measure that can be

[7] The Serious Crime Act 2015 strengthened further the legislation on FGM which now includes: the right to anonymity for victims; the offence of failing to protect a girl aged under 16 from the risk of FGM; and the duty of professionals including teachers to notify police

applied through the Family Court. The Protection Order offers the means of protecting actual or potential victims from FGM under civil law. The FGMPO is aimed at safeguarding girls at risk of FGM (including those who are already victims) at home in the UK or when they are abroad. The FGMPO is timed to come into effect ahead of the summer school holidays when girls are at higher risk of being taken out of the UK for FGM. Due to the nature of FGM, special courts have been designated to deal with FGMPOs and anyone who breaches a FGMPO faces a heavy penalty. Following their introduction on 17 July 2015, 28 applications and 18 orders were made for FGMPOs between July and September 2015.

Breach of an FGMPO is a criminal offence carrying a sentence of up to five years in prison. As an alternative to criminal prosecution, a breach could be dealt with in the Family Court as a contempt of court, carrying a maximum of two years' imprisonment.

Who can apply for an order?

- the person who is to be protected by the order;
- a relevant third party (such as the local authority); or
- any other person with the permission of the court (for example, teachers, health care professionals, police, family members).

FGMPOs are unique to each case and contain legally binding conditions, prohibitions and restrictions to protect the person at risk of FGM. These may include:

- confiscating passports or travel documents of the girl at risk and/or family members or other named individuals to prevent girls from being taken abroad;
- ordering that family members or other named individuals should not aid another person in any way to commit or attempt to commit an FGM offence, such as prohibiting bringing a "cutter" to the UK for the purpose of committing FGM.

The court can make an order in an emergency so that protection is in place straightaway. The rules covering the court process on FGMPOs are contained in Part 11 of the Family Procedure Rules 2010. Orders can be applied for in the same way as a Forced Marriage Protection Order (ref).

Examples of the types of orders the court might make are:

- to protect a victim or potential victim of FGM from being taken abroad;
- to order the surrender of passports or any other travel documents, including the passport/travel documentation of the girl to be protected;
- to prohibit specified persons from entering into any arrangements in the UK or abroad for FGM to be performed on the person to be protected;
- to include terms in the order which relate to the conduct of the respondent(s) both inside and outside of England and Wales; and
- to include terms which cover respondents who are, or may become, involved in other respects (or in place of the original respondents) and who may commit or attempt to commit FGM against a girl.

when they discover that FGM appears to have been carried out on a girl under 18. Section 73 also added a section, 5A, to the Female Genital Mutilation Act 2003 headed "Female genital mutilation protection orders" which provides that Schedule 2, as added to the 2003 Act, enables the making of FGM protection orders (FGMPOs).

FGMPOs are injunctions made by a court to prohibit persons from performing particular acts that might lead to a named individual being subject to FGM. FGMPOs are detailed and case-specific. They may last for a specified period of time or effectively be indefinite (i.e. they may remain in force until a new Order is made to the contrary). As victims of FGM may be unable to protect themselves, section 73 of the Serious Crime Act 2015 enables others to apply for an FGMPO on behalf of a victim or person at risk, provided the applicant first obtains the permission of the court. Section 73 of the Serious Crime Act 2015 also allows 'relevant third parties' to apply for an FGMPO without first obtaining the permission of the court. The Lord Chancellor is in charge of appointing relevant third parties to make applications of various sorts, and with regard to FGMPOs these include the police and local authorities.

When the police obtain an FGMPO, arrangements are usually made for the victim to remain in contact with the police and vice versa. The local authority and relevant health and education authorities are also alerted, and are often closely involved throughout. Since being named a relevant third party, local authorities have been vigilant in working to identify, and take immediate action in, cases of FGM by using section 5A of the Female Genital Mutilation Act 2003, in conjunction with care proceedings, to obtain the appropriate orders to protect victims and those at risk. However, it is important to recognise that the majority of victims desire to return home once an FGMPO, and any protective orders made under the Children Act 1989, have taken effect. Suggesting that victims should always be removed from their family home ignores both victims' wishes and also the difficulties of being removed from one's normal environment.

Case *Re E (Children)*

This case is one of the first applications for a Female Genital Mutilation Protection Order (FGMP0) pursuant to Schedule 2 to the Female Genital Mutilation Act 2003, which was inserted by s.73 of the Serious Crime Act 2015 and came into force on Friday, 17th July 2015. In the case of *Re E (Children) (FGMPO),* a mother made an application on behalf of her daughters without notice for an FGMPO as their father wanted the children to be circumcised. The court considered the girls were at very high risk of undergoing circumcision and granted the application as a matter of urgency.

The matter was listed before Mr Justice Holman, who made an order under the following provisions:

1. prohibiting mother and father from removing the girls from England and Wales;
2. restraining father from threatening, intimidating, harassing or pestering mother or the girls, either personally or through another person;
3. prohibiting father from coming within 100 metres of the girls' home and school.

The judgment was welcomed by lawyers and by FGM activists who support victims of this harmful practice. By showing that the courts will use their powers to protect children in these circumstances Re E (Children) (FGMPO) should also encourage mothers to make similar applications. Further strengthening this helpful judgment, the Home Office has in the last six months consulted on the draft statutory multi-agency guidance on FGM. The consultation focuses on the provision of advice and support to frontline professionals and organisations which are responsible for safeguarding and promoting the welfare of FGM victims. The new statutory guidance will, no doubt, increase awareness of FGM. In addition, it aims to tackle

this practice through measures such as protection, punishment, enforcement and support.

FGM Mandatory Reporting

From 31 October 2015, regulated health and social care professionals and teachers in England and Wales must report to the police 'known' (visually identified or verbally disclosed) cases of FGM in under 18s which they identify in the course of their professional work.[8] The Home Office has published procedural information on: the duty to help health and social care professionals, teachers and the police understand the legal requirements placed upon them; a suggested process to follow; and, an overview of the action which may be taken if they fail to comply with that duty. This procedural information also aims to give the police an understanding of this duty and the next steps to take on receipt of a report.

This duty will not, however, apply in relation to at risk or suspected cases, or in cases where the woman is over 18. In these cases, professionals are required to follow existing local, safeguarding procedures.

FGM and Care Proceedings

In January 2015 in B & G (Children) No 2 [2015] EWFC 3, the President of the Family Division provided guidance for future cases where, in the context of care proceedings, a child may have suffered from FGM. This recent case makes the point that a child who has suffered from FGM could be considered to have reached the care proceedings threshold, but that possibility is not a given, and that each case should be considered on its facts, since section 31 of the Children Act 1989 states that when seeking a care or supervision order a local authority must be able to show that the "threshold criteria have been met: that the child must be suffering, or likely to suffer, significant harm. And that the harm or likelihood of harm must be attributable to one of the following:

- the care given to the child, or likely to be given if the order were not made, not being what it would be reasonable to expect a parent to give; or
- the child being beyond parental control."

(Sloan, 2015)

The B and G case involved care proceedings brought by the local authority on the basis that G had been subjected to Type IV FGM. If G had been subjected to FGM, there would also be a need to determine the implications in relation to planning for her and her brother's future. The local authority was unable, on the evidence, to establish that G either had been or was at risk of being subjected to any form of FGM. In this particular case, the President found that the young girl had not been subjected to FGM. However, he provided guidance for future cases, reiterating that any form of FGM constitutes "significant harm" within the meaning of ss. 31 and 100 of the Children Act 1989 and could never constitute reasonable parenting (ss. 68, 71). However, he cautioned that "local authorities and judges are probably well advised not to jump too readily to the conclusion that proven FGM should lead to

[8] The duty does not apply in relation to at risk or suspected cases, or in cases where the woman is over 18. In these cases, professionals are required to follow existing local, safeguarding procedures.

adoption" (s.185). The President noted that it was sobering to consider that this was the first of only a handful of FGM cases to have come before the family courts. The President of the Family Division stressed that local authorities had to be proactive about taking measures to prevent FGM and that the Court "must not hesitate to use every weapon in its protective arsenal if faced with a case of actual or anticipated FGM" and that the inherent jurisdiction must be mobilised in its prevention (s. 78).[9]

Her Majesty's Inspectorate of Constabulary (HMIC) research on FGM and related harmful practices

In April 2015, Her Majesty's Inspectorate of Constabulary was instructed by the Home Secretary to review, for the first time, the police response to 'honour'-based violence. The report Depths of Dishonour, Hidden Voices and Shameful Crime was based on HMIC inspections and research as well as a study of interviews with victims by researchers from the University of Roehampton and the University of Bristol's Centre for Gender and Violence Research. The academics interviewed victims and survivors of 'honour'-based violence, forced marriage and female genital mutilation to uncover how they felt about their dealings with police officers (Hester, Gangoli, Gill and Mulvihill, 2015). Of the 50 interviewees, around a third (n=14) of the sample had experienced FGM, all as children and all in their (or their parents') country of origin. None of those who had experienced FGM had reported it to the police in the UK or elsewhere.[10]

Participants with experience of FGM expressed mixed feelings about reporting new cases that they were aware of to the police. Some feared retribution from the wider community, and some were concerned that reporting would represent an interference in private family life.

Yes, but we cannot report to the police because I don't want to interfere with other people's lives. If I see someone is doing FGM, I don't want to interfere with other people. That's not fair. […] If someone does FGM and I report to the police that family will come to me and I get into trouble. (HMIC28, Group interview, Non-Reporters, FGM)

In the context of the FGM cases that the researchers examined, interviewees suggested FGM is a very private affair between the child and the parents. Participants said it would be very hard for them to speak to the police, unless they knew 'for sure' that FGM had taken or would take place, in case, for example, doing so led to the children being removed from the family. This extra level of secrecy overlaid the cultural code of protecting the family and community that already existed. The interviewees recognised that this combination of secrecy and culture may make it particularly difficult to facilitate reporting of FGM (Hester, Gangoli, Gill and Mulvihill, 2015).

Some of the participants who had experienced FGM questioned its treatment as a separate issue in law and practice, arguing that it should be considered child abuse. They felt it fuelled a preoccupation with 'culture' and 'certain communities', which distracted from the central task of protecting all children from all types of harm. The

[9] Source: http://www.familylaw.co.uk/news_and_comment/re-b-and-g-children-no-2-2015-ewfc-3

[10] Source: https://www.justiceinspectorates.gov.uk/hmic/wp-content/uploads/the-depths-of-dishonour.pdf

following participant, who was cut in Sierra Leone aged 14, believed that the terminology was a barrier to reporting.

And it was at that point that I heard this language about 'FGM'. And as soon as I read it, I felt like a knife had gone into my heart, to be honest. Because I think up until that point, I was living with my body quite freely, maybe naively. Until I heard that term. And that's when that intrusion of what happened to me became very raw. […] I was reading this information and thinking so I am a freak, and my parents are the worst people ever, and my culture is disgusting, you know? And I felt that this doesn't ring true to me: I don't feel that my parents or my culture are bad but what I do feel is that my human rights have been taken away from me. My body was altered without my consent. […] So those were the times when I felt like I was the 'mutilated' lady. I think that is why the campaign has been stuck for 30 years. It won't change till the terminology changes. All power to survivors, but I don't know why they want to align themselves to those labels. […] I would help someone to report because it is against the law. [But I would term it] 'genital alteration' – to alter another person's body without their consent (HMIC18, Non-Reporter, FGM).

All the participants in this study who had experienced FGM agreed that FGM is a cultural practice and not a religious requirement and they claimed to reject FGM for their own daughters (Hester, Gangoli, Gill and Mulvihill, 2015).

Promising practices: prevention, victims' support services and access to justice

While appropriate sanctions are required to punish the perpetrators of female genital mutilation (FGM), it is equally important that there is adequate support for victims and those at risk. However, political and financial support has increasingly centred on law enforcement responses to FGM, an approach which has resulted in a decrease in funding for specialist services. To protect victims, a change in emphasis is required. Rather than the prosecution of perpetrators becoming the focus of both policy and practical measures concerning FGM, significant material resources need to be made available to aid women, whether they choose to exit abusive relationships or attempt to resolve their difficulties with their spouse and/or family. Giving the criminal justice system sole authority to manage this aspect of the politics of intimacy reflects short-term, crisis-orientated thinking rather than a strong understanding of the problems underlying FGM and other forms of gender-based violence.

While examples of good practice shed light on successful strategies for accomplishing specific goals, the key to tackling and preventing FGM is to integrate a diverse range of activities and measures, including awareness-raising, health and educational initiatives, support services, training and campaigning. The following examples demonstrate how four organisations have recognised that a holistic response is needed and have developed a wide range of strategies to support victims and to tackle and prevent FGM.

a) The UK's first FGM web app, **Petals**, is designed to allow teenagers to learn about FGM anonymously and get help if they are at risk. This free app has been developed by Coventry University. It was funded by the Department for Education, and is endorsed by the NSPCC.

b) As part of a Department for Education programme, **New Steps for the African Community** (NESTAC) is delivering FGM training to staff and pupils in three high schools in Manchester. The Community Safety Partnership has awarded additional funding to extend this training to a further seven high schools in Manchester. NESTAC will also provide train the trainer sessions to these schools to ensure the future sustainability of the programme.
c) **Bristol's Primary Care Trust** (PCT) has led the city's focus on FGM. A multi-stakeholder group, including representatives from the health, police and third sectors, has focused on mainstreaming FGM prevention as a child protection issue. The PCT has funded three main community groups (from different ethnic communities, so that messages against FGM are not overly associated with a single ethnic group, which can be stigmatising) to carry out FGM prevention work, which has included raising awareness of the legal and health implications of FGM. The incorporation of FGM prevention into child protection has bolstered support from frontline agencies, and visible community support has increased.
d) The **Violence Against Women and Girls** (VAWG) Model - This approach can be illustrated by recent activities in the London Borough of Lambeth. The local authority lead for VAWG selected eight strands to focus on in their VAWG strategy. An initiative funded project lobbied for its inclusion in the strategy. FGM is now discussed in multi-stakeholder meetings, which include representatives from the healthcare profession, the local authority, social care and police. The local authority has funded a 'one stop shop' service for women affected by violence. Front line staffs screen all women attending services for FGM. The borough has also funded empowerment training for a small group of women from affected communities, who are taking anti FGM messages back to their communities.

Prevention of FGM is crucial if the human rights of women and girls are to be protected and their human dignity preserved. Specifically, prevention means sparing potential victims the trauma of FGM. Given the fact that families of victims often perpetrate this crime, prevention can also ensure that victims do not experience physical or emotional alienation from their families, something which compounds the trauma they have experienced. Importantly, prevention also gives otherwise vulnerable persons the chance to retain their physical integrity, dignity, individual freedom and autonomy by giving them the chance to make their own decisions about their well-being and future health.

Article 12 of the Istanbul Convention 139 specifically prescribes that state parties must "take the necessary measures to encourage all members of society, especially men and boys, to contribute actively to preventing all forms of violence covered by the scope of this Convention" and that "culture, custom, religion, tradition or so-called 'honour' shall not be considered as justification for any acts of violence" covered by the Convention. The Convention provides a number of concrete obligations for the prevention of violence against women which are also relevant to preventing FGM.[11]

These are:

1. awareness-raising at all levels, including with the public at large – Article 13;

[11] Source: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=09000016800d383a

2. the inclusion of teaching materials to prevent violence against women in education curricula – Article 14;
3. training for relevant professionals – Article 15;
4. preventive intervention and treatment programmes – Article 16; and
5. participation of the private sector and the media – Article 17.

Where next?

Many of the organisations and NGOs which work in the area of FGM have stressed the positive aspects of the recent civil remedies that have been introduced. However, they have also made the case for the need for a diverse range of responses to FGM and related abuses. Specialist outreach services, education and awareness-raising work in schools and the community, welfare services, childcare facilities, and the provision of specialist refuge spaces are all necessary if FGM is to be tackled effectively. Unfortunately, the recent legislative developments concerning FGM have not been accompanied by additional funding for these types of work. The Government needs to invest in promising practices and organisations like the ones described above if they are to achieve maximum effectiveness. Moreover, in exploring both the promise and the limits of criminal and civil remedies for FGM, it is important to recognise that diverse types of responses need to be integrated, rather than applied in an either/or manner, if the UK is to successfully identify and punish the perpetrators of FGM while simultaneously assisting victims.

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