Female Genital Mutilation (FGM) is the most commonly-used term for a range of painful and potentially life-threatening procedures carried out on pre-pubescent girls (usually between 4-12 years old) but in some cultures as early as a few days after birth or as late as prior to marriage. Globally, it is estimated that approximately 140 million females have undergone the procedure and an estimated 3 million young girls are at risk of FGM each year¹.

The World Health Organisation (WHO, 2008) defines FGM, also referred to as ‘cutting’ or ‘female circumcision’, as: “… the partial or total removal of the external genitalia or injury to the female genital organs whether for cultural or any other non-medical reasons”².

Although FGM is recognised internationally as a harmful social convention, the true nature of this covert tradition has remained unknown to Western populations largely unaffected by the practice. Interest has recently been reignited across Europe, including the UK as a result of increasing global migration and the growing prevalence of FGM practices within these countries.

Justifications for the Practice
There is no definitive evidence why this ritual began and the reasons for the perpetuation of FGM are both varied and complicated. Various superstitions continue to surround FGM, predominantly as a result of established cultural customs and attitudes. FGM has long been presented as a religious requirement with many religious groups, such as Muslim, Jewish and Christian currently practicing FGM despite the practice being not specifically mandated in the Koran or the Bible.

Although this gender-based violence is outlawed in many countries, pressure from within communities, strong cultural customs and deeply-held traditional attitudes have meant that the practice is perpetuated across all socio-economic strata. Families often encourage

their daughters to undergo the procedure as it is considered to be a necessary part of ‘raising their daughter properly’. It is seen as a rite of passage from childhood to womanhood, leading to acceptance into group society and improving marriageability. The FGM process is also believed to signify purity, cleanliness and strong morals in women and a way of preserving the family’s honour by discouraging promiscuity before marriage. In some instances, FGM is considered to be more aesthetically pleasing and enhances male sexual pleasure. Rejection of these societal norms leads to victimisation and being ostracised by their community.

**The Effects of FGM**

FGM refers to procedures that are believed to intentionally and permanently alter or cause injury to the victim. Traditional ‘cutters’ are usually medically untrained women who use non-sterile instruments (blades, sharp stones, scissors, broken glass) in sometimes primitive environments and without anaesthesia or antiseptics.

The pain of the procedure is severe and the trauma suffered by the victim is rarely forgotten. FGM is performed on females often without their permission and against their will – girls are sometimes forcibly restrained and blindfolded during the procedure. Counselling services have reported that the way in which young girls are subjected to FGM give rise to feelings of regret, anger and of having been betrayed by their parents.

The immediate consequences of FGM can vary from sepsis, haemorrhage, shock or death while the long-term consequences could include urinary, menstrual or obstetric complications and blood-borne viruses such as HIV and hepatitis. Cases of maternal mortality following childbirth are also higher when women have been subjected to FGM. Indeed, FGM has no known health benefits.

Attempts have been made to medicalise the procedure i.e. having the procedure carried out by doctors, nurses and midwives, giving a clear message that FGM should be condoned despite being outlawed in 2008. The UN, WHO and FIGO however all: “...oppose any attempt to medicalise the procedures or allow its performance in health establishments or by health professionals”.

**The Prevalence of FGM Practices**

FGM is becoming a global problem, requiring a global solution although it is suspected that the true extent of the issue may be largely unknown.

WHO states that FGM is mostly practiced in 28 countries across the North African continent and parts of the Middle East, and Egypt in particular where the practice is endemic. Global migration patterns have also increased the risk of FGM among women.

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5 [www.figo.org.uk](http://www.figo.org.uk) – “FGM still prevalent in Egypt” (March 2015)
and girls in European Union countries, including the UK and in the USA. The International Federation of Gynaecology and Obstetrics (FIGO) has reported a growing number of FGM instances in the UK, with statistics reaching approximately 4,000 cases since data first started being collected in September 2014\(^6\). The London Metropolitan Police identified that 6,500 girls in London alone are at risk of FGM\(^7\) while hospitals in Northern and Southern England and the Midlands have also reported increased instances of FGM cases\(^8\).

**The Legal Position**

Legislative measures against FGM have been adopted by a number of countries but have rarely been enforced until recently. For example, in January 2015 an Egyptian court imprisoned the first doctor ever brought to trial in the country on FGM charges that resulted in the death of a 13-year old girl, suggesting that historically the law has not been a deterrent in the face of societal norms\(^9\).

The UK government has also implemented various legislation and policy initiatives\(^10\). The practice of FGM has been illegal in the UK since 1985 by virtue of the Prohibition of Female Circumcision Act 1985, later replaced by the Female Genital Mutilation Act 2003 [in England, Wales and Northern Ireland; Prohibition of Female Genital Mutilation (Scotland) Act 2005 in Scotland].\(^11\) The 2003 Act was the first step towards seriously criminalising the practice in Britain. Although acquitted, it would be a further eleven years before the first British doctor was tried for allegedly performing FGM on a woman who had given birth in a UK hospital.\(^12\)

The Serious Crime Act 2015, enacted in March 2015, signals the Government’s continuing commitment to preventing and eventually ending this practice by amending various provisions of the Female Genital Mutilation Act 2003:

- The remit of the offence is expanded through the criminalisation of aiding, abetting, counselling or procuring a non-UK national / permanent resident of the UK to undergo non-medical FGM procedures (new Section 3 of the 2003 Act) or FGM acts performed outside the UK by a UK-national or permanent resident of the UK (new Section 4 of the 2003 Act).
- A new section 3A has been added to the 2003 Act by virtue of Section 72 of the 2015 Act, making it an offence for anyone responsible for a girl under 16 years of age (i.e. has Parental Responsibility, frequent contact or has assumed responsibility for the child as a parent) to fail to protect her from being subjected to FGM. The maximum penalty on

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\(^6\) [www.figo.org.uk](http://www.figo.org.uk) – “Human rights campaigner leads UK anti-FGM project” (May 2015)

\(^7\) [www.met.police.uk/cs/](http://www.met.police.uk/cs/) - “Multi Agency Practice Guidelines on FGM”


\(^10\) Position Statement: Female Genital Mutilation, Royal College of Midwives (July 2015)


\(^12\) “Crime or Culture – Female Genital Mutilation”: Criminal Law and Justice Weekly, 24th April 2015
conviction is 7 years in prison, a fine or both. The accused would only be able to rely on the defences of: (1) there being no apparent significant risk at the time and that they could not have reasonably be expected to be aware of a risk, or (2) that they had taken all reasonable steps to protect the child.

- In response to the suspicion that many victims refuse to come forward out of fear, a new Section 4A and Schedule 1 of the 2003 Act has been created, prohibiting by means of injunction the publication of any information that is likely to lead to an FGM victim being easily identifiable (Section 71 of the 2015 Act). This parallels the anonymity offered to victims of sexual abuse under the Sexual Offences (Amendment) Act 1992. The new 2015 Act provision offers anonymity from the time the allegation is made for the rest of the victim’s life unless disclosure of the victim’s identity is necessary to secure the criminal conviction of the perpetrator (Article 6 ECHR) or hinders the reporting of proceedings (Article 10 ECHR).

- From July 2015, Section 73 of the 2015 Act (now Section 5A and Schedule 2 of the 2003 Act) was enacted and states that a Female Genital Mutilation Protection Order can be made to protect young girls or women against FGM procedures by restricting potential perpetrators. The procedures for these Protection Orders are reported to have been modelled on the Forced Marriage Protection Orders under the Forced Marriage Civil Protection Act 2007. A criminal offence is committed if the terms of these Orders are breached, with a maximum penalty for 5 years imprisonment being possible.

Historically, medical practitioners and social services within the UK have appeared reluctant to report their suspicions of FGM since it had not been considered a child protection matter. However, Section 74 of the 2015 Act creates a new Section 5B of the 2003 Act, the most recently enacted section of the amended 2003 Act (enacted 31st October 2015). Section 5B places a mandatory reporting duty on teachers, medical professionals and social care professionals in England and Wales to report to the police any disclosures made to them that a girl under 18 years of age has been subjected to FGM or report any suspicions that they may have during the course of their normal duties, that FGM has been performed on a girl under 18 years of age for non-medical reasons.

**Conclusion**

There have been many concerns over the deficiencies in the amendment to the 2003 Act. Ekaney and Proudman in their article “FGM and the Serious Crime Act 2015” argue that the 2015 Act does not go far enough in the Government’s commitment to preventing and protecting adult women from violence and appears contradictory. For example the 2003 Act criminalises FGM in respect of both adults and minors yet the 2015 Act states that professionals have no statutory duty to report females aged 18 or over; it is also arguable that there is a potential ‘failure to protect a girl from risk of FGM’ conviction against the parents or guardians of an 18 year old woman if the procedure was undertaken while she...
was a minor. Further legislative changes may therefore be ripe for consideration as professionals become more informed about this secretly pervasive practice and better understand the consequences on those involved.

The Orchid Project reports that legislative frameworks alone are insufficient. Shifting attitudes among relevant communities is the most important factor in ending FGM. UNICEF, who leads a global programme to accelerate the termination of FGM, believes it could be eliminated within a generation. Indeed, some attempts at ending the tradition have already been successful for example, a project based in Senegal. Gambia has also become the most recent country to publicly ban the practice of FGM although it is yet to legislate against it. Although preventative strategies from both health and human rights paradigms have yet to yield a major decline in the instances of FGM, the Orchid Project believes that educating the public has been more successful in raising awareness than affecting behaviour.

**Children & Education Team – ELS**

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