



# **Female Genital Mutilation in the United Kingdom**

**August 2016**





# Contents

<b>Introduction .....</b>	<b>5</b>
<b>Background .....</b>	<b>6</b>
What is Female Genital Mutilation?.....	6
How widespread is FGM in the UK?.....	9
What are the main motivations for FGM? .....	11
Women’s sexuality .....	11
Custom and tradition .....	12
Social pressure .....	12
Religion.....	13
What are the health consequences of FGM?.....	13
Identifying FGM .....	13
<b>Legal Framework.....</b>	<b>15</b>
Crime of FGM .....	15
Penalty .....	17
Extra-territorial Scope .....	17
Victim Anonymity.....	18
Offence of failing to protect a girl from risk of genital mutilation .....	19
Female genital mutilation protection orders .....	20
Duty to notify police of FGM .....	20
<b>FGM Convictions .....</b>	<b>22</b>
<b>Measures .....</b>	<b>24</b>
<b>International Human Rights Law.....</b>	<b>26</b>
Right to Life .....	29

Right to not be subjected to torture or inhuman or degrading treatment or punishment .....	31
Right to be free from gender discrimination.....	33
Rights of the Child .....	35
Right to the highest attainable standard of health .....	36
Right to Protection of Physical and Psychological Integrity.....	37
Rights of persons with disabilities .....	38
<b>Conclusion .....</b>	<b>40</b>

## **Introduction**

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Increasing evidence is emerging that Female Genital Mutilation (FGM) exists within the UK. The aim of this report is to offer a better understanding of this practice within the UK, particularly in relation to human rights. This report provides an overview of the basic elements of FGM – the different types; how widespread it is; the main motivations behind the practice; the health consequences; and how to identify its use. It sets out the legal framework that has been setup in the UK to criminalise this practice; it considers the lack of convictions related to FGM in the UK; and it provides examples of good practice for measures that could be taken to help improve implementation of the laws that exist. The report also looks at FGM through a human rights lens, establishing the obligations that the UK has under international and regional human rights law in a bid to effectively eradicate the presence of FGM within the UK. It concludes with recommendations to be considered for improving the UK's approach to eliminating FGM and adhering to its human rights obligations.

# Background

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## What is Female Genital Mutilation?

Female Genital Mutilation (FGM)<sup>1</sup> 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.<sup>2</sup> *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'.<sup>3</sup>

**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.<sup>4</sup> In some cases, the seal is later closed again to recreate an infibulation, usually after childbirth when deinfibulation is necessary. This procedure is

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<sup>1</sup> 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, 'Multi-agency Practice Guidelines: Female Genital Mutilation' (HM Government, 2014), at 11.

<sup>2</sup> World Health Organisation, 'An Interagency Statement' (WHO, 2008).

<sup>3</sup> UNICEF, 'Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change' (UNICEF, 2013), at 7.

<sup>4</sup> *Ibid.*

referred to as reinfibulation. FGM-performing community usually refer to Type III FGM as Pharonic circumcision or Pharonic infibulation.<sup>5</sup> It is thought Pharonic refers to the origins of the practice in ancient Egypt.<sup>6</sup>

**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.<sup>7</sup> The introduction of pricking has even been suggested as a replacement of more invasive procedures as a form of harm-reduction.<sup>8</sup>

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<sup>5</sup> Comfort Momoh, *Female Genital Mutilation* (Radcliffe Publishing, 2005).

<sup>6</sup> Efua Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*. (Minority Rights Group, 1995), at 33.

<sup>7</sup> 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, 'An Interagency Statement' (WHO, 2008), at 28.

<sup>8</sup> *Ibid*, at 26.



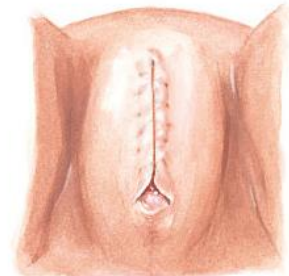
**Type I**



**Type II**



**Type III**



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

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.<sup>9</sup> The arrangements for the procedure usually includes the child being held down on the floor by several women with the procedure performed without medical expertise or sterilized medical instruments.<sup>10</sup> 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<sup>11</sup> due to the 'medicalisation' of the practice overseas (see Egypt) or on the black market in the UK.<sup>12</sup> 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.<sup>13</sup> This is commonly known as the 'cutting season'.

### **How widespread is FGM in the UK?**

In the UK and some European countries, FGM tends to occur amongst migrant communities, including refugees and asylum seekers from FGM-practising countries.<sup>14</sup> 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

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<sup>9</sup> *Ibid*, at 3.

<sup>10</sup> HM Government, 'Multi-agency Practice Guidelines: Female Genital Mutilation' (HM Government, 2014), at 13.

<sup>11</sup> *Ibid*.

<sup>12</sup> Efua Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*. (Minority Rights Group, 1995), at 131.

<sup>13</sup> HM Government, 'Multi-agency Practice Guidelines: Female Genital Mutilation' (HM Government, 2014), at 12.

<sup>14</sup> Comfort Momoh, *Female Genital Mutilation* (Radcliffe Publishing, 2005).

2011.<sup>15</sup> Northern Ireland and Scotland were excluded from the study. There have been no systematic estimates of the prevalence of FGM in Northern Ireland. Nevertheless, there is anecdotal evidence from the Royal College of Nursing and non-governmental organisations that FGM is present in Northern Ireland. Since September 2014, the Health and Social Care Information Centre began collecting data on FGM within England on behalf of the Department of Health and NHS England to improve the NHS response to FGM and help commission services to support women and girls.<sup>16</sup> This project found that in 2015-2016 there were 5,700 new cases of FGM within England, 18 of these cases were performed in the UK.<sup>17</sup>

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.<sup>18</sup> The age when FGM is performed on victims varies with local traditions and customs but is believed to be decreasing in some countries.<sup>19</sup> 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.<sup>20</sup> However, as the campaign against FGM intensifies, parents are possibly cutting children younger to prevent detection.<sup>21</sup> Girls

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<sup>15</sup> Alison Macfarlane and Efua Dorkenoo 'Prevalence of Female Genital Mutilation in England and Wales: National and Local Estimates' (City University and Equality Now, 2015).

<sup>16</sup> 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>

<sup>17</sup> HSCIC, 'First ever annual statistical publication for FGM shows 5,700 newly recorded cases during 2015-2016', 21 July 2016. Available at: <http://digital.nhs.uk/article/7180/First-ever-annual-statistical-publication-for-FGM-shows-5700-newly-recorded-cases-during-2015-16>

<sup>18</sup> World Health Organisation, 'An Interagency Statement' (WHO, 2008), at 4.

<sup>19</sup> *Ibid.*

<sup>20</sup> Efua Dorkenoo, *Cutting the Rose: Female Genital Mutilation: The Practice and its Prevention*. (Minority Rights Group, 1995).

<sup>21</sup> *Ibid.*, at 131.

may be cut alone or with a group of family members or peers from their community.<sup>22</sup>

The research that does exist in relation to FGM is focused on Types I, II and III. 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 and why this particular type is chosen. It could be that Type IV is difficult to detect, thus parents and excisors are able to avoid prosecution,<sup>23</sup> or due to the potentially milder health consequences of the practice.

### **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.<sup>24</sup> 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.

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<sup>22</sup> Anika Rahman and Nahid Toubia, *Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies*. (Zed Books, 2000), at 3.

<sup>23</sup> 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 Charlotte Proudman, 'Case analysis of *B and G (Children) (No 2)* [2015] EWFC 3' *Family Law Week*. Available at: <http://www.familylawweek.co.uk/site.aspx?i=ed142550>

<sup>24</sup> Anika Rahman and Nahid Toubia, *Female Genital Mutilation: A Practical Guide to Worldwide Laws & Policies*. (Zed Books, 2000).

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.<sup>25</sup> 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.<sup>26</sup> 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 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,

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<sup>25</sup> HM Government, 'Multi-agency Practice Guidelines: Female Genital Mutilation' (HM Government, 2014), at 11.

<sup>26</sup> *Ibid.*

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,<sup>27</sup> there is no religious basis for the procedure. FGM predates Christianity, Islam, and Judaism, and key religious texts do not prescribe FGM.<sup>28</sup> 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,<sup>29</sup> birth complications, pain during sexual intercourse, and infertility and in rare cases, death.<sup>30</sup>

### **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.

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<sup>27</sup> Toubia, N. (1995a). Female Genital Mutilation. In J. Peters & A. Wolper (Eds.), *Women's rights, human rights: International feminist perspectives*. Psychology Press. Page 225.

<sup>28</sup> HM Government, 'Multi-agency Practice Guidelines: Female Genital Mutilation' (HM Government, 2014), at 12.

<sup>29</sup> A significant minority of females are mutilated more than once.

<sup>30</sup> World Health Organisation, 'An Interagency Statement' (WHO, 2008), at 33-35.

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.

## Legal Framework

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FGM has been illegal in the UK since 1985, by virtue of the Prohibition of Female Circumcision Act 1985. This legislation has since been repealed and replaced. In England, Wales and Northern Ireland, the criminalisation of FGM is currently dealt with under the Female Genital Mutilation Act 2003; this Act has full application within these jurisdictions.<sup>31</sup> In Scotland the 1985 Act was replaced by the Prohibition of Female Genital Mutilation (Scotland) Act 2005.<sup>32</sup>

Following a Home Affairs Committee report into FGM, it was recommended that a national action plan be introduced. It was intended that this action plan 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”.<sup>33</sup> As a result the Serious Crimes Act 2005 was implemented. This Act extends the scope of the 2003 Act. It also introduced a number of new legal measures aimed at protecting victims and potential victims of FGM. The application of the 2005 Act across the UK differs depending on the provision. The following section provides an overview of the protections offered within the UK legal framework regarding FGM.

### Crime of FGM

It is a crime to perform FGM in the UK.<sup>34</sup> 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.<sup>35</sup> This is 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

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<sup>31</sup> Available at: <http://www.legislation.gov.uk/ukpga/2003/31/contents>

<sup>32</sup> Available at: <http://www.legislation.gov.uk/asp/2005/8/contents>

<sup>33</sup> House of Commons Home Affairs Select Committee, ‘Female Genital Mutilation: The Case for a National Action Plan’ (House of Commons, 2014), at para 22.

<sup>34</sup> Section 1, FGM Act 2003; Section 1, Prohibition of FGM (Scotland) Act 2005.

<sup>35</sup> Section 1(1), FGM Act 2003; Sections 1(1) and 1(2), Prohibition of FGM (Scotland) Act 2005.



labour or has just given birth for purposes connected with the labour or birth.<sup>36</sup> In determining whether an operation is necessary for the mental health of a girl “it is immaterial whether she or any other person believes the operation is required as a matter of custom or ritual”.<sup>37</sup> It is also illegal to assist a girl in the UK to carry out FGM on herself.<sup>38</sup> Scottish Ministers may order the modification of actions that equate to FGM and the definition of an “approved person”.<sup>39</sup>

The nationality or residence status of the victim is irrelevant, provided that FGM takes place in the UK. This follows from the Bar Human Rights Committee of England and Wales finding that “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”.<sup>40</sup> The Committee’s comments also make a case for including extra-territorial aspects to the crime of FGM, which is discussed below.

An investigation is required to examine whether section 1(2)(a) of the FGM 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<sup>41</sup>. 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.<sup>42</sup>

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<sup>36</sup> Sections 1(2) and 1(3), FGM Act 2003; Sections 1(3), 1(4) and 1(5), Prohibition of FGM (Scotland) Act 2005.

<sup>37</sup> Section 1(5), FGM Act 2003; Section 1(6), Prohibition of FGM (Scotland) Act 2005.

<sup>38</sup> Section 2, FGM Act 2003; Section 3(1)(b), Prohibition of FGM (Scotland) Act 2005.

<sup>39</sup> Section 2, Prohibition of FGM (Scotland) Act 2005.

<sup>40</sup> Bar Human Rights Committee England and Wales, ‘Report of the Bar Human Rights Committee England and Wales to the Parliamentary Inquiry into Female Genital Mutilation’ (Bar Human Rights Committee England and Wales, 2014), at 3.

<sup>41</sup> House of Commons Home Affairs Select Committee, ‘Female Genital Mutilation: The Case for a National Action Plan’ (House of Commons, 2014), at para 32.

<sup>42</sup> Royal College of Obstetricians and Gynaecologists Ethics Committee, ‘Ethics Opinion Papers: Ethical Considerations in Relation to Female Genital Cosmetic

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.<sup>43</sup> 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.<sup>44</sup> FGM-performing communities perceive there is a “double standard” whereby there is a focus on black and ethnic minority communities, while the dominant community undergoes female genital cosmetic surgery without criminal repercussions.<sup>45</sup> In this way, communities use female genital cosmetic surgery as a justification for continuing the practice of FGM.

## **Penalty**

The penalty for FGM in the UK can be a prison sentence, fine or both.<sup>46</sup> Under the Female Circumcision Act 1985 the maximum penalty for performing female circumcision, or FGM, was five years.<sup>47</sup> This has been extended to 14 years under the FGM Act 2003 for England, Wales and Northern Ireland,<sup>48</sup> and the Prohibition of FGM (Scotland) Act 2005 for Scotland.<sup>49</sup>

## **Extra-territorial Scope**

There are extra-territorial aspects to FGM within UK law, which have developed over time. The FGM Act 2003 and the Prohibition of FGM (Scotland) Act 2005 limited these extra-territorial aspects to UK nationals or permanent UK residents.<sup>50</sup> The Serious Crimes Act

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Surgery (FGCS)’ (Royal College of Obstetricians and Gynaecologists Ethics Committee, 2013).

<sup>43</sup> House of Commons Home Affairs Select Committee, ‘Female Genital Mutilation: The Case for a National Action Plan’ (House of Commons, 2014), at para 89.

<sup>44</sup> *Ibid.*

<sup>45</sup> *Ibid.*

<sup>46</sup> Section 5, FGM Act 2003; Section 5, Prohibition of FGM (Scotland) Act 2005.

<sup>47</sup> Section 2(a), Prohibition of Female Circumcision Act 1985.

<sup>48</sup> Section 5, FGM Act 2003.

<sup>49</sup> Section 5, Prohibition of FGM (Scotland) Act 2005.

<sup>50</sup> Section 4(1), FGM Act 2003; Section 4(1), Prohibition of FGM (Scotland) Act 2005.

2005 extended the scope to include habitual residents.<sup>51</sup> This applies across the UK.

There is no statutory definition of habitual residence.<sup>52</sup> A person is deemed habitually resident in the UK is 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 etc.).

Under these new provisions, it is an offence across the UK for a UK national, permanent UK resident or other person habitually resident in the UK to perform FGM abroad;<sup>53</sup> to assist a girl to perform FGM on herself outside the UK;<sup>54</sup> and to assist, from outside the UK, a non-UK person to carry out FGM outside the UK on a UK national, permanent or habitual resident.<sup>55</sup>

The 2005 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.

### **Victim Anonymity**

A new section 4A and Schedule 1 have been inserted into the FGM Act 2003, by virtue of section 71 of the Serious Crimes Act 2005. This provision extends across the UK, excluding Scotland. This amendment provides 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

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<sup>51</sup> Section 70(1), Serious Crimes Act 2005.

<sup>52</sup> Council Regulations (EEC) No 1408/71; Regulation (EC) No 883/2004.

<sup>53</sup> Section 4(1), FGM Act 2003; Section 4(1), Prohibition of FGM (Scotland) Act 2005.

<sup>54</sup> Section 3(1), FGM Act 2003; Section 3(1)(b), Prohibition of FGM (Scotland) Act 2005; Section 70(1), Serious Crimes Act 2005.

<sup>55</sup> Sections 3(2)(a) and 4(2), FGM Act 2003; Section 4(2), Prohibition of FGM (Scotland) Act 2005; Section 70(1), Serious Crimes Act 2005.

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.<sup>56</sup>

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

Under section 72 of the Serious Crimes Act 2005, a new Section 3A offence of failing to protect a girl under the age of 16 from risk of FGM is introduced into the FGM Act 2003. This provision extends across the UK, excluding Scotland. A person is liable for the offence if they are responsible for a 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.<sup>57</sup> 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.<sup>58</sup>

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.<sup>59</sup> The second defence is that the defendant took reasonable steps to protect the girl from being the victim of FGM.<sup>60</sup>

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<sup>56</sup> Bar Human Rights Committee England and Wales, ‘Report of the Bar Human Rights Committee England and Wales to the Parliamentary Inquiry into Female Genital Mutilation’ (Bar Human Rights Committee England and Wales, 2014).

<sup>57</sup> Section 3A(3), FGM Act 2003; Section 72(2), Serious Crimes Act 2005.

<sup>58</sup> Section 3A(4), FGM Act 2003; Section 72(2), Serious Crimes Act 2005.

<sup>59</sup> Section 3A(5)(a), FGM Act 2003; Section 72(2), Serious Crimes Act 2005.

<sup>60</sup> Section 3A(5)(b), FGM Act 2003; Section 72(2), Serious Crimes Act 2005.

## **Female genital mutilation protection orders**

Section 5A is inserted into the FGM Act 2005 by section 73 of the Serious Crimes Act 2005. This provision extends across the UK, excluding Scotland. It introduces the new Schedule 2 into the 2003 Act. The schedule provides for FGM Protection Orders,<sup>61</sup> 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.<sup>62</sup> FGM protection orders are modelled on forced marriage protection orders introduced by the Forced Marriage (Civil Protection) Act 2007.<sup>63</sup>

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.

## **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. This provision was introduced by section 74 of the Serious Crimes Act 2005, which does not extend to Northern Ireland or Scotland. It imposes a statutory duty on 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

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<sup>61</sup> 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](http://www.familylaw.co.uk/news_and_comment/fgmpo-figures-published-for-first-time-in-family-court-statistics#.Vvp5AMdBDdk)

<sup>62</sup> *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](http://www.familylaw.co.uk/news_and_comment/re-e-children-female-genital-mutilation-protection-orders-2015-ewhc-2275-fam#.Vvp52MdBDdk)

<sup>63</sup> Forced marriage protection orders extend to Northern Ireland under Schedule 1 of the Forced Marriage (Civil Protection) Act 2007.

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.

## FGM Convictions

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There have been no FGM convictions in the UK. As of February 2015, regarding FGM in England and Wales, there was one prosecution; three cases were being considered by the Crown Prosecution Service (CPS); four cases had not yet passed to the CPS; the CPS had decided to not prosecute in 11 cases; and the police had decided to take no further action in one case.<sup>64</sup>

In 1993 a medical practitioner was struck off by the General Medical Council for performing female circumcision in the UK while knowing the operation was illegal.<sup>65</sup> This practitioner's case did not lead to prosecution. The only prosecution to be brought in the UK regarding FGM was against Dr Dhanuson Dharmasena, for the manner in which he stitched up a mother following the birth of her first child, and the complainant's husband, Hasan Mohamed was charged with intentionally encouraging an offence of FGM, and aiding, abetting, counselling or procuring Dr Dharmasena to commit an offence. The case was brought in March 2014 and both individuals were acquitted in February 2015 on the basis that Dr Dharmasena conducted a procedure that was linked to the labour, not for the purposes of performing FGM as allowed for under section 1(2) of the FGM Act 2003.<sup>66</sup> The Royal College of Obstetricians and Gynecologists commented that this case highlighted "complex issues" and "the resource implications for NHS services, including early identification and referral, better record-keeping and information-sharing between healthcare professionals".<sup>67</sup> It also stressed the need to "distinguish between FGM/reinfibulation and medical-indicated surgical procedures to correct trauma".<sup>68</sup> The *Dharmasena* case is one to learn valuable lessons from, in a way

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<sup>64</sup> CPS, 'Statement on FGM trial', 4 February 2015. Available at: <http://blog.cps.gov.uk/2015/02/statement-on-fgm-trial.html>

<sup>65</sup> J Black and G Debelle, 'Female Genital Mutilation in Britain' (1995) 310 *British Medical Journal* 1590, at 1591.

<sup>66</sup> For summary of case see:

<http://www.criminallawandjustice.co.uk/features/First-Prosecution-FGM>

<sup>67</sup> Royal College of Obstetricians and Gynecologists, 'RCOG statement on FGM trial verdict', 4 February 2015. Available at: <https://www.rcog.org.uk/en/news/rcog-statement-on-fgm-trial-verdict/>

<sup>68</sup> Royal College of Obstetricians and Gynecologists, 'RCOG statement on FGM trial verdict', 4 February 2015. Available at: <https://www.rcog.org.uk/en/news/rcog-statement-on-fgm-trial-verdict/>

that does not prevent future prosecutions from being brought when a more appropriate case is identified.

There are a number of reasons that it has been difficult to secure a conviction for FGM in the UK, in spite of the existence of the practice.<sup>69</sup> First, 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.

Second, 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.

Third, 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.

Fourth, 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.

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<sup>69</sup> Dexter Dias, Felicity Gerry and Hilary Burrage, '10 reasons why our FGM law has failed and 10 ways to improve it', *The Guardian*, 7 February 2014.



## Measures

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Legislation cannot unilaterally eradicate the practice of FGM. There is a need to introduce measures that assist with the implementation of and adherence to legislation. The establishment of the Welsh Government Strategic FGM Leadership Group and the actions it is taking offers an example of good practice in this regard.

The Welsh group has introduced a number of measures to raise awareness of FGM, to develop the knowledge of professionals and to support communities to break down the barriers associated with exposing and ending FGM. These measures include:

- **setting up a strategic FGM leadership group** – this is made up of key strategic decision makers from statutory, non-statutory and voluntary organisations. Its role is to support the governance and reporting arrangements of FGM; provide direction and advice to the existing advisory bodies; and monitor and evaluate activity.
- **establishing an action plan** – this action plan provides a basis for data gathering and information sharing; training and awareness raising; communications engagement plan; law enforcement; health work programme; community engagement; and evaluation and development of protocols and guidance.
- **developing legislation to place a statutory duty to produce a range of local strategies which cover FGM** – these include strategies on multi-agency collaboration, awareness raising, training and workplace policies and were established by the Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015.
- **introducing safeguarding in education guidance** – this guidance highlights the issue of FGM and provides detailed information on the risk indicators and links to further guidance.
- **hosting events** – these events have included a conference aimed towards raising awareness on the issue among

professionals, and holding culturally mediated and safeguarding training events for educational professionals which examine the issue of FGM.

- **to provide funding** – this funding has been used to train frontline staff, to produce a FGM toolkit for professionals and parents as a teaching aid, and to raise awareness of the health impact of FGM. The funding has been used to develop a partnership with Bawso, an all-Wales service which provides specialist and holistic support to black and minority ethnic communities.
- **to develop a national training framework** – this would provide training to key professionals right across the public sector, to help them to identify cases of FGM and to support survivors.

Other measures to consider are to:

- **introduce 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** – this suggests investing 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.
- **educate** – this could include introducing FGM and violence against women and girls teaching into the National Curriculum, or teaching through art (for example the National Theatre of Scotland's production of 'Rites').<sup>70</sup>

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<sup>70</sup> Available at:

## International Human Rights Law

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FGM is recognised as a harmful practice and violation of the human rights of girls and women.<sup>71</sup> The UK is formally committed to a range of international and regional human rights instruments that indirectly protect against the practice of FGM. These are:

International treaties	Signature	Ratification
Convention relating to the Status of Refugees and its Protocol relating to the Status of Refugees 1951 (Refugee Convention)	28 July 1951	11 March 1954
International Covenant on Civil and Political Rights 1966 (ICCPR)	16 September 1968	20 May 1976
International Covenant on Economic, Social and Cultural Rights 1966 (ICESCR)	16 September 1968	20 May 1976
Convention on the Elimination of all Forms of Discrimination against Women 1979 (CEDAW)	22 July 1981	7 April 1986
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment 1984 (CAT)	15 March 1985	8 December 1988
Convention on the Rights of the Child 1989 (CRC)	19 April 1990	16 December 1991
Convention on the Rights of Persons with Disabilities 2006 (CRPD)	30 March 2007	8 June 2009

Regional treaties	Signature	Ratification
European Convention for the Protection of Human Rights and Fundamental Freedoms 1950 (ECHR)	4 November 1950	8 March 1951
European Social Charter 1961	18 October 1961	11 July 1962
European Convention for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 1987	26 November 1987	24 June 1988

[https://www.nationaltheatrescotland.com/content/mediaassets/pdf/Rites\\_freesheet\\_web.pdf](https://www.nationaltheatrescotland.com/content/mediaassets/pdf/Rites_freesheet_web.pdf)

<sup>71</sup> World Health Organisation, 'An Interagency Statement' (WHO, 2008), at 8.

European Social Charter (Revised) 1996	7 November 1997	-
Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence 2011 (Istanbul Convention)	8 June 2012	-

The Human Rights Act 1998 places a statutory duty on public authorities to comply with the rights contained within the European Convention on Human Rights (the ECHR).<sup>72</sup> The ECHR is the only human rights instrument to be given direct effect within the UK. However, by ratifying the above instruments, the UK has consented to be bound by the obligations contained within. While the UK has not ratified the European Social Charter (Revised) 1996 or the Istanbul Convention, by signing these treaties it is obligated to refrain, in good faith, from acts that would defeat the object and purpose of the treaty. Specific to Northern Ireland, the Northern Ireland Act 1998 makes provision to ensure that Northern Ireland public authorities act compatibly with the UK's international obligations.<sup>73</sup> This is reflective of the Belfast (Good Friday) Agreement 1998.<sup>74</sup>

As discussed below, these human rights instruments indirectly prohibit FGM under the broad themes of:

- The right to life;
- The right to not be subjected to torture or inhuman or degrading treatment or punishment;
- The right to be free from gender discrimination;
- The rights of the child;
- The right to the highest attainable standard of health;
- The right to protection of physical and mental integrity; and
- The rights of persons with disabilities.

The legal regime regarding eradicating FGM is also complemented by a series of political consensus documents, which reaffirm human rights and call upon governments to strive for their full respect,

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<sup>72</sup> Sections 2 and 3(1), Human Rights Act 1998.

<sup>73</sup> Sections 24 and 26, Northern Ireland Act 1998.

<sup>74</sup> Strand One, para 33(b) and Strand Three, para 2, Belfast (Good Friday) Agreement 1998.

protection and fulfilment.<sup>75</sup> The documents relevant regarding FGM are:

<b>Consensus documents – International</b>
Vienna Declaration and Programme of Action, 25 June 1993
United Nations General Assembly, 'Declaration on the Elimination of Violence against Women', 20 December 1993
Beijing Declaration and Platform for Action of the Fourth World Conference on Women 1995
United Nations General Assembly, 'Resolution on Traditional or Customary Practices, Affecting the Health of Women and Girls', 12 December 1997
United Nations General Assembly, 'Resolution on Traditional or Customary Practices, Affecting the Health of Women and Girls', 9 December 1998
United Nations General Assembly, 'Resolution on Traditional or Customary Practices, Affecting the Health of Women and Girls', 17 December 1999
United Nations General Assembly, 'Resolution on Traditional or Customary Practices, Affecting the Health of Women and Girls', 19 December 2001
United Nations Educational, Scientific and Cultural Organisation (UNESCO) Universal Declaration on Cultural Diversity 2001
United Nations General Assembly, 'Resolution 61/143: Intensification of Efforts to Eliminate all Forms of Violence against Women', 30 January 2007
United Nations Economic and Social Council (ECOSOC)'s, Commission on the Status of Women, 'Resolution 51/2 on Ending Female Genital Mutilation' (2007)
United Nations General Assembly, 'Resolution 67/146: Intensifying Global Efforts for the Elimination of FGM', 5 March 2013
Programme of Action of the International Conference on Population and Development (ICPD) 2014

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<sup>75</sup> World Health Organisation, 'An Interagency Statement' (WHO, 2008), at 8.

<b>Consensus documents – Europe</b>
Council of Europe, 'Resolution 1247 on Female Genital Mutilation', 22 May 2001
European Parliament, 'Resolution A5-0285/2001 on Female Genital Mutilation', 20 September 2001
European Parliament, 'Resolution on the Current Situation in Combating Violence against Women and any Future Action (2004/2220(INI))', 2 February 2006
European Parliament, 'Resolution on Combating Female Genital Mutilation in the EU (2008/2071(INI))', 24 March 2009
European Parliament, 'Resolution on the Elimination of Violence Against Women', 26 November 2009
Council of Europe Parliamentary Assembly, 'Gender-related Claims for Asylum', 26 July 2010
Council of Europe Parliamentary Assembly, 'Recommendation 1903 (2010) Fifteen Years since the International Conference on Population and Development Programme of Action', 29 January 2010
European Parliament, 'Resolution on Ending FGM (2012/2684(RSP))', 14 June 2012

Largely these documents have called for an end to the practice of FGM, facilitated by introducing legislative measures that criminalise this practice and to put policies, strategies and duties in place to prevent the use of FGM. They also promote the use of legislative and other measures to embed actions that will help eradicate the practice such as awareness raising, promoting education and training, empowering those affected and who will potentially be affected, and offering support to individuals that have been subjected to FGM.

### **Right to Life**

While deaths from FGM are rare, this practice does pose a threat to life. A risk comes from "severe bleeding leading to haemorrhagic shock, neurogenic shock as a result of pain and trauma, and overwhelming infection and septicaemia".<sup>76</sup>

The right to life is protected under:

<sup>76</sup> A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at para 50.

- Article 2, ECHR;
- Article 6, ICCPR;
- Article 6, CRC; and
- Article 10, CRPD.

Article 33 of the Refugee Convention acknowledges the obligation to not expel or return a refugee if her life was under threat on account of “race, religion, nationality, membership of a particular social group or political opinion”. This could include the practice of FGM.

The right to life is not to be “narrowly interpreted”.<sup>77</sup> The State is to take reasonable steps to prevent intentional and unintentional deprivation of life.<sup>78</sup> Not only is the State to not take life, it is also under a duty to protect life. This includes introducing a legal framework that protects life, such as introducing laws that criminalise FGM. The European Court of Human Rights (ECtHR) has also established that this imposes a positive obligation on the State to take proactive action where there is a “real and immediate risk to life”<sup>79</sup> towards “an identified individual or individuals from the criminal acts of a third party”<sup>80</sup> that the State ought to have known about.<sup>81</sup> This requires public authorities to take action regarding FGM, particularly if the procedure poses a real and immediate risk to life.

The State is also under an obligation to investigate any suspicious death.<sup>82</sup> It requires that the investigation is effective<sup>83</sup> and official.<sup>84</sup> For example, it must be of the State’s own motion;<sup>85</sup> prompt;<sup>86</sup>

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<sup>77</sup> ‘CCPR General Comment No 6: Article 6 (Right to Life)’, 30 April 1982, at para 5.

<sup>78</sup> *Wockel v Germany*, Application No 326165/96, Judgment of 16 April 1998; *Öneryildiz v Turkey* (2005) 41 EHRR 325; *Solomou and Others v Turkey*, Application No 36832/97, Judgment of 24 June 2008.

<sup>79</sup> *Osman v United Kingdom* (2000) 29 EHRR 245, at para 116.

<sup>80</sup> *Mahmut Kaya v Turkey* (2000) ECHR 129, at para 86.

<sup>81</sup> *LCB v United Kingdom* (1998) 27 EHRR 212; *Öneryildiz v Turkey* (2005) 41 EHRR 325.

<sup>82</sup> *Ergi v Turkey* (1998) ECHR 59 at para 82; *Shanaghan v United Kingdom* (2001) ECHR 330; *Öneryildiz v Turkey* (2005) 41 EHRR 325, at para 91.

<sup>83</sup> *Jelic v Croatia* (2014) ECHR 601, at para 63.

<sup>84</sup> *McCann v United Kingdom* (1995) ECHR 31, at para 161.

<sup>85</sup> *Ibid*, at para 173; *Hugh Jordan v United Kingdom* (2001) ECHR 327, at para 105.

<sup>86</sup> *Hugh Jordan v United Kingdom* (2001) ECHR 327; *Shanaghan v United Kingdom* (2001) ECHR 330; *McKerr v United Kingdom* (2001) ECHR 329.

carried out with reasonable expedition;<sup>87</sup> thorough;<sup>88</sup> independent and impartial;<sup>89</sup> and subject to public scrutiny.<sup>90</sup> This requires an effective and official investigation to be conducted into a death potentially resulting from FGM.

## **Right to not be subjected to torture or inhuman or degrading treatment or punishment**

It is internationally recognised that FGM can amount to torture.<sup>91</sup> This is on the basis that, like torture, “FGM involves the deliberate infliction of severe pain and suffering”.<sup>92</sup> The period of torture as a result of FGM can be short term or last throughout life.<sup>93</sup> Whether the effects of FGM fall within this remit, they must meet a minimum level of severity, which is determined by the duration of the treatment; the physical and mental effects of the treatment on an individual; and the sex, age and state of health of the victim.<sup>94</sup>

Torture is prohibited under all circumstances.<sup>95</sup> As a principle of customary law, the obligations attached to torture also apply

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<sup>87</sup> *Hugh Jordan v United Kingdom* (2001) ECHR 327, at para 138.

<sup>88</sup> *Kolevi v Bulgaria* (2009) ECHR 1838, at para 201.

<sup>89</sup> *Kamalak v Turkey*, Application No 2251/11, 8 October 2013, at para 31.

<sup>90</sup> *McCann v United Kingdom* (1995) ECHR 31, at para 159.

<sup>91</sup> E/CN.4/1986/15, 'Report by the Special Rapporteur, Mr P Kooijmans, appointed pursuant to Commission on Human Rights Resolution 1985/33', 19 February 1986, at para 38; E/CN.4/2002/83, 'Report of the Special Rapporteur on Violence against Women, Its Causes and Consequences, Ms Radhika Coomaraswamy, submitted in accordance with Commission on Human Rights Resolution 2001/49: Cultural Practices in the Family that are Violent towards Women', 31 January 2002, at para 6; A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at paras 50-54; CAT/C/GC/2, 'General Comment No 2: Implementation of Article 2 by States Parties', 24 January 2008, at para 18; United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences, '15 Years of the United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences (1994-2009)' (United Nations Commission on Human Rights, 2009), at 40.

<sup>92</sup> A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at para 50.

<sup>93</sup> *Ibid*, at para 50.

<sup>94</sup> *Ireland v United Kingdom* (1980) 2 EHRR 25, at para 162.

<sup>95</sup> Articles 3 and 15(2), European Convention on Human Rights 1950; Articles 4(2) and 7, International Covenant on Civil and Political Rights 1966; CAT/C/GC/2, 'General Comment No 2: Implementation of Article 2 by States Parties', 24 January 2008, at para 1.



irrespective of treaty status within individual States.<sup>96</sup> The right to not be subjected to torture or inhuman or degrading treatment or punishment is protected within:

- Article 3, ECHR;
- Article 7, ICCPR;
- All articles, CAT;
- All articles, European Convention on Torture;
- Articles 37 and 39, CRC;
- Article 17(1)(b), European Social Charter (Revised) 1996; and
- Article 15, CRPD.

The United Nations Committee against Torture has made it clear that:

State parties are obligated to adopt effective measures to prevent public authorities and other persons acting in an official capacity from directly committing, instigating, inciting, encouraging, acquiescing in or otherwise participating or being complicit in acts of torture.<sup>97</sup>

This includes introducing laws criminalising FGM. The obligation to take action extends to where:

State authorities or others acting in official capacity or under colour of law, know or have reasonable grounds to believe that acts of torture or ill-treatment are being committed by non-State officials or private actors and they fail to exercise due diligence to prevent, investigate, prosecute and punish such non-State actors or private individuals.<sup>98</sup>

This applies when preventing and dealing with cases of FGM.

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<sup>96</sup> United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences, '15 Years of the United Nations Special Rapporteur on Violence against Women, Its Causes and Consequences (1994-2009)' (United Nations Commission on Human Rights, 2009), at 40.

<sup>97</sup> CAT/C/GC/2, 'General Comment No 2: Implementation of Article 2 by States Parties', 24 January 2008, at para 17.

<sup>98</sup> *Ibid*, at para 18.

## **Right to be free from gender discrimination**

Discrimination against women is defined as:

...any distinction, exclusion or restriction made on the basis of sex which has the effect or purpose of impairing or nullifying the recognition, enjoyment or exercise by women, irrespective of their marital status, on a basis of equality of men and women, of human rights and fundamental freedoms in the political, economic, social, cultural, civil or any other field.<sup>99</sup>

The World Health Organisation has confirmed that as a practice, FGM, “reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women”.<sup>100</sup> It also categorises FGM as a form of violence against women.<sup>101</sup> The United Nations General Assembly has acknowledged that violence against women amounts to discrimination on the basis that it is:

rooted in historically unequal power relations between men and women and that all forms of violence against women seriously violate and impair or nullify the enjoyment by women of all human rights and fundamental freedoms and constitute a major impediment to the ability of women to make use of their capabilities.<sup>102</sup>

This is supported by the Council of Europe which understands violence against women as:

a violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion, or

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<sup>99</sup> Article 1, Convention on the Elimination of All Forms of Discrimination against Women 1979.

<sup>100</sup> World Health Organisation, ‘An Interagency Statement’ (WHO, 2008), at 1.

<sup>101</sup> World Health Organisation, ‘Understanding and Addressing Violence against Women: Female Genital Mutilation’ (WHO, 2012), at 1.

<sup>102</sup> A/RES/61/143, ‘Resolution adopted by the General Assembly on Intensification of Efforts to Eliminate all Forms of Violence Against Women’, 19 December 2006, at preamble.

arbitrary deprivation of liberty, whether occurring in public or in private life.<sup>103</sup>

The General Assembly has further found that custom, tradition or religious beliefs cannot be used as excuses for avoiding the elimination of violence against women, including FGM.<sup>104</sup>

The right to be free from gender discrimination is provided by:

- Articles 2(1), 3 and 26, ICCPR;
- Articles 2 and 3, ICESCR;
- Articles 1, 2 and 5, CEDAW;
- Article 2, CRC.

Under Article 5 of CEDAW, State parties are obligated to:

take all appropriate measures... to modify the social and cultural patterns of conduct of men and women, with a view to achieving the elimination of prejudices and customary and all other practice which are based on the idea of the inferiority or the superiority of either of the sexes or on stereotyped roles for men and women.

As explained by the United Nations Population Fund, FGM is “a practice reserved for women and girls” which is “aimed at controlling women’s sexuality”.<sup>105</sup> Consequently, “it incorporates a fundamental discriminatory belief in the subordinate role of women and girls in society”.<sup>106</sup> Therefore, in order to put an end to this discrimination and to comply with human rights standards, the practice of FGM must be eliminated.

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<sup>103</sup> Article 3(1), Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence 2011.

<sup>104</sup> *Ibid*, at para 5.

<sup>105</sup> United Nations Population Fund, ‘Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation’ (UNPF, 2014), at para 4.1.

<sup>106</sup> *Ibid*.

## Rights of the Child

As a practice that is mainly performed on 0-15 year olds,<sup>107</sup> FGM is of particular interest regarding children's rights. The Committee on the Rights of the Child has recognised FGM as a violation of children's rights and called for its abolition, including adopting laws and public campaigns against the practice.<sup>108</sup> The relevant treaty regarding the protection of children's rights is the Convention on the Rights of the Child 1989.

In addition to the CRC rights discussed in other sections, children are given specific protection in relation to freedom from all forms of mental and physical violence and maltreatment.<sup>109</sup> The process and effects of FGM place this practice within this category.<sup>110</sup>

State parties must ensure that "the best interest of the child shall be a primary consideration" regarding "all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies."<sup>111</sup> This requires that "protection and care" is undertaken "as is necessary for [the child's] wellbeing."<sup>112</sup> It extends to "institutions, services and facilities responsible for the care or protection of children."<sup>113</sup> It also takes into account the duties of parents, legal guardians, or other individuals who are legally responsible.<sup>114</sup> The United Nations Population Fund has found that "the negative effects of FGM on children's development" breaches the best interests of the child.<sup>115</sup> Article 24 of the CRC, also imposes a specific obligation on State Parties to "take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children". Consequently, public

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<sup>107</sup> World Health Organisation, 'An Interagency Statement' (WHO, 2008), at 4.

<sup>108</sup> CRC/C/15/Add.83, 'Concluding Observations of the Committee on the Rights of the Child: Togo', 21 October 1997, at para 48.

<sup>109</sup> Articles 16 and 19, Convention on the Rights of the Child 1989.

<sup>110</sup> A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at para 50.

<sup>111</sup> Article 3(1), Convention on the Rights of the Child 1989.

<sup>112</sup> Article 3(2), *Ibid.*

<sup>113</sup> Article 3(3), *Ibid.*

<sup>114</sup> Article 3(2), *Ibid.*

<sup>115</sup> United Nations Population Fund, 'Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation' (UNPF, 2014), at para 4.7.

authorities and private individuals who have responsibility for a child's well-being should be taking measures that protect that child from FGM, given the negative health impacts and motivations behind this practice.

### **Right to the highest attainable standard of health**

The practice of FGM can impact upon physical and mental health.<sup>116</sup> According to the Committee on Economic, Social and Cultural Rights the right to the highest attainable standard of health contains the right to health care, but does not impose a right to be healthy.<sup>117</sup> It does include a right to timely and appropriate health care.<sup>118</sup> This is relevant in relation to addressing the negative effects of FGM. In determining appropriate health care, the individual's biological and socio-economic preconditions and a State's available resources must be considered.<sup>119</sup>

The right to the highest attainable standard of health is protected within:

- Article 11, European Social Charter 1961;
- Article 12 of the ICESCR;
- Article 24, CRC;
- Article 11, European Social Charter 1996; and
- Article 25, CRPD.

As a socio-economic right, the right to the highest attainable standard of health can be divided into minimum core obligations which are to be given immediate effect and obligations that are to be progressively realised. Both sets of obligations are to be implemented with regard to the maximum available resources and are not to be subject to deliberate regression.<sup>120</sup> Access to essential primary health care is a minimum core obligation; this

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<sup>116</sup> A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at para 50.

<sup>117</sup> E/C.12/2000/4, 'CESCR General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)', 11 August 2000, at para 8.

<sup>118</sup> *Ibid*, at para 11.

<sup>119</sup> *Ibid*, at para 9.

<sup>120</sup> E/1991/23, 'CESCR General Comment No 3: The Nature of States Parties' Obligations', 14 December 1990, at para 9; Article 4, Convention on the Rights of the Child 1989.

includes providing appropriate training for health personnel, including education on health and human rights.<sup>121</sup> Regarding FGM this includes providing training to health professionals on the illegality of FGM, identifying case of FGM and the procedures for dealing with such cases.

## **Right to Protection of Physical and Psychological Integrity**

The right to private life includes the right to protection of physical and psychological integrity. This is protected under:

- Article 8, ECHR;
- Article 17, ICCPR; and
- Article 19, CRC.

It is linked to the principle of human dignity, which forms the foundation of human rights and is understood to be inviolable.<sup>122</sup> It is also linked to the right to “make independent decisions in matters affecting one’s own body”.<sup>123</sup>

Measures that affect physical integrity or mental health “must [have] sufficiently adverse effects” to qualify as an interference with the right to a private life.<sup>124</sup> They are also subject to a number of limiting factors, such as whether the measure was proportionate “in accordance with the law” or “necessary in a democratic society”.<sup>125</sup> The measures can be the result of the actions of State actors or private individuals.<sup>126</sup>

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<sup>121</sup> E/C.12/2000/4, ‘CESCR General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)’, 11 August 2000, at para 36 and 44(e).

<sup>122</sup> Preamble, International Covenant on Civil and Political Rights 1966; Preamble, International Covenant on Economic, Social and Cultural Rights 1966; Preamble, Convention on the Elimination of all Forms of Discrimination against Women 1979; Preamble, Convention on the Rights of the Child 1989; Preamble, Convention on the Rights of Persons with Disabilities 2006.

<sup>123</sup> *Storck v Germany* (2005) 43 EHRR 96, at para 143; United Nations Population Fund, ‘Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation’ (UNPF, 2014), at para 4.3.

<sup>124</sup> *Bensaid v United Kingdom* (2001) 33 EHRR 10, at para 46.

<sup>125</sup> Article 8(2), European Convention on Human Rights 1950.

<sup>126</sup> *Storck v Germany* (2005) 43 EHRR 96, at para 149.

Consideration should be given to whether the individual gave consent and if they had capacity to do so, particularly since most FGM is performed on young girls.<sup>127</sup> Regarding children's consent:

States Parties shall assure to the child who is capable of forming his or her own views that the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.<sup>128</sup>

Irrespective, the pain, trauma and debilitation resulting from FGM can affect the individual's physical integrity or mental health short-term and long-term.<sup>129</sup> Human rights standards impose an obligation on State parties to take measures to protect against such a violation of physical and mental integrity. Also, respect for dignity "implies an acceptance of [women's] physical qualities, including the natural appearance of their genitals and their normal sexual function".<sup>130</sup>

### **Rights of persons with disabilities**

The United Nations Population Fund has found "there is evidence that FGM can result in disability and maternal morbidities. The health consequences of FGM (especially infibulation) can be considered a disability inflicted after birth".<sup>131</sup> This includes physical and mental disabilities that can continue throughout life.<sup>132</sup> In this regard, the relevant provision is Article 26 of the CRPD.

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<sup>127</sup> United Nations Population Fund, 'Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation' (UNPF, 2014), at para 4.3.

<sup>128</sup> Article 12, Convention on the Rights of the Child 1989.

<sup>129</sup> A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at para 50 and 51.

<sup>130</sup> United Nations Population Fund, 'Implementation of the International and Regional Human Rights Framework for the Elimination of Female Genital Mutilation' (UNPF, 2014), at para 4.3.

<sup>131</sup> *Ibid*, at para 4.7; A/54/38/Rev.1, 'CEDAW General Recommendation No 24: Article 12 of the Convention' (1999), at para 12(b).

<sup>132</sup> A/HRC/7/3, 'Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Manfred Nowak', 15 January 2008, at para 50 and 51.

Article 26 provides that persons with disabilities have a right to habilitation and rehabilitation services. This imposes an obligation to ensure access to care following debilitating and traumatic FGM practices. This care extends to assisting to attain and maintain “maximum independence, full physical, mental, social and vocational ability, and full inclusion and participation in all aspects of life”.<sup>133</sup>

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<sup>133</sup> Article 26(1), Convention on the Rights of Persons with Disabilities 2006.



## Conclusion

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In recent years there has been a significant political willingness to address FGM in the UK, as a whole, through redesigning legislation. Progress has been made under the FGM Act 2003, the Prohibition of FGM (Scotland) Act 2005 and the Serious Crimes Act 2005. However, potential legislative loopholes regarding female genital cosmetic surgery need to be examined. Consideration should also be given to offering sufficient support when police are notified of FGM and the scope of this duty, which currently only applies in England and Wales.

Regarding prosecution, it is notable that there has been a lack of prosecutions within the UK. However, the *Dharmasena* case demonstrates that any decision to prosecute should be appropriate and aimed towards effectively tackling the issue of FGM.

International human rights law requires that legislation is combined with other measures to ensure the law is effectively implemented, and ultimately, FGM is *eliminated*. An example of steps that could be taken towards these requirements is provided by the actions of the Welsh Government Strategic FGM Leadership Group. Its actions include setting up a FGM leadership group; establishing an action plan; developing legislation to place a statutory duty to produce a range of local strategies which cover FGM; introducing safeguarding in education guidance; hosting events; providing funding for training frontline professionals; and developing a national training framework.

Other measures to consider are making safeguarding training for frontline professionals mandatory; providing funding for community-level projects; promoting education; and conducting further research on type IV FGM.