

It is time to rethink the UK policy response to female genital mutilation

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KEY MESSAGES

- The number of new cases of FGM/C experienced by UK resident girls is low, but it remains highly prevalent in older women who had FGM/C as children outside of the UK
- Despite this, UK government policy is focused on criminal prosecution of new cases rather than providing support for people living with long term consequences of FGM/C
- We need to focus UK FGM/C policy on proportionate prevention initiatives and providing appropriate care for those already affected
- FGM/C affected communities should be more meaningfully involved in research agenda setting and policymaking

Sakaria Ali and colleagues argue that UK policy measures against female genital mutilation/cutting are disproportionately focused on criminal prosecution as a deterrent rather than community-based prevention including providing appropriate care to those living with the long term consequences of FGM/C.

Female genital mutilation and/or cutting (FGM/C) is internationally regarded as both a health and human rights issue.¹ Not including elective female genital ‘cosmetic’ surgeries, which may count as FGM/C under the WHO definition as there is no consent criterion (Box 1), global prevalence estimates suggest that over 200 million women and girls are living with different forms of medically unnecessary genital cutting.^{1,2,3} Increased migration from historically high-prevalence communities to lower prevalence contexts such as the United Kingdom (UK) has prompted efforts to understand the level of ongoing risk of FGM/C for women and girls with heritage in those communities.

The effectiveness of these efforts is a matter of contention. Most of the current UK national policy on FGM/C was introduced on the assumption, increasingly questioned by scholars, that prevalence in affected communities in the UK closely mirrors country-of-origin estimates.⁴ Applying international prevalence estimates directly to the 2011 England and Wales census, it has been suggested that tens of thousands of UK resident girls could be at risk of genital cutting.⁵ However, this fails to account for converging evidence of changing attitudes among FGM/C affected communities and the impact of migration.⁴ Furthermore, the strengthening of legal provisions against FGM/C through the Serious Crime Act 2015 and heightened awareness amongst health and other professionals have brought increased attention to this practice, acting as a possible deterrent and complementing community-led prevention campaigns, which have also shifted social norms around the practice of FGM/C in the UK.^{6,7,8}

Notwithstanding this, in England and Wales the achievement of just one successful prosecution for FGM/C offences in 2019 is considered by many stakeholders to be a collective professional failure given the large numbers of girls believed to be at risk according to government policy.⁹ Since the initial prohibition of FGM/C almost 40 years ago increasing criminal penalties have been added alongside safeguarding provisions to detect suspected cases (Box 2).^{6,10} Given these developments, it is necessary to take a fresh look at the evidence regarding current practice patterns in this context.

Building on a previous call to consider the risk of harm to affected communities posed by existing policies and/or exaggerated estimates, we provide an up-to-date synthesis of all available evidence bearing on FGM/C prevalence.⁹ We find that the prevalence of FGM/C in the UK is likely much lower than previously presumed and that a different policy response to the practice is required. Solutions should include an emphasis on primary means of prevention within communities, allocation of resources to providing appropriate care for women who have already experienced FGM/C, and in-depth community engagement in policymaking rather than an overreliance on criminal deterrence.

Box 1. WHO definition and classification of female genital mutilation
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The World Health Organization (WHO) defines FGM as all practices involving the ‘the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons’.¹ Increasingly it is argued ‘FGM’ should be replaced with ‘female genital cutting’ (FGC) due to inconsistencies and biases associated with ‘mutilation’.² We use ‘FGM/C’ in recognition of this controversy.

WHO classification includes four major types:¹

Type 1: Partial or total removal of the clitoral glans and/or prepuce, or both

Type 2: Partial or total removal of the clitoral glans and/or labia minora, with or without excision of the labia majora

Type 3 (infibulation): Narrowing of the vaginal orifice with creation of a covering seal by cutting and opposing the labia minora or majora (or both), with or without partial or total excision of the clitoral glans/prepuce

Type 4: All other harmful procedures to the female genitalia for non-medical purposes—for example, pricking, piercing, or cutting

Prevalence of FGM/C in the UK

There are thousands of women living with FGM/C in the UK, most of whom had the procedure before moving to the UK.⁴ A 2022 review of available prevalence indicators, corroborated across multiple sources (including the NHS FGM Enhanced Dataset), strongly suggests that the number of new cases of FGM/C experienced by UK resident girls under 18 years of age is very low.⁴ This is supported by the British Paediatric Surveillance Unit study from 2021 in which all consultant paediatricians were asked each month whether they had seen a case of FGM/C each over a two-year period.¹¹ This study identified 103 cases of FGM/C in girls aged under 16 years including the case leading to successful prosecution in 2019. Based on this surveillance data and an analogous Australian study, it is likely that most of these cases had taken place prior to migration.^{11,12} Nevertheless, it remains unclear how many UK resident girls under 18 years are currently at risk of FGM/C.⁴

Qualitative research conducted in Europe shows that communities largely abandon the practice on migration.^{13,14} Part of this change in attitudes has been linked to the impact of new societal norms (e.g. being cut not bestowing social advantage), education and a generational shift, with young people leading abandonment campaigns in their new countries.^{15,16,17} There is evidence that some people hold negative attitudes to FGM/C, prior to migration.^{16,17} Survey based research also indicates a significant change in attitudes against the practice in high prevalence locations.¹⁸

Despite this growing body of evidence, the 2023 updated UK government ‘FGM Resource Pack’ issued by the Home Office continues its messaging about the ‘hidden’ practice of FGM/C, implying a large undetected prevalence.¹⁹ This perpetuates the assumption that the small number of prosecutions for FGM/C mean current policies and their implementation are ineffective. We suggest an alternative

90 explanation, representing a positive development, which is that the scale of this practice in the UK is
91 far lower than assumed.²⁰

93 **FGM/C legislation in the UK and Europe**

94
95 In the UK, legislation tackling FGM/C was introduced through the Prohibition of Female
96 Circumcision Act 1985 and later enhanced in a series of legislative changes (Box 2).¹⁰ Following the
97 2014 Girl Summit, the UK government published the first FGM National Plan which included
98 measures to change what they described as a ‘historically passive approach to FGM’ by police and the
99 Crown Prosecution Service.²¹ Mandatory reporting duty for FGM/C and FGM Protection Orders
100 (FGMPOs) were introduced in England and Wales, as part of the Serious Crime Act 2015, following a
101 1-month consultation process with limited involvement of stakeholders outside government.⁶ The new
102 guidance for professionals following this Act led to increased activity amongst health and other
103 professionals including new national information sharing across services. It also introduced the FGM
104 Enhanced Dataset, which records positive responses recorded by health professionals who have asked
105 patients about experiences of FGM/C during medical encounters.²¹ However, publicly available
106 findings on prevalence, mandatory reporting and health complications from this dataset remain scarce.

107
108 In other parts of the UK there have been different policy responses. Northern Ireland uses their
109 existing child protection procedures to respond to suspected FGM/C, which includes mandatory
110 reporting for all child abuse.²² The Scottish government undertook a detailed consultation process
111 with statutory, community and third sector stakeholders, which produced the Scottish National Action
112 Plan for FGM in 2016.²³ In 2019 they evaluated this national plan and included FGMPOs.²⁴ These
113 varied perspectives on FGM/C legislation within the UK raises the question of what a proportionate
114 and effective response to ending FGM/C should be.

115
116 Similar questions are being considered elsewhere in Europe. Launched in 2011, the Istanbul
117 Convention for action on violence against women was ratified by the European Union in 2023.²⁵ The
118 law offers an important deterrent and sends a message that certain practices are not allowed, but there
119 are different legal responses to criminal prosecution in FGM/C cases.²⁶ In some countries, such as in
120 Sweden and Switzerland, there are specific legal provisions against FGM/C, but in Germany, France
121 and the Netherlands prosecution is through laws against child abuse and bodily harm.^{25,27} UK
122 policymakers have drawn comparisons with France, which has had over 40 criminal prosecutions for
123 bodily harm caused by FGM/C (the majority in the 1990s), as a reason for focussing on prosecution as
124 a deterrent to the practice.²⁸

Box 2. Key FGM Legislation and Policy in England & Wales

Prohibition of Female Circumcision Act 1985

- made it an offence for any person (i) to excise, infibulate or otherwise mutilate the whole or any part of the labia majora or labia minora or clitoris of another person, or (ii) to aid, abet, counsel or procure the performance by another person of any of those acts on that other person's own body.
- distinguished between those surgical operations which were "necessary for the physical or mental health of the person... and performed by a registered medical practitioner" from those relating to "custom or ritual".
- made offences punishable with a fine or a 5 year maximum term of imprisonment, or both

Female Genital Mutilation Act 2003

- made it an offence for any person to aid, abet, counsel or procure a girl to excise, infibulate or otherwise mutilate the whole or any part of her labia majora, labia minora or clitoris
- made it an offence for a UK citizen to assist a non-UK national or UK resident to undertake FGM/C outside the UK on a UK national or UK permanent resident
- extended the maximum term of imprisonment from 5 to 14 years.

Serious Crime Act 2015

- further enlarged its territorial jurisdiction to include any individual who is habitually resident in the UK, as well as those who are UK nationals or UK permanent residents
- made failing to protect a girl from the risk of FGM/C an offence, punishable with a maximum term of imprisonment of 7 years
- introduced anonymity for persons against whom an FGM/C offence is alleged to have been committed
- introduced a Mandatory Reporting Duty for social care, education and health professionals requiring them to make a report to the police if the person discovers that an act of female genital mutilation appears to have been carried out on a girl who is aged under 18.
- introduced civil FGM Protection Orders for women/girls considered at risk of FGM/C

Female Genital Mutilation Information-Sharing (FGM-IS)

- Since 2014 allows authorised healthcare professionals and administrative staff throughout England to view information about girls under the age of 18 with a family history of FGM/C

NHS FGM Enhanced Dataset

- Since 2015 requires clinicians in acute trusts, mental health trusts and GP practices to record in the patient notes and submit data to NHS Digital when patients with FGM/C are identified, including the type of FGM/C.

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127 Mandatory reporting and FGM Protection Orders

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129 Clinicians in general practice, NHS acute and Mental Health Trusts in England must record FGM/C
130 disclosures in the 'FGM Enhanced Dataset' which is captured within the national information sharing
131 system for health and social care in the UK called NHS Digital. Until March 2020, only 2.5% of GP
132 practices and 62.7% of NHS Trusts had ever submitted information to the Dataset.²⁹ Clinicians are
133 mandated to submit information such as personal details, family history and type of FGM/C from

patients to NHS Digital, without consent from the women/girls concerned. Instead, clinicians are advised to inform patients regarding this secondary data submission and to provide an opportunity to object to it.^{30,31}

Similarly, the new FGM information sharing (FGM-IS) system in England and Wales flags the medical records of female infants born to women with FGM/C without parental consent.¹⁹ Women report feeling re-traumatised by clinicians repeatedly collecting information about their past experiences of FGM/C and they say this distracts from their other health needs.³² These experiences can be alienating and stigmatising for women in vulnerable moments accessing health services.³³ To date, the UK government has not evaluated the potential harmful consequences of these information systems on the people involved nor established any use to inform policy and practice which might justify them.

In addition to new mandatory information sharing, health professionals are required to report to the police if they establish that FGM/C has been carried out on a girl under 18 years of age. Freedom of information (FOI) data suggests that among the police forces, that did not have data suppressed, in 2020- 2021 there were 55 alleged FGM/C offences recorded under the mandatory reporting duty in England and Wales.³⁴ There is some suggestion that mandatory reporting may have increased the willingness of health, social care and education professionals to detect and report on FGM/C.^{31,35} However, the wider impact of the mandatory reporting duty of FGM/C in under 18s is not yet known.³⁵

The mandatory reporting duty has been criticised for extending the reach of criminal law responsibilities to health and other professionals working outside of the criminal justice system.³⁶ This has contributed to inexperienced professionals overreporting FGM/C in girls of colour, who were in fact not cut, which has unintended harmful consequences.³⁷ A study from 2020 evaluating the presentation of children referred to a specialist dedicated children's FGM/C clinic in London found that more than 60% had not undergone FGM/C.³⁷ In England and Wales, concerns about FGM/C in under 18s referred to police and social care may result in joint agency investigations, and even children being removed from their families before a medical assessment has been conducted and a diagnosis of FGM/C confirmed.^{37,38}

FGMPOs typically involve local authorities (or police and health professionals) making an application on behalf of the 'person-to-be-protected', with the majority of FGMPOs being granted in relation to people aged under 18. As civil measures they are granted by family courts, and they are primarily intended to protect at-risk women and girls although they can also be used with the intention of protecting those who have had FGM/C.⁶ These orders were modelled on Forced Marriage Protections

Orders. FGMPO conditions can vary from withholding the passports of children for long periods to mandatory genital examinations.³⁹ Like other well intended FGM/C policies their impact on and effectiveness in protecting women and girls is unclear and needs further research.

Shaping a new UK policy direction

A policy shift in the UK is needed from primarily pursuing criminal prosecutions for FGM/C to one that centres health care for those living with the consequences of this practice.^{9,40} The available evidence suggests that FGM/C is not common among UK resident girls.^{4,11} In comparison it remains highly prevalent among older women from FGM/C affected communities and health services need to better reflect the needs of this group.^{4,40} To date, most attention has been directed at ~10% of affected women, globally and in the UK, with WHO Type 3 (infibulation), which leads to more acute and chronic health complications on average compared to other types.^{41,42} However, it is the other WHO Types 1, 2 and 4 that are the majority experience and not as easily identifiable on examination (Box 1).¹¹ As a result, women living with these latter FGM/C types may not be recognised. We suggest that the complex physical and psychological needs of all women with FGM/C (not only those with infibulation or who are pregnant) must be given greater attention.

Primary prevention through grassroots educational initiatives have shown success in positively affecting change in communities where FGM/C is historically prevalent. We urge the UK government to support this work, which is mostly done by charities who provide counselling for affected women, train professionals and link policymakers with the experiences of affected communities.³² Prioritising community enabled prevention work and health improvements sends a strong message of support to FGM/C affected communities.

Health professionals require training on sensitive approaches to diagnosing FGM/C and taking proportionate safeguarding approaches.³² Women living with FGM/C point out that even when this diagnosis is confirmed, it must not be automatically assumed that their particular health problems stem from this cause.^{13,33} In addition, it should not be assumed that girls born to mothers with FGM/C are necessarily at risk.⁴³

The challenge for the UK government, and its European counterparts, is to uphold the ‘due diligence’ standard in protecting women and girls from all forms of violence, while not causing harm through invasive and inappropriate interventions. Requests for submission of intimate information are not required by those with experience of other forms of child abuse and have been described by women and girls affected by FGM/C as retraumatising.³³ Such intrusive and disproportionate measures lead to families losing both trust in statutory service providers and their sense of belonging in Britain.³⁸

208
209 Policymakers should invite meaningful inclusion of women with a diverse range of FGM/C lived
210 experiences as this has not yet happened.⁴⁰ This relates to setting of research agendas, policy
211 development and implementation across health services. By actively involving FGM/C affected
212 communities in policymaking we can correct some of the aspects of current policies and build on the
213 progress made over the last decade.

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