

# An Unpunished Crime:

The lack of prosecutions  
for female genital  
mutilation in the UK

Julie Bindel

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## About the author

Julie Bindel is a writer, broadcaster and researcher. Since 1979 she has been active in the global campaign to end violence against women and children, and has written extensively on rape, domestic violence, sexually motivated murder, prostitution and trafficking, child sexual exploitation, stalking, and the rise of religious fundamentalism and its harm to women and girls.

Julie has authored over 30 book chapters and academic reports on a range of topics pertaining to gender inequality and abuse. She writes regularly for the *Guardian*, *New Statesman*, *Sunday Telegraph* and *Standpoint* magazine, and appears regularly on the BBC and Sky News. She is a Visiting Journalist at Brunel University (2013–14) and is writing a book on the state of the lesbian and gay movement in the UK (Guardian Books, 2014).

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Designed by sarahbettsworthdesign@talktalk.net  
Printed and bound in the United Kingdom

Published by the New Culture Forum

New Culture Forum Ltd  
55 Tufton Street  
London SW1P 3QL  
Tel: 0207 340 6059  
[www.newcultureforum.org.uk](http://www.newcultureforum.org.uk)

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## Acknowledgements

Thank you to the following individuals for supporting and participating in this research project:

Faduma Ali

Jason Ashwood (Metropolitan Police Service)

Sarita Bingeman

Pam Bowen (Crown Prosecution Service)

Dr Ash Chand

Joy Clarke

Waris Dirie

Jane Ellison MP

Kaitlin Ewing

Tess Finch-Lees

Jason Green

Lisa Harker

Ella Hayward

Leyla Hussein

Nisan Kesete

Betty Makoni

Denise Marshall

Comfort Momoh

Yeliz Osman

Kitty Richardson

Alison Saunders (Crown Prosecution Service)

Hawa Sesay

Joan Smith

Keir Starmer (former Director of Public Prosecutions)

Danielle Thom

Anne Marie Waters

Linda Weil-Curiel

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# 1

## Introduction

Of all the many human rights abuses that women and girls are forced to endure worldwide, few are crueller than the practice of Female Genital Mutilation (FGM). This is a procedure that belongs in the dark ages, not the twenty-first century. Its continued existence in Britain and across the globe promotes a savage form of discrimination against the female population, undermining the cause of equality and reinforcing institutionalised misogyny.

Sometimes euphemistically – and erroneously – called ‘female circumcision’, the practice inflicts appalling physical and psychological damage on its victims. Rooted in superstition, FGM has absolutely no benefits whatsoever; on the contrary, it is a humiliating and agonising ritual that can bring serious short- and long-term health problems. When used against adult women, FGM is a form of extreme violence; when used against girls, it is child abuse. And what is so tragic is that the vast majority of victims are indeed children: FGM is usually performed on girls aged between five and eight. In some cultures it can be carried out within days of birth, while in others it may take place just prior to marriage.

The catalogue of torture is terrifying. It is estimated that worldwide some 140 million girls and women alive today have been forced to undergo FGM (World Health Organization, 2013). The practice is common across large swathes of north-eastern, central and western Africa, as well as across the Middle East and Asia. According to a 2013 report from the United Nations Children’s Fund (UNICEF), no less than 98 per cent of women from Somalia, 96 per cent from Guinea and 91 per cent from Egypt have undergone the ordeal. Other countries where the overwhelming majority of women have been mutilated in this way include Eritrea (89 per cent), Sierra Leone (88 per cent) and Ethiopia (74 per cent) (UNICEF, 2013).

It is intolerable that such appalling suffering should be going on in the ‘developing’ world. Major international bodies like the UN, the European

Union, UNESCO, UNICEF and the World Bank should be putting as much effort into eradicating this practice as into fighting poverty, AIDS and famine, or into promoting economic growth and education. The same is true of non-governmental organisations (NGOs) and other anti-poverty campaigns. While they live in the shadow of the knife, women can never be free to reach their potential.

**“It is estimated that worldwide some 140 million girls and women alive today have been forced to undergo FGM”**

In the nineteenth century, clitoridectomy (a form of FGM that involves removal of the clitoris) was practised by some gynaecologists in Europe and the United States to ‘cure’ women of masturbation and insanity. But never has the practice been as widespread in Britain and Europe as in recent decades. Global migration has seen a significant increase in the size of the African, Asian and Middle Eastern communities within Europe. While it may enrich European society and promote cultural diversity, this trend also means that FGM is now widely practised in Britain and Europe. In 2007, FORWARD and the Department of Health estimated that around 66,000 women and girls in the UK had undergone FGM and that over 20,000 girls aged under 15 were at risk of the procedure (FORWARD/ Department of Health, 2007). However, these estimates are based on figures from the 2001 census, since when there has been a big increase in the scale of immigration. Our own research suggests that the number of women and girls living with FGM in the UK is more likely to be around 170,000 – almost three times the existing official figures – and that 65,000 girls aged 13 and under are at risk of mutilation (see Appendix D).

Yet despite the growing prevalence of abuse in Britain, precious little substantive action has been taken by the authorities to counter it. While specific legislation has been enacted to outlaw the practice – the Prohibition of Female Circumcision Act 1985 and the Female Genital Mutilation Act 2003 – *not a single successful prosecution has been brought against FGM practitioners*. And yet a survey for this report shows that professionals working in this field believe that a few high-profile criminal actions could act as a deterrent and demonstrate that the state is taking this form of violence against women as seriously as other forms. A law that is never enforced and that can be ignored with impunity eventually falls into contempt, leaving those it was meant to protect even more vulnerable.

**“While specific legislation has been enacted to outlaw the practice ... not a single successful prosecution has been brought against FGM practitioners”**

Equally disturbing is the lack of any high-profile publicity campaign targeting FGM – a failure that undermines public awareness of the issue and again leaves victims feeling isolated. The absence of any effective official campaign on FGM is in stark contrast to the ‘Zero Tolerance’ campaigns run by the police, government and local authorities to target domestic violence; these offer hope to abused women and signal a change in attitude within the criminal justice system. According to Lisa Harker, head of strategy at the National Society for the Prevention of Cruelty to Children (NSPCC): ‘The United Kingdom’s child victims of female genital mutilation are hidden behind a wall of silence. Like other forms of abuse, if female genital mutilation is not exposed it will continue to thrive and more


children will suffer’ (NSPCC, 2013a). At its worst, silence amounts to collusion.

There are a number of factors behind this disturbing hesitancy to tackle the issue. One is the widespread feeling that it is a low priority for the state. As a result, the professionals in the field, from criminal prosecutors to healthcare practitioners, do not receive adequate training. A second factor is the lack of engagement and education within FGM-practising communities. A third is the difficulty of compiling evidence: it is extremely hard to get victims to speak out, especially when they are already under intense social pressure from their families and peers in their community. FGM itself is a physical manifestation of that cycle of oppression and fear. This difficulty is exacerbated by the fact that the collection of data on FGM by institutions lacks uniformity and there are currently no universally applied codes for referring to FGM in medical records.

By far the most important factor, however, is excessive cultural sensitivity: quite simply, there is a reluctance to combat the practice of FGM for fear of appearing reactionary or prejudiced. Here, the laudable desire to show respect for other cultures has degenerated into a form of paralysis – a terror of taking vigorous action just because the practice occurs overwhelmingly in migrant communities. There is also a religious angle to this nervousness, since almost all practitioners – and victims – of FGM are Muslims or Christians, though it needs to be stressed that FGM is essentially a *cultural* practice, and that it appears to pre-date Islam and Christianity. Nevertheless, given the continuing controversies about the role of faith in western societies, it is not surprising that there is a deep concern about appearing heavy-handed. As our survey shows, such sensitivities cause many professionals to be reluctant to intervene or even to conduct physical examinations. The profound irony is that this perspective generates a kind of discrimination of its own, since the victims remain

unprotected precisely because of their race.

We must adopt a new approach – one that puts women and girls first. Recognition of cultural diversity cannot be used as a cover for inaction. In essence, the issue is straightforward: in Britain, we are all supposed to be equal before the law, regardless of race or creed. FGM amounts to child abuse or violence against women, both of which are serious offences against the law. They need to be dealt with robustly. As the Council of Europe has put it, dismissing arguments of political correctness:

It is a matter of urgency to make a distinction between the need to tolerate and protect minority cultures and turning a blind eye to customs that amount to torture and inhuman or barbaric treatment of the type the Council of Europe wishes to eradicate. (Council of Europe Parliamentary Assembly, 2001) 



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# 2

## Definition and global incidence

### Definition

The World Health Organization (WHO) defines FGM as ‘procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons’ (WHO, 2013). The UK generally subscribes to this definition, stating that FGM covers ‘procedures that include the partial or total removal of the external female genital organs for cultural or other non-therapeutic reasons’ (Department of Health, 2011).

Within this definition, the WHO further recognises four major types of FGM:

- Clitoridectomy: partial or total removal of the clitoris or, in very rare cases, only the prepuce.
- Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora.
- Infibulation: narrowing of the vaginal opening through the creation of a covering ‘seal’. The seal is formed by cutting and repositioning the inner or outer labia, with or without removal of the clitoris.
- Unclassified: all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterising the genital area. (WHO, 2013)

The physical harm done to women and girls by FGM can be gauged from the above descriptions of the savagely invasive techniques used. This level of mutilation and harm is why it is so wrong to describe FGM as ‘female circumcision’. The male equivalent of clitoridectomy, in which all or part of the clitoris is removed, would be the amputation of most of the penis. The male equivalent of infibulation – which involves not only clitoridectomy, but also the removal or closing off of the sensitive tissue around the vagina – would be removal of the entire penis, its root of soft tissue and part of the scrotal skin (Rahman and Toubia, 2000).

### Incidence

It is estimated that worldwide 140 million girls and women alive today have undergone the procedure (WHO, 2013). The practice is common in northern and central Africa, in some countries of Asia and the Middle East, and also among migrants from these areas who live in other countries, such as the UK and France (WHO, 2013).

According to UNICEF, the ten highest rates of FGM (as a proportion of the female population) are in the following African countries:

- Somalia, 98 per cent of women and girls
- Guinea, 96 per cent
- Djibouti, 93 per cent
- Egypt, 91 per cent
- Eritrea, 89 per cent
- Mali, 89 per cent
- Sierra Leone, 88 per cent
- Sudan, 88 per cent
- Gambia, 76 per cent
- Burkina Faso, 76 per cent. (UNICEF, 2013)

Outside Africa, the practice also occurs in Yemen (where it is estimated that 23 per cent of women and girls have undergone the procedure), Iraq (among sections of the Kurdish population), and also Indonesia and Malaysia in Southeast Asia. Far smaller numbers of cases have been recorded in India, the United Arab Emirates, Sri Lanka, Oman, Peru and Colombia. In recent decades, the practice has grown significantly among the migrant communities of North America, Scandinavia, Europe and the United Kingdom.

### Impact

FGM has numerous short- and long-term consequences and complications, including severe pain, shock, haemorrhage (bleeding), tetanus or sepsis (bacterial infection), urine retention, open sores in the genital region, injury to nearby genital tissue, recurrent bladder and urinary tract infections, cysts,

infertility, denial of any sexual pleasure, an increased risk of childbirth complications and newborn deaths, and in some cases death (WHO, 2013).

**“FGM has numerous ... consequences and complications, including severe pain, shock, haemorrhage (bleeding) ... recurrent bladder and urinary tract infections ... infertility ... an increased risk of childbirth complications ... and in some cases death”**

Faduma Ali offered this vivid account of the suffering she endured when she underwent the procedure in her native Somalia:

My grandmother and mother had it done, so it seemed natural ... There were four of us ... But because I was the bravest, I was told to go first. My grandmother and the other girls' mothers held me down and the woman cut me with a knife. It's like someone is cutting your finger off without pain relief. My blood was shooting into her face and eyes. (Khaleeli, 2013)

The wound and her vagina were sewn up, leaving Faduma with a hole the size of a match head. Through this she had to pass urine and menstrual blood. Since there was no medical equipment in Faduma's village, three thorns were used in place of stitches. The consequences of the surgery lasted long after the operation itself:

They gave you milk and waited to see if you could urinate ... If not, they cut you open a little more. For two weeks, it is agony ... The minute you have it done you have problems ... When you

have your period, it is very painful and when you have children it is very painful.

Faduma said her first labour lasted five days and that the midwives 'had to cut me everywhere' to get the baby out.

Another victim, Waris Dirie, who subsequently became a UN goodwill ambassador in the campaign against FGM, recalls: 'Mama tied a blindfold over my eyes. The next thing I felt my flesh was being cut away. I heard the blade sawing back and forth through my skin. The pain between my legs was so intense I wished I would die' (FORWARD, 2013).

Even though there are few studies on the psychological effects of FGM, girls have reported disturbances to sleep, eating, mood and cognition shortly after the procedure, and many girls and women experience fear, anger, bitterness and low self-esteem (Rahman and Toubia, 2000). Leyla Hussein, an anti-FGM activist and psychotherapist, says that her own experience of FGM had a profound impact:

I only became aware of how much I'd been affected psychologically by ... FGM when I fell pregnant. I was severely depressed and I hated being vaginally examined; it was my worst nightmare. And I remember the doctors wondering: why is she so scared? I realized later it was my body experiencing flashbacks, reminding me of what had happened to me when I was six. (Hussein, 2013)

The reasons for performing FGM vary from place to place, and usually reflect the beliefs and customs of the local community. In essence there are four main explanations for the practice:


- Custom and tradition: in many communities, FGM is performed as a rite of passage from childhood to adulthood, equipping the girl for marriage, husband and children.

- Controlling female sexuality: in many cultures the honour of a family or a clan depends on a girl's virginity or sexual restraint.
- Religion: although FGM is a cultural (not a religious) practice that probably pre-dates the arrival of Christianity and Islam in Africa, and although it is not a requirement of either faith, there are some who associate the practice with religion.
- Social pressure: in communities where most women go through the procedure, family, friends and others in the community create an environment in which FGM becomes a component of social conformity. (Rahman and Toubia, 2000)

As Leyla Hussein says:

FGM is a form of identity. Women in my community worry that they won't be considered a good Somali woman if they haven't undergone FGM. But let's be clear: this is a practice that controls women's sexuality, and it continues today because we still live in an environment where women are restricted. (Hussein, 2013)

In the same vein, Faduma Ali from Somalia recalls: 'Everyone had it done ... If you didn't, you were shunned' (Khaleeli, 2013).

Definitions, particularly legal ones, are crucial to how FGM is understood and dealt with. The language used to describe the crime can serve to minimise its seriousness (for example, calling it 'cutting' or 'circumcision') and to place it in a 'cultural' rather than a criminal framework. To refer to FGM as a 'cultural' issue is to mask the very real harm it causes, and to offer those in the criminal justice system and beyond a ready-made excuse for why the UK has yet to secure a criminal conviction. 

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# 3

## International law

The drive for conformity in the FGM-practising communities comes into direct conflict with a wide range of laws and resolutions passed by international and regional bodies to uphold the human rights of women and girls. As a result, failure to act against female genital mutilation represents not just a betrayal of women, but also a breach of international law.

**“Failure to act against female genital mutilation represents not just a betrayal of women, but also a breach of international law”**

Respect for the dignity of all humans lay at the heart of the foundation of the United Nations (established 1945) and the Council of Europe (established 1949), both developments fuelled by revulsion at the horrors of the Second World War. Although FGM was not specifically mentioned in the earliest declarations of either the UN or the Council of Europe, the practice certainly fell within the ambit of many of them – especially the injunctions to combat discrimination against women, to ban torture, to promote freedom from cruel, inhuman and degrading treatment, and to protect life and liberty. These fundamental rights are enshrined in:

- the Universal Declaration of Human Rights (1948);
- the International Covenant on Civil and Political Rights (1966);
- the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) (1979); and
- the European Convention on Human Rights (1950).

The responsibility towards children was further set out in Article 19 of the United Nations

Convention on the Rights of the Child (1989):

States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. (United Nations, 1989)

Article 37 adds that ‘States Parties shall ensure that no child shall be subjected to torture or other cruel, inhuman or degrading treatment’ (United Nations, 1989).

Since the early 1990s, as awareness of the problem has grown, a number of international pronouncements have specifically condemned or prohibited FGM:

- In 1993, the UN General Assembly issued a Declaration on the Elimination of Violence against Women. Article 2 makes it clear that FGM should be regarded as a form of violence against women: ‘Violence against women shall be understood to encompass, but not be limited to, the following: ... Physical, sexual and psychological violence occurring in the family, including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation’ (United Nations, 1993).
- The 1995 Beijing Declaration and Platform for Action urges governments to eliminate violence against women by ‘enact[ing] and enforc[ing] legislation against the perpetrators of practices and acts of violence against women, such as female genital mutilation’ (United Nations, 1995: 52).

- In 2010, the UN Commission on the Status of Women adopted a resolution entitled ‘Ending Female Genital Mutilation’. In unequivocal terms, the document attests that ‘female genital mutilation violates, and impairs or nullifies the enjoyment of the human rights of women and girls’. Furthermore, it urges ‘States to take all necessary measures, including enacting and enforcing legislation to prohibit female genital mutilation and protect girls and women from this form of violence, and to end impunity’. At the same time, governments are encouraged ‘to allocate sufficient resources to the implementation of legislation and action plans aimed at abandoning female genital mutilation’ (UN Commission on the Status of Women, 2010: 2–6).
- The Council of Europe Parliamentary Assembly Resolution 1247 on female genital mutilation (2001) states that FGM ‘should be regarded as inhuman and degrading treatment within the meaning of Article 3 of the European Convention on Human Rights, even if carried out under hygienic conditions by competent personnel’. The resolution calls on member states: ‘to introduce specific legislation prohibiting genital mutilation and declaring genital mutilation to be a violation of human rights and bodily integrity; to adopt specific time limits for prosecution that enable the victims to go to court when they reach the age of majority, and to grant organisations the right to bring action; and to prosecute the perpetrators and their accomplices, including family members and health personnel, on criminal charges of violence leading to mutilation, including cases where such mutilation is committed abroad’ (Council of Europe Parliamentary Assembly, 2001).
- Article 38 of the Council of Europe’s Convention on Preventing and Combating Violence against Women, drawn up in 2011 and known as the

Istanbul Convention, declares that: ‘Parties shall take the necessary legislative or other measures to ensure that the following intentional conducts are criminalised: (a) excising, infibulating or performing any other mutilation to the whole or any part of a woman’s labia majora, labia minora or clitoris; (b) coercing or procuring a woman to undergo any of the acts listed in point (a); (c) inciting, coercing or procuring a girl to undergo any of the acts listed in point (a)’ (Council of Europe, 2011).

- In December 2012, a landmark resolution – ‘Intensifying Global Efforts for the Elimination of Female Genital Mutilation’ – was passed by the UN General Assembly. It calls for a global ban on FGM (UN General Assembly, 2012).

Within the context of international legislation there is no excuse for inaction. All governments have a duty to protect the rights of women and girls. So-called cultural sensitivities should not be a barrier to fulfilling that duty and have no place in dealing with a violent crime against a child or adult. As we have seen, there are a number of international bodies, including the UN and the WHO, that have made tackling the crime of FGM a serious priority. That the UK lags behind a number of countries, and appears to fall short of international standards in prosecuting this particular form of child abuse, is concerning and disappointing. 🌀

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# 4

## The situation in the UK today

### Incidence

As in other western European countries, the incidence of FGM in the UK is deeply disturbing:

- Around 170,000 women and girls in the UK today have undergone FGM (own figures; see Appendix D).
- Some 65,000 girls aged 13 and under are at risk of mutilation (own figures; see Appendix D).
- More than 70 women and girls seek medical treatment every month for FGM (NSPCC, 2013a).
- Some 7,000 women affected by FGM give birth in London every year (Equality Now, 2010).
- In the last two years alone, over 1,700 women and girls have been referred to specialist clinics that deal with FGM (Metropolitan Police, 2013).

However, it is believed that the true number of those who have undergone FGM is likely to be much higher, since only a small fraction of victims seek medical help (Metropolitan Police, 2013).

In an interview with a journalist, Betty Makoni, an award-winning international campaigner against the abuse of women, claimed that FGM is prevalent in Britain. Drawing on her campaigning experience and connections to African communities, she maintained that it is not uncommon for babies to be taken overseas to be ‘stitched up’ or for ‘cutting parties’ to be held in the UK, where group rates are offered to reduce costs. She also highlighted another type of FGM that involves not cutting or stitching, but rather pulling the labia and clitoris out, or ‘elongating’ them. This was the agonising procedure that Betty herself experienced as a child. Despite the widespread application of this operation in the UK, Betty regrets that the British media have not done more to expose it (Finch-Lees, 2013).

### Early legislation and policy

The issue in the UK has been not a lack of policy or

legislation, but rather an institutional unwillingness to enforce the law. Agencies have all the legal instruments they need. As well as the international conventions outlined above, a series of powerful domestic measures has been introduced since the mid-1980s.

Policy development in Britain began in 1980, partly inspired by the rise in the number of African students and migrants to the UK. That year, the Minority Rights Group published a report entitled *Female Circumcision, Excision and Infibulation: The facts and proposals for change*, which advocated a specific criminal law against FGM. The call was taken up in 1982 during a debate in the House of Lords. Such pressure resulted in the Prohibition of Female Circumcision Act 1985, which outlawed the procedure for the first time.

**“The issue in the UK has been not a lack of policy or legislation, but rather an institutional unwillingness to enforce the law”**

A year later, parliament formally ratified the UN Convention on the Elimination of All Forms of Discrimination against Women, which the British government had first signed in 1981. But the UN committee overseeing the implementation of this convention grew concerned that in many member states the fine words of the declaration were not being matched by action. In 1990, in its General Recommendation No. 14, the Committee on the Elimination of Discrimination against Women recommended that states should take appropriate and effective measures to eradicate FGM. This would include collecting and disseminating data on FGM, supporting women’s national and local-level organisations working to eliminate the practice, providing appropriate training for professionals,

including FGM in national health policies and creating appropriate strategies aimed at eradicating the practice. Five years after the passage of the 1985 UK legislation, the theme of non-enforcement was already becoming apparent.

Child protection legislation is another tool in the UK's armoury that could help bring an end to FGM. Although the Children Act 1989 does not specifically include FGM, the practice can certainly be classified as a cause of significant harm to the child, as laid out in Section 47. Similarly, Section 11 of the updated Children Act 2004 gives professionals and volunteers from all agencies and departments (health, education, police and social services) clear statutory responsibilities to safeguard and promote the welfare of children. It imposes an obligation on them to protect a child from any harm, including physical and psychological abuse.

There are also child protection laws that relate to specific parts of the United Kingdom. Section 65 of the Children (Northern Ireland) Order 1995 states that if any police officer or member of state believes that a child could be at immediate risk of significant harm, he or she should consider the use of police protection measures, including removal and accommodation of the child. And Section 55 of the Children (Scotland) Act 1995 states: 'A sheriff may grant an order ... for an assessment of the state of a child's health or development, or of the way in which he has been treated (to be known as a "child assessment order")'.

### **The Female Genital Mutilation Act**

The specific British law against female genital mutilation was strengthened and updated in 2003 by a private member's bill introduced in parliament by the Labour MP Ann Clwyd.

Under this Act, which came into force in March 2004, it is against the law to carry out, aid or abet any form of FGM, including excision, infibulation or mutilation in relation to the whole or any part of the labia majora, labia minora, prepuce of the

clitoris, the clitoris, or the vagina. The penalties were increased significantly compared to the 1985 Act, and allowed the courts to impose sentences of between five and fourteen years on perpetrators who carry out the procedure or on parents who allow their children to be thus mutilated. The principle of extraterritoriality is also applicable, making FGM a criminal offence even if it is performed abroad (whether or not it is lawful in the country where the procedure is carried out). Welcoming the legislation, Home Secretary David Blunkett said:

No cultural, medical or other reason can ever justify a practice that causes so much pain and suffering ... Female genital mutilation is a very harmful practice that is already rightly illegal in this country ... Regardless of cultural background, it is completely unacceptable and should be illegal wherever it takes place. (BBC, 2004)

In Scotland, an FGM-specific Act was introduced in 2005, since under devolution the Female Genital Mutilation Act 2003 did not extend north of the border. The Prohibition of Female Genital Mutilation (Scotland) Act 2005 carries similar penalties to those introduced for the rest of the UK.

### **Additional initiatives**

Alongside legislation, a number of policy initiatives have emphasised the duty of institutions to tackle FGM. In 2011, the coalition government issued its *Call to End Violence against Women and Girls: Action plan*. Coordinated by the Home Office, this plan called, as part of its overall strategy to tackle violence against women and girls, for 'the development of learning programmes for the Police' and the production of 'guidelines for prosecutors dealing with potential cases of FGM' (Home Office, 2011). The plan further stressed that violence against women and girls occurs in all countries and is an issue that cuts across borders.

There have been other recent policy developments. One saw the publication by the Department of Health of ‘multi-agency practice guidelines’ on FGM for professionals and volunteers (Department of Health, 2011). This document paid particular attention to the identification of girls at risk and of those who have already been subjected to FGM. The other important paper came from the Crown Prosecution Service (CPS) and was entitled ‘Female Genital Mutilation Legal Guidance’. It detailed how the law on FGM should be implemented and set out the challenges faced by prosecutors in bringing cases of FGM to court (CPS, 2013c).

### Health Passport

Back in 2011, the Dutch government introduced an official document that girls can carry and show their relatives to prove that FGM is illegal in the Netherlands. The aim was to give migrant girls a sense of protection if they came under cultural pressure within their communities to undergo the procedure.

Impressed with the scheme, in November 2012 the British government launched a one-year pilot to trial the ‘Health Passport’. The document, available in numerous languages and designed to be discreetly carried in a purse or passport, warns that British residents can face up to 14 years in jail if they arrange for FGM to be carried out abroad. It is signed by the director of public prosecutions and several government ministers. Supporting the idea, Conservative MP Jane Ellison, head of the all-party parliamentary group on FGM, said:

I want to see this statement being tucked inside a girl’s passport – it won’t stop all FGM but it could be invaluable if a parent is in two minds or an older sibling, who may have had it happen to them, is trying to protect a young sister. The message is now clear – a girl from the UK is protected by our laws, home and abroad. (Batha, 2012)

Sadly, the rhetoric has not been backed up by action in the courts.

### Project Azure

London, the most diverse city in the United Kingdom and host to the largest African communities, has been a particular focus of policy work because of its unique demographic structure. Project Azure (Carroll, 2010) was set up in 2006 by the Metropolitan Police Service’s Child Abuse Investigation Command (SCD5) to try to prevent FGM in London. Although the project’s initial remit was specifically to develop prevention and awareness campaigns to protect girls in London, it has evolved and now serves as the Metropolitan Police’s lead on all issues of FGM. The current aims of the project are to:

- develop prevention strategies and initiatives;
- raise awareness and educate police, professionals and communities;
- provide advice, support and guidance for referrals and investigations; and
- develop intelligence opportunities.

SCD5’s Partnership Team is responsible for Project Azure, but it is not an investigative unit. Any cases reported to the police that require investigation are dealt with either by the local Child Abuse Investigation Team (CAIT) or else by SCD5’s Major Investigation Team or Serious Case Team. Project Azure also provides expert advice and guidance to all investigations in London, including non-SCD5 cases. To support these investigations, SCD5 has developed standard operating procedures, attached as Appendix C.

In 2007, the Metropolitan Police also launched a summer campaign, which offered up to £20,000 reward for information leading to the arrest and prosecution of anyone carrying out female genital mutilation in London (Metropolitan Police, 2007).



## Mayoral taskforce

In 2012, in his manifesto for re-election as London mayor, Boris Johnson promised to set up a special taskforce to tackle FGM, again reflecting the vital role that the capital has in confronting this challenge in the UK. Such a body – known as the Harmful Practices Taskforce – has now been formally established, with the writer and human rights activist Joan Smith as its first chair. Speaking in June 2013, she said: ‘Although a part of me is very dismayed by the fact that we haven’t had any prosecutions, I also think it is an incredibly difficult thing to get right.’ Among the difficulties she cited in bringing prosecutions were ‘the high burden on witnesses’ and the fact that children would ‘have to give evidence against parents’ (Crerar, 2013).

The taskforce, which is still in its early stages, is hoping to involve different agencies concerned with harmful traditional practices, including FGM, and to take a holistic approach towards tackling these. According to the refreshed mayoral strategy on violence against women and girls (MOPAC, 2013), the taskforce is to focus on four key areas:

- early identification and prevention of FGM by integrating education on harmful practices into schools, delivering quality training to professionals who come across those at risk of FGM (such as in health, education, police, social services) and developing clear processes and mechanisms to enable practitioners to assess and identify those at risk of FGM, flag the risk and make the necessary referral;
- including harmful practices such as FGM in safeguarding policies and interventions, and improving access to specialist support services for victims and those at risk of FGM;
- securing prosecutions for FGM to hold perpetrators to account and to deter others from performing FGM, and also monitoring the effectiveness of the criminal justice system in tackling the problem; and

- working with specialist organisations and the community to develop outreach activities and raise awareness among those communities affected.

## Female genital mutilation helpline

In an initiative to provide support to FGM victims, the National Society for the Prevention of Cruelty to Children (NSPCC) launched a new FGM-specific helpline in June 2013. This charity has no hesitation in calling the procedure a form of abuse.

Backing the launch was Hawa Sesay, who was mutilated in her native Sierra Leone at the age of 13 and now lives in Britain. Like many other victims, she almost bled to death during the procedure: ‘It is just luck. If you are lucky, you don’t die. A lot of girls die that way.’ She wanted to see more done to end the abuse: ‘Enough is enough’ (Newman, 2013).

As of September 2013, the helpline had received 96 contacts (voice and non-voice): 18 for advice, 35 for referral and 43 for an enquiry.<sup>1</sup> Information was available for 27 contacts: 8 related to abuse that had taken place on the same or the previous day; 11 related to abuse in the previous month; 5 were about abuse that had taken place in the previous 6–12 months; and 3 related to historic abuse. Although the dataset is small, it does seem to indicate that the helpline is being used more for current or very recent incidences of FGM.

Of those contacts for which information is available (44), 23 were made by professionals, 11 by members of the public and 10 by a parent, carer or relative of the child. It is interesting that, according to the available data, no survivors of FGM had themselves made contact using the helpline.

All information received by the helpline is routinely referred to the local police, children’s services and the Metropolitan Police. By September 2013, some 35 referrals had been made to the police, and these had resulted in 47 investigations, none of which had led to a conviction.

The dedicated helpline is a very significant

1. Information provided by the NSPCC, September 2013.

development: previously, the NSPCC could not record cases of FGM or other harmful practices, as it did not gather the information separately from other types of physical child abuse. Since professionals calling the helpline are encouraged to refer cases to the police or children's services, Dr Ash Chand, head of strategy and development for minority ethnic children at the NSPCC, believes that this will create a change in the mind set, hopefully leading to more prosecutions in the future.<sup>2</sup>

John Cameron, head of the helpline, agrees, commenting that the calls received showed the 'need for a single anonymous point of contact for information' (Martinson, 2013).

### **Joint Crown Prosecution Service and Metropolitan Police Service Protocol**

Even with the support of Project Azure, there have still been *no prosecutions or convictions*. Indeed, in August 2012, the Metropolitan Police admitted that in the previous year its Child Abuse Investigation Command had received no correspondence at all about enforcement of the FGM law. In response to this admission, Jenny Jones, an elected representative of the London Assembly, said the Metropolitan Police was 'failing in its duty to gain justice' for the victims of FGM (Rickman, 2012).

**“In August 2012, the Metropolitan Police admitted that in the previous year its Child Abuse Investigation Command had received no correspondence at all about enforcement of the FGM law”**

This is a point that is echoed by the UN Committee overseeing implementation of CEDAW. In 2008, although it welcomed the enactment of the Female Genital Mutilation Act 2003 and the

Prohibition of Female Genital Mutilation (Scotland) Act 2005, it voiced its concern that there had been no prosecutions under the legislation: 'The Committee urges the State party [the UK] to ensure the full implementation of legislation to prohibit female genital mutilation, including prosecution of perpetrators, with a view to eliminating this harmful traditional practice' (CEDAW Committee, 2008: 8).

In July 2013, the UK government again came under scrutiny over its implementation of CEDAW. The UN Committee subsequently published its 'concluding observations'. These included its concern at:

reports that female genital mutilation persists in some communities in the State party. The Committee further recalls its previous concluding observations ([A/63/38], paras 278 and 279) and remains concerned that there still have not been any convictions for performing female genital mutilation.

The Committee reiterates that the State party should ensure the full implementation of its legislation on female genital mutilation. The Committee recommends that the State party ensure that the Crown Prosecution Service is provided with the support necessary to effectively prosecute perpetrators of this offence. (CEDAW Committee, 2013: 7)

In a bid to ensure that all cases involving FGM are investigated and prosecuted thoroughly and consistently, a joint protocol by the Crown Prosecution Service for London and the Metropolitan Police Service (MPS) was drawn up in June 2013.

Setting out the approach for police and prosecutors, Alison Saunders CB, then the chief crown prosecutor for CPS London, said:

By signing this protocol ... we are making it

clear that the practice of FGM is one that is unlawful and should not be condoned. We will work with MPS colleagues to prosecute offenders and support victims. Cases of FGM are challenging to prosecute but this protocol sets out how each case will be carefully and consistently considered, as well as ensuring that the welfare of the victim is paramount at all times. The document will ensure that close working between the CPS and the MPS on cases of Female Genital Mutilation continues, so that strong cases can be built against those who perpetrate this violent and invasive crime. (CPS, 2013a)

Stressing his support for the protocol, Detective Chief Superintendent Keith Niven said:

The Metropolitan Police Service is committed to supporting survivors of FGM and identifying the individuals involved in the commission of offences connected to this abhorrent practice. FGM cannot be disguised as being part of any culture, it is child abuse and offenders will be relentlessly pursued. The introduction of this new joint protocol with the Crown Prosecution Service will enable investigators and prosecutors to work closely together to bring those responsible to justice. There are many challenges involved in cases such as these and we fully understand the difficulties some face when deciding whether to report to police. I would like to take this opportunity to provide reassurance that the welfare of the victim is paramount at all times. We have trained child protection officers who will support survivors throughout the process, treating them with the utmost respect and sensitivity. We encourage survivors or those with information to come forward and enable the MPS and CPS to prosecute offenders and eradicate this crime from our communities. (CPS, 2013a)

The joint protocol (CPS, 2013b) assures the public that, although cultural taboo and a reluctance to report the crime to the police have been major obstacles, the CPS and the police will work closely to raise awareness and to ensure that whenever cases are reported, they are thoroughly investigated, and that victims and witnesses are supported throughout the criminal justice process.

The Metropolitan Police's Sexual Offences, Exploitation and Child Abuse Investigation Command will work with a CPS lawyer to ensure that the investigation and prosecution of FGM is coordinated. The CPS lawyer will provide a provisional assessment of the case, lines of further enquiry, identification of the likely charges and an indication of the evidence required to support them. The CPS will be proactive in identifying and, where possible, rectifying evidential deficiencies and in bringing to an early conclusion those cases that cannot be strengthened by further evidence.

The protocol expects the institutions to go further: if it is suspected that the victim has been pressurised or is frightened, they should investigate and assess whether prosecution for intimidation is possible. They should also look at what support has been offered and see whether the intervention of a local specialist support service could make a difference. The CPS will, if appropriate, ask the court to delay any hearing to allow this to be done.


In cases where the victim withdraws her complaint but confirms that the complaint is true, the police and the CPS should consider the feasibility of continuing without the victim's evidence. In such cases, a decision to proceed will only be taken by the chief crown prosecutor or deputy chief crown prosecutor after consultation with the police and the CPS lawyer.

The protocol also states that those involved in the investigation and prosecution of FGM should have appropriate and adequate training and be knowledgeable about FGM practices and cultural awareness:

The investigative team will include an officer with enhanced knowledge of FGM practices and cultural awareness who will remain attached to the case until the conclusion of the enquiry and any subsequent court proceedings. Key witness statements will be taken by the investigative team. (CPS, 2013b)

The CPS will select an advocate with the necessary skills and expertise to prosecute every FGM case.

Any medical examination of the victim should take place in a dedicated examination suite. This ensures that both victim care and the integrity of the evidence are maximised. The specific requirements of victims with special needs will always be considered. The medical examination of the victim should be carried out by an appropriately FGM-trained forensic physician, forensic nurse or paediatrician. Where practicable the wishes of the victim will be taken into account and adhered to in terms of the gender and/or ethnicity of the physician or nurse.

In every case that is the subject of investigation, an individual should be identified to provide a single point of contact with the victim. Whether this is the investigating officer, a member of the investigation team, a witness care officer, a CPS caseworker or some other person, the files of the police, the CPS and the Witness Care Unit should be conspicuously marked, to make it clear to all parties who is responsible for communicating with the victim and for keeping records of any action. When a case is to be dropped or a charge reduced – and if the police and the CPS decide it is appropriate to do so – the police will personally deliver an explanatory letter to the victim. 

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# 5

## Why no prosecutions? – Our research findings

Despite three decades of international and national anti-FGM legislation, policy initiatives, awareness-raising and training, the figures for the UK show that in the last decade there has been a substantial increase in the number of women and girls at risk of female genital mutilation, as well as in the number of women and girls living with its consequences.

And yet there has been not a single prosecution. This constitutes a grave violation of the rights of girls and women in the UK, as well as gross neglect of child protection and safeguarding laws.

The better to understand the diverse reasons behind this failure and the extent of the problem, within the context of this report some 1,818 Freedom of Information (FOI) requests were sent out between August and September 2013 to police forces, local authorities, hospitals and schools across England and Wales, and to the Crown Prosecution Service. A total of 666 responses were received.

Institutions were asked a range of questions, depending on their area of expertise. However the main focus was on obtaining the following information:

- Are those who work in these institutions adequately trained in recognising and responding to FGM?
- Do these institutions formally identify and record FGM cases specifically (rather than under a generic heading)?
- Do these institutions have appropriate referral and reporting pathways for FGM cases?

Furthermore, a separate survey was sent to a range of professionals – mainly those who have a role in, or a connection with, the criminal justice system (i.e. police, social services, health professionals and the Crown Prosecution Service). This was designed to look at the attitudes and views of professionals working in these fields. In all, 36 responses were received (see Appendix A, Figure 1).

### Barriers to investigation and prosecution

#### Difficulty in detecting cases and gathering evidence

One of the reasons offered by survey respondents for the lack of prosecutions was the difficulty in identifying the crime (29.03 per cent, n=9), due to the low level of reporting by the victim or others; another reason given was the difficulty in persuading victims (in most cases children) to testify against the perpetrators (usually including the parents) (29.03 per cent, n=9). Others mentioned the difficulty of gathering the appropriate evidence, including medical evidence (16.13 per cent, n=5). According to one respondent, ‘the standard of evidence required by CPS is difficult to obtain. It is unrealistic to expect child victims to report or provide evidence against family.’

Professionals interviewed for this research stated that investigation and prosecution should go ahead without overly relying on the child or victim as a

	FOI requests sent	FOI responses received
Local authorities	174	166
Hospitals	174	161
Schools	1,426	296
Police forces	43	42
Crown Prosecution Service	1 (to head office)	1

witness. They say that the current heavy reliance on young girls for evidence may be one of the biggest barriers to prosecution. Therefore, the burden of gathering evidence and the necessary information should rest with professionals such as the police and social services. The fact that those subjected to FGM are commonly children means that they are not able to self-refer and therefore it is right to place the onus on professionals to ensure that the correct action is taken. It is bad practice to ask survivors and victims to do the policing and undertake prevention work. Keir Starmer, until recently head of the Crown Prosecution Service, said:

I think we stood back and we waited for a victim to walk through the door of a police station. That was never going to happen ... We need a proactive strategy, an intelligence-led strategy, because young girls are very unlikely to come forward with evidence against their own family and risk going into care. What I set up a year ago was a round table to really think outside the box and think strategically how we can go forward with a victimless prosecution and intelligence-led operations. And we have been working on that for a year. We've now had two covert operations in the last 12 months, where we have been able to gather evidence, and I'm convinced that by that strategy we are getting much closer to a prosecution. (BBC, 2013)

Leyla Hussein, an anti-FGM activist and psychotherapist said: 'No child is going to come out and testify against their parents. At the same time we need to exercise the law because FGM is a human rights violation and these girls deserve justice' (Hussein, 2013).

The professionals emphasised that, in order for the law to function properly in protecting children, it will have to be brought centre stage in society. Concerned adults need to see that they have a role to play in ensuring that legislation does protect

children, since often the youthfulness of those who are affected by FGM means that they cannot read the legislation or report to a police station if they experience it. The response of stakeholders is crucial in ensuring that the legislation protects children.

**“Concerned adults need to see that they have a role to play in ensuring that legislation does protect children, since often the youthfulness of those who are affected by FGM means that they cannot read the legislation or report to [the] police”**

But it is not just love of their parents that prevents children from coming forward; sometimes they are reluctant to do so out of fear. And if a child has seen a professional in conversation with her abuser, she will feel unable to place sufficient trust in that professional to relate what has happened. The professionals emphasised that it was very important to be allied with the child in any case of FGM, and not to make assumptions about parents' motivation for subjecting their daughter to FGM.

In order for a child or a victim to come forward and even be a witness, it is very important that the necessary support is in place throughout the process. Alison Saunders, at the time the chief crown prosecutor for CPS London, said:

Victims can be reluctant to report this type of abuse, especially when it may involve giving evidence against their own family. The [joint CPS–MPS] protocol stresses the importance of making sure the victim is supported in every way possible and that they are put in touch with local specialist support services at the start of any investigation. Additional support will also include the use of special measures, a

court familiarisation visit, referral to specialist support services and the use of specialist officers and prosecutors who are sensitive to the issues involved. When a case is charged a dedicated, single point of contact with the victim will also be appointed which we hope will make the victim feel more confident and secure during the prosecution process. (CPS, 2013a)

Some professionals have mixed feelings about going ahead with a prosecution without the permission of the child; young victims might feel there is no guarantee that they will be listened to, and that could prevent them from coming forward. However, there is some precedent for proceeding with a prosecution without the participation of, or evidence from, the victim as witness – for example in murder cases, a crime committed against a pre-verbal child, a crime against an elderly person with dementia, or a crime against a person with learning disabilities. The CPS also has guidelines on proceeding with a prosecution in some domestic violence cases when the victim does not want, or is not able, to give evidence or to be a witness in a case. The guidelines state that:

When victims ask the police not to proceed any further with the case and say that they no longer wish to give evidence ... this does not mean that the case will automatically be stopped ... If the victim confirms that the complaint is true but still wants to withdraw, we [the CPS] will consider first whether it is possible to continue without the victim's evidence (the evidential stage) and then, if it is possible, whether we should continue with the case when the victim does not support the prosecution (the public interest stage) ... If we suspect that the victim has been pressured or frightened into withdrawing the complaint, we will ask the police to investigate further. The investigation may reveal new offences, for example, harassment or witness intimidation, or may

reveal that bail conditions have been breached ... If the reason for a victim or witness's withdrawal is based on fear or intimidation, the prosecutor will consider the evidence and decide whether further charges should be brought ... In cases where we have sufficient other evidence, we may decide to proceed without relying on the evidence of the victim at all. (CPS, 2013e)

With intelligence-led policing and the use of surveillance against those suspected of perpetrating FGM, it ought to be possible to gather sufficient evidence to mount a prosecution without having to rely on evidence from victims. It would be necessary in such circumstances for sufficient ongoing funding to be raised, in order to ensure that prosecutions initiated in this way can continue to a proper and effective conclusion.

The barriers to prosecuting child sexual abuse cases have been rigorously tackled in recent years and, despite ongoing difficulties, child protection experts, police and prosecutors have continued to seek new ways to bring justice for the victims. The same commitment has to be exercised by those with a responsibility for advocating for the victims and bringing perpetrators to justice.

The proper identification of possible cases of FGM and the successful accumulation of the evidence required to prosecute such cases are, at present, undoubtedly compromised by a lack of compulsory training among professionals, and by the absence of mandatory recording and reporting systems within the health service, the social services, education and the police. As we shall see, the results of the FOI requests and the special survey undertaken for this report give a clearer picture of the current situation with regard to these issues.

### **Awareness of female genital mutilation among professionals**

If the Crown Prosecution Service is to prosecute FGM perpetrators, it cannot do so without the input

and effective support of all other institutions tasked with the protection and wellbeing of these girls and women – i.e. the health service, the social services, schools and the police.

## Training

First, our survey found that the majority (97 per cent) of those who responded said they were familiar or fairly familiar with FGM (Appendix A, Figure 2). The level of FGM training reported was also high (84 per cent) (Appendix A, Figure 3).

Moreover, the majority of respondents considered FGM to be a human rights/child rights issue, a child safeguarding/protection issue or a violence against women and girls issue. None of those who responded thought it was a private matter that ought to be dealt with in private (Appendix A, Figure 4).

Almost all respondents knew that FGM is a criminal offence, and all but one agreed that it should be (Appendix A, Figure 5). Respondents identified the following actions as criminal offences under the Female Genital Mutilation Act 2003:

- performing FGM (97 per cent);
- taking a British national or permanent resident abroad for FGM (97 per cent);
- helping someone to perform FGM (97 per cent).

However the responses to the wide-ranging FOI requests paint a patchier and less encouraging picture. They reveal a piecemeal approach and provide evidence of a lack of universality in FGM training for employees within the institutions considered.

Of the 166 local authorities that responded to the FOI requests, a significant minority (51) stated that they did not provide their employees with any training on FGM; 108 reported that they did. Similarly, of the 161 hospitals that responded, only 92 said they provided staff training on FGM, and again a substantial number (58) said they did not. Four said either that the information was not available or

that they were unable to answer the question due to time constraints.

Of the 296 schools that responded to the FOI request, 221 said they provided training, but again a significant number (71) did not (four failed to answer). Finally, 35 of the 42 police forces that responded reported that they provided training for FGM cases, while six said they did not.

**“Of the 161 hospitals that responded [to our FOI requests], only 92 ... said they provided staff training on FGM”**

These figures show an absence of an across-the-board recognition of the importance of FGM training among those institutions that should be most concerned with the health and wellbeing of those women and girls most at risk. It is cause enough for concern that many responding institutions did not provide adequate training, but the answers to the FOI requests went on to reveal that even among those that did there was considerable variation in the type of training – and indeed in the number of staff who had undertaken it.

So, for instance, of the hospitals that did provide FGM training, five mentioned it as being part of child protection training, 36 as part of safeguarding training, one as specialist awareness training, and one as a mere one-hour seminar as a postgraduate specialty. Moreover, the number and type of staff that actually received training varied hugely from hospital to hospital: for example, six stated that all staff received training on FGM, whereas 19 replied that only midwives did; five hospitals reported that some doctors received training; and one hospital mentioned that some nurses did.

This somewhat random picture also applies to those local authorities that provide FGM training: 32 mentioned it as part of child protection training; seven reported that it featured just as part of ‘other



courses'; and two simply mentioned 'informal workshops'. And again, the number of employees who had received training varied considerably: six authorities stated that all staff had had training, whereas three responded that it had been given to some safeguarding staff only.

The pattern was similar in education. Of the 296 schools that responded to the FOI request, 108 claimed that all their employees had received training; 68 stated that only between one and seven members of staff had been trained – and the majority of responses indicated that in fact the number was only one or two.

Finally, in the case of the police, there was also some variation in approach among the forces' responses: training came under various headings, including domestic abuse, stalking and honour-based violence risk identification (DASH) and, in one instance, diversity training. One force stated (admirably) that all its employees had received training; one responded that 358 'employees' had been trained; and one claimed that 150 'officers' had undergone training. Less encouragingly, at least eight forces mentioned that only some staff (in a couple of instances just five or six employees) had received training; and four forces responded that only new officers were trained in FGM.

Some respondents to the FOI requests referred to internal guidelines that their employees could download from the institution's website if they felt they needed guidance – hardly a proactive approach to the training of employees. And as the results from our accompanying survey (below) illustrate, providing guidelines is often not enough.

### **Effectiveness of guidelines**

The majority of the professional practitioners who responded to the survey (87.1 per cent) reported having internal guidelines on how to respond to cases of FGM (Appendix A, Figure 13). The same proportion also reported using external guidelines, including the government's multi-agency practice

guidelines on FGM (Department of Health, 2011) (Appendix A, Figure 14). Some 90 per cent of those surveyed were aware of these guidelines (Appendix A, Figure 15).

The multi-agency practice guidelines on tackling and preventing FGM were published in early 2011 to support front-line professionals, such as teachers, health professionals, police officers and social workers. The guidelines also give instructions on how to gather evidence of FGM effectively, in order to secure a prosecution and provide the necessary support to the victim.

Despite this, when asked how effective they felt the guidelines had been and how well they had been used, many were not sure that they had been effective, and some thought certain aspects had been more effective than others. One respondent mentioned poor distribution as one of the problems (Appendix A, Figure 16).

These findings are echoed in a recent study by the Royal College of Midwives, which observed that professionals displayed a similar lack of confidence in existing guidelines on FGM. Those who took part in the study also felt there was a lack of integration of the subject into existing local authority documents and healthcare policy (Royal College of Midwives et al., 2013).

### **Knowledge and use of special initiatives**

Respondents were asked about their familiarity with, and utilisation of, some of the other existing special initiatives covered in Section 4 above.

Slightly over half of those who responded to the survey had some prior knowledge of the UK's trial of the Health Passport (Appendix A, Figure 7). However, not many felt that it was an effective mechanism for preventing FGM. Even the few respondents who thought it could be effective maintained that it would only be so if used alongside other preventive and punitive measures (Appendix A, Figure 8).

Knowledge of the NSPCC's new FGM helpline was more widespread, with the majority of respondents claiming to know of the initiative (Appendix A, Figure 9). However, not many of those who responded to the survey had accessed the helpline – in fact, only one reported having used it (Appendix A, Figure 10).<sup>3</sup>

### **Lack of recording and reporting of female genital mutilation cases**

A further barrier to the prosecution of FGM perpetrators is the lack of identification and reporting of girls and women who are at risk of, or who have undergone, FGM. When front-line institutions (police, local authorities, schools, the NHS) come into contact with women or girls who have undergone or are at risk of undergoing FGM, they are currently not required by law to record the FGM cases they come across. Moreover, if they do record such cases, they are not required to log them under a specific 'FGM' code. As a result, cases of female genital mutilation are frequently logged alongside other non-FGM cases, under generic headings such as 'abuse'.

While the majority of those who responded to the survey reported having come across FGM in their work, only 48.39 per cent said that their organisation actually recorded instances of FGM. According to the remainder of the responses, either the organisation did not keep records, or the particular respondent did not know if it did (Appendix A, Figure 17).

The respondents also differed in the steps they subsequently took in relation to the FGM cases they came across (Appendix A, Figure 11):

- 21.21 per cent (n=7) reported the case to social services;
- 18.18 per cent (n=6) referred the victim to the health authorities;
- 12.12 per cent (n=4) discussed the situation

with the parents of the child;

- 12.12 per cent (n=4) reported the case to the police;
- 3.03 per cent (n=1) reported it to school authorities.

Asked about the outcomes of the FGM cases they had encountered, 12.12 per cent of the professional practitioners reported having prevented the abuse (Appendix A, Figure 12).

**“Only 48.39 per cent [of those that responded] said that their organisation actually recorded instances of FGM”**

If we look at the responses to the FOI requests, we can see that this same issue of inadequate recording also emerges there as worryingly prevalent.

A remarkable 83 hospitals (out of the 161 that responded to the FOI requests) stated that they did not formally record FGM cases. A further 19 said they could not answer the question, either because their internal recording systems did not allow them to record FGM cases as FGM specific, or because it would take too long to sift through individual, hard-copy case files.

The lack of a specific code for FGM that could be used to flag up cases certainly hinders any attempt to ascertain the full extent of the problem or to improve the support and protection given to girls and women at risk. Indeed, according to the National Clinical Classification Helpdesk, 'there is no ICD-10 code to solely classify female genital mutilation'. Many of the hospitals that do record FGM might therefore use a more generic code, such as N90.8, which means it would be logged under 'other specified non-inflammatory disorder of the vulva and perineum'. Or indeed it might be recorded non-specifically as (in the case of one hospital) 'assault by sharp object'. Another recorded it as an 'open wound'.

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26 3. This could be because the survey was conducted just after the helpline was launched.

The same variation applied to the police. When asked whether they had received FGM referrals over the past three years, of the 16 police forces that provided numbers, eight (19 per cent) stated that they had not received any referrals of FGM. Two forces did not log cases; 17 did not answer on account of data protection; and a further seven stated that they could not answer due to internal recording systems that did not cater for the logging of FGM-specific cases. When one considers that just eight forces (19 per cent) had received 286 referrals in the previous three years, it can be deduced that non-specific logging by a further seven almost certainly masks a significantly higher incidence.

The 166 responses received from local authorities revealed a similar patchiness: 25 (15 per cent) stated that they could not answer the FOI question on referrals, as they did not log FGM cases at all; 17 (10 per cent) did not record such cases under a specific FGM code, and so could not give an accurate answer; and 20 (12 per cent) stated that such information was held in individual case notes and it would take too long to go through these in order to establish whether a referral for FGM had been made.

Finally, in the case of the 296 schools (out of 1,426) that responded to the FOI request, 196 (66 per cent) formally logged FGM, while 36 (12 per cent) did not.

We can conclude from these figures that the ability of these institutions to gather FGM-specific data is seriously compromised by the lack of a consistent approach to the automatic recording of FGM cases, as well as by the absence of logging systems that allow FGM to be specified. Such inadequacies result in an inability within the various institutions to properly analyse and monitor FGM numbers, observe trends or supervise the manner in which cases are dealt with. It has therefore become harder to establish even the extent of the problem (the number of women and girls affected by FGM in the UK), while the chances of producing and

collating evidence for potential prosecutions are considerably diminished.

The problems of training and logging are serious enough, but they are compounded and intensified when we look at the referral of cases to the various authorities. Very few institutions bother to refer a child or woman at risk of FGM to the local authorities or the police. The responses of hospitals to our FOI requests showed that, of the 3,032 FGM cases treated during the three-year period, a mere 248 (just 11 per cent) were referred to local authorities, and only ten (5 per cent) to the police.


These figures are shockingly low. Furthermore, 41 hospitals did not log any such onward referrals, and a further 12 could not respond on account of the lack of FGM-specific logging. One health authority actually stated: ‘We have treated women with FGM, these are not acute cases and it is not the Health Board’s responsibility to report this to the local authorities.’

**“Even when the local authorities are made aware of a problem, the appropriate child protection orders are not used and the local authorities do not refer cases to the police”**

Even when the local authorities are made aware of a problem, the appropriate child protection orders are not used and the local authorities do not refer cases to the police. The information obtained through the FOI requests shows that most local authorities do not apply to the civil courts for emergency protection orders, child assessment orders, supervision orders, care orders, prohibited steps orders, orders for the surrender of passports or wardships. The figures show that, of the 89 case referrals to local authorities during 2010–13, just one local authority applied for a child protection order (it is not clear whether this

was a child assessment order, a supervision order or a care order). Furthermore, only 11 girls were sent for a medical examination on the grounds of suspected FGM, and a mere six were placed on the child protection register.

Finally, of the forces that reported having received FGM referrals, only one police force requested medical examinations for reported FGM cases (in three of the four cases referred to it). Three forces stated that medical examinations had not been requested, and a further three could not answer (again either because they did not log FGM at all or because the systems did not allow FGM-specific logging); one force refused to respond for reasons of data protection. No police force reported using police protection powers (to remove girls suspected of being at risk), although again the majority (32 – 76 per cent) did not respond on account of data protection.

In conclusion, there can be little doubt that, taken together, the findings both of the FOI requests and of our special survey paint a picture that should raise serious concerns about levels of staff training, reporting and referral. In the next part of the report, we turn our attention to what needs to be done at all levels to ensure that the crime of FGM in the UK is finally and effectively eradicated. 

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# 6

## Tackling female genital mutilation: what needs to change?

It was clear from speaking to professionals that the successful prosecution of FGM perpetrators would play a crucial role in tackling the crime. However, focusing on prosecution *alone* is unlikely to ensure the complete eradication of the practice of FGM.

In 2011, the Council of Europe authored a convention on preventing and combating violence against women, including female genital mutilation (Council of Europe, 2011). This convention, signed by the UK government, stressed that, if all forms of violence against women are to be ended, what is required is not only *prosecutions*, but also *protection* for women and girls at risk, integrated *policies* across governments and departments, and *prevention* strategies. This approach is commonly known as the ‘Four Ps’ (Council of Europe, 2011).

Such an approach allows us to tackle the root causes of FGM, rather than just wait for cases to enter the criminal justice system – at which point the damage has already been done. At the earliest stage, *prevention* measures (such as educating people about the criminal nature of FGM) mean that the practice can be firmly classed as a crime – rather than as a cultural practice – in the minds of potential victims, their families and the professionals employed to protect children. Education to address the wider gender inequalities that underpin the practice of FGM will also play a role in long-term prevention.

*Protection* and support for potential victims – including placing girls at risk on a child protection register – not only serves to shield girls from harm, but also allows for the collection of data on FGM (essential for prosecutions to be effective) and for other potential victims within a family to be monitored.

Integrated and consistent *policies* across departments are needed to create a cohesive approach to FGM, where data is recorded consistently and thoroughly, and where institutions are equipped to communicate and share information.

Finally, the *prosecution* of perpetrators of FGM

sends an unambiguous message that this crime will not be tolerated in the UK.

In this section, we look at the specific recommendations offered by professionals for the effective tackling of FGM.

### The criminal justice system

In the first place, all the professionals interviewed for this research agreed that the criminal justice system, including prosecutions (and ultimately convictions), will play a crucial role in tackling FGM. Interviewees agreed that, while the prosecution of perpetrators plays a vital role in redressing the injustice done to the victim, it also acts as an important deterrent to possible FGM-related crimes.

One stakeholder felt it was important to demonstrate to the perpetrators of this crime that their actions would have serious consequences, otherwise the criminal justice system would be seen to be taking this form of violence against women and girls less seriously than other forms. Many said that a few high-profile prosecutions could be very useful in terms of sending a strong signal to those practising FGM.

However, prosecutions and convictions, though important, are not the sole indicator of success – and nor are they a panacea. Our interviewees felt that it was important to remember that every prosecution or possible prosecution represents a case of FGM that we have failed to prevent. Prosecution needs to be used in conjunction with other available measures, such as community engagement, prevention, awareness-raising and education. Professionals felt that the criminal justice system certainly has a place in the prevention of FGM, as indeed it does in any other kind of illegal, gender-based violence. At the heart of the criminal justice system there should be a victim- or survivor-centric approach, where the girl or woman has all the appropriate services that will enable the scars of abuse and trauma to heal.

One professional voiced the hope that there would be some change as a result of the CPS’s new

approach, which follows pressure from a range of institutions that have said it needs to take FGM more seriously, give greater consideration to supporting victims, and support them through criminal proceedings.

### **More education and communication required**

This research highlights the fact that there is a dire need for better education and training on the subject of FGM, even among professionals. Those who come across cases of FGM are still not sure how to handle them, confused as to whether it is an issue of child protection, child abuse or just ‘something to do with tradition and culture’. This lack of clarity in the minds of professionals has prevented them from embarking on the child protection process when they hear of girls who are vulnerable or who have been subjected to FGM. Until we reach the point where professionals understand what FGM is, know how to respond to it and feel comfortable about intervening appropriately, it is going to be very difficult to prevent the mutilation of girls and young women.

### **Aligning FGM with other forms of child abuse and using child protection procedures**

There is a feeling that FGM is treated and understood as a lesser type of child abuse, and not as a gross violation of a child’s rights and body. In the majority of cases, if a child reports sexual abuse or rape, teachers and others know what to do and when to call the police. But with FGM, even if people know that it is a crime, and even if they have had ample training sessions, there is still a hesitancy to act. This leaves the child unprotected and feeling disbelieved. One professional referred to this as ‘othering’ children who are victims of FGM.

Another professional expressed frustration that when a child discloses to a professional that she has undergone or may be about to undergo FGM, the professional would tend to talk to a specialist

organisation or to the parents of the child, rather than to the police (as would probably happen in the event of any other kind of child abuse). The duty to safeguard the child needs to be placed squarely with those who are charged with safeguarding her, rather than with some specialist organisation.

**“There is a feeling that FGM is treated and understood as a lesser type of child abuse, and not as a gross violation of a child’s rights and body”**

If FGM is considered on a par with other forms of child abuse, professionals believe that those encountering it will see the need to deploy the whole range of legislation and child protection procedures – not just the Female Genital Mutilation Act – to bring prosecutions and secure convictions for FGM.

### **Mandatory reporting of female genital mutilation and medical examinations**

The convictions that the UK so desperately needs simply cannot happen if professionals continue to fail to report cases. Making the reporting of FGM to the authorities mandatory – or indeed making it a crime *not* to report suspected FGM – might make professionals more proactive and robust in how they deal with the problem. This would place the onus on institutions or individuals who know that a girl is at risk of FGM to report the fact. One respondent explained that in France or the Netherlands, if a professional is found to be complacent in preventing FGM, criminal charges may be brought. A responsibility to report would prevent similar complacency in this country.

There has been recent discussion about changing the law to make it mandatory to report child abuse cases; the mandatory reporting of FGM cases should

also form part of this discussion. As Keir Starmer, former director of public prosecutions, has said: ‘I think the time has come to change the law and close a gap that’s been there for a very long time. I think there should be a mandatory reporting provision’ (Halliday, 2013). Holding professionals such as teachers and health workers liable for failing to alert the police to suspected child abuse cases, including FGM, could be an effective way of preventing abuse from happening in the first place.

**“[The] time has come to change the law and close a gap that’s been there for a very long time. I think there should be a mandatory reporting provision’  
– former Director of Public Prosecutions Keir Starmer,  
in the *Guardian*”**

Medical examinations also need to become a mandatory part of FGM investigations. Not only are such examinations vital to confirm the status of suspected victims (and to provide them with follow-up medical and emotional support), but information on a girl’s FGM status is important in determining whether other family members may be at risk. Although such examinations may be perceived by professionals as invasive, the Child Protection Standing Committee of the Royal College of Paediatrics and Child Health notes that these examinations are not experienced as traumatic by children or parents (Royal College of Midwives et al., 2013).

### **Role of different professionals**

Professionals in schools, the medical sector and social services need to play a key role in identifying and responding to cases of FGM. Successful prosecutions depend on their ability to log cases

consistently and to create a solid evidence base that the police and the CPS can utilise. Without this, the true scale of FGM in the UK will remain unknown and, more importantly, prosecutors will lack the necessary information to punish those who mutilate women and children.

In order to accumulate this evidence, professionals should receive more thorough and more regularly deployed training that will better equip them to spot and respond appropriately to cases of FGM. Agencies need to develop consistent codes and recording conventions, so that FGM cases can be tracked and evidence for prosecution can be readily accessed. Those interviewed for this research feel that it is time for professionals to put ‘cultural sensitivity’ to one side and see the practice for what it is – child abuse and violence against women. Rather than skirting around the issue, they feel that robust action is required – by all those who are entrusted with protecting and safeguarding women and girls.

### **Health services**

The health services have a crucial role to play, as they have a direct insight into the lives both of women who have suffered FGM and of their daughters, who are potential victims.

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Currently, FGM cases are regularly logged under generic codes that pertain to all types of medical issues relating to the genitalia. This blunts the health authorities’ ability to gather FGM-specific

data. A universally recognised code for FGM must be developed, so that it is clear from medical notes if a woman or a girl has undergone the procedure.

The guidelines for health professionals should deal with how to discuss the issue of FGM with a woman who has clearly been a victim of FGM or who may require protection; this should not be done on an ad hoc basis, with a practitioner taking it upon him or herself to broach the subject with the woman. There should be a standard procedure for any health professional who comes across a woman who has suffered FGM, particularly if she is about to give birth to a daughter. There needs to be a national mechanism for monitoring mothers who have experienced FGM and who become known to health services through midwifery, so that the services can follow up the child and the family.

One professional compared this dialogue to the conversation that a practitioner is expected to have with a pregnant woman who smokes: it is not done on an ad hoc basis and they discuss the potential risk to the child. There should be similar dialogue on FGM, and health professionals need to receive training in how to have such conversations in a professional manner, without putting the mother and child at risk, perhaps mirroring the conversations that midwives and nurses have with women about domestic violence.

As things stand, health professionals do not report or refer cases of FGM for investigation, invoking 'patient confidentiality'. Anne Marie Waters, a spokeswoman for the pressure group One Law for All, comments:

The doctors don't report it, they don't know they have to report it. This I know for a fact. Doctors would dictate various reports on patients and I have seen it many times ... female circumcision is mentioned as if it was a wart – it's just, like, mentioned casually – there is not really even any attention to it. I remember asking a consultant,

the [genitourinary – GU] consultant about this and whether she had ever reported a woman who had been mutilated and whether she had daughters or anything. She answered me with 'I don't have any duty to do so, why would I do that?' And this is a senior consultant in a GU clinic.

Rosina Cottage QC specialises in rape and abuse cases involving young and vulnerable victims. She believes that 'medical professionals could play a key role in ensuring perpetrators are brought to justice by raising the alarm as soon as they see evidence that a girl has been harmed' (Bentham, 2013a).

This view was reiterated by Comfort Momoh, an FGM specialist who runs the African Well Woman Clinic at St Thomas' Hospital:

... a very significant number of women are being treated for FGM, but there are still lots out there who are not being identified because they don't know where to go for help, aren't being referred by GPs or are too scared to come forward. I'm really worried about girls, in particular. Where are they going to seek help? The GPs who are their first point of call often don't have the knowledge. We also need teachers and lecturers to do more to at least signpost girls towards help. (Bentham, 2013b)

She adds that it is essential that new guidelines from the Department of Health and medical professional bodies are issued, so that institutions can share information about victims and girls at risk in a coherent fashion, without deterring women from reporting their plight.

The failure to share information on cases also harms potential victims, since information on the FGM status of a girl's female family members will strongly indicate whether she herself is at risk (Royal College of Midwives et al., 2013).



### **Social services**

According to professionals interviewed, in many instances social services receive a referral but do not act upon it, either because they think there is insufficient evidence of a genuine risk, or because the family assures them that FGM is not being considered. A simple assurance of that sort would not generally be accepted if some other form of violence against a child was suspected. One stakeholder pointed out that such a course of action also entirely undermines any faith that a child might have that she could disclose FGM and be believed: whatever her parents say is accepted as the truth.

The professionals emphasised the importance of having referrals to social services consistently picked up and systematically followed through. As things stand, the protection provided to girls and women is inadequate and quite patchy. In 2013, MPs inquiring into FGM were reportedly ‘appalled’ that there had been 148 referrals of FGM in the previous four years, but that not a single girl had been placed on the child protection register by police or social services (UK International Development Committee, 2013). Professionals in social services must utilise existing guidelines, develop concrete channels for referral and record data thoroughly, so that it can be used both to support police investigations and to inform wider statistics on the problem.

### **School and teachers**

It was noted by professionals that schools are central to tackling the FGM problem: of all the agencies (bar health) they have perhaps the greatest access to children from communities that are hard to reach. Schools may be the first to know that a child is missing, and teachers will often know in advance that a girl is going away for the summer holidays to her family’s country of origin.

Since school is where children spend most of their time, professionals believe that FGM ought to feature in school lessons, so that children are aware of it. They feel it is important for schools to

emphasise that FGM is not just something done to particular children, but is in the category of ‘bad things that happen to people and that we must try to prevent’. If children were taught in schools about FGM at the same time as they are taught about other violence issues, that would avoid the issue being seen as just the problem of a particular group – an attitude that marginalises ethnic minority children. While it is important to recognise that a school cannot take the place of a parent, it does have a role in helping children to become healthy and safe members of society – and it needs to go some way towards compensating for parental failure to provide information.

**“If children were taught in schools about FGM at the same time as they are taught about other violence issues, that would avoid the issue being seen as just the problem of a particular group – an attitude that marginalises ethnic minority children”**

Joy Clarke, lead specialist midwife for women affected by FGM at the Whittington Hospital in London, stresses that teachers have to be vigilant:

When [girls] come back [from a trip abroad], teachers need to recognise if FGM has taken place. The persona of the child would change; she would be less likely to be involved in physical activity at school. Perhaps she will spend a longer time in the toilet, because if the vaginal opening is small, it will take her longer. Or she may go to the toilet more often, because she has an infection. (Williams, 2013)

According to professionals interviewed for this research, teachers still regard FGM as something ‘other’ than child abuse, and they are still not clear how to act when a case is reported to them – even though they would have no doubt what to do if faced with some other kind of child abuse or gender-based violence.

It was reported that one head teacher felt that nothing of the sort could happen in his school, and so he refused to put up a poster to raise awareness of FGM. Many schools will deny that FGM is a problem for them; but even if the issue affects just one girl, a school should be aware of what the risk indicators are, so that it can put safeguarding measures in place and share information expeditiously – before it is too late.

The situation is exacerbated by the Department for Education’s lack of engagement. One professional said it does not adopt a prescriptive approach: it is not going to tell schools to include FGM awareness-raising in lessons, or tell them that they have to do something to tackle the issue. This has resulted in a very patchy understanding of, and response to, FGM in different schools.

**“[Every] school should be aware of what the risk indicators are, so that it can put safeguarding measures in place and share information expeditiously – before it is too late”**

Some schools are quite proactive because of the individuals involved, but they are few and far between; most do not have any education on FGM. They may have some awareness of the problem, but they would not necessarily know how to go about intervening. Unless all school staff – not just the teachers, but the school nurses and other staff

members – are aware of the issues and know what the indicators of risk are, the opportunity to protect girls at risk and to prevent FGM from happening will be lost. Prevention should not be left up to interested individuals; there should be a procedure that is systematic and mainstream.

A 2013 survey conducted by the NSPCC revealed that the lack of appropriate training for teachers in recognising the warning signs of FGM was preventing them from alerting the appropriate authorities. It found that 83 per cent of the 1,000 teachers who participated in the survey had had no training in how to deal with girls at risk of FGM (NSPCC, 2013b). One in six (16 per cent) also said that they did not know that FGM is illegal in the UK, and nearly as many do not regard FGM as child abuse. One teacher who was questioned for the survey said: ‘This issue is something that I have neither heard of, nor had training around. I feel uncomfortable that I do not know enough about this to help protect the children I teach.’ Another said: ‘I suppose I really only thought it was a practice which occurred in other countries. It hadn’t occurred to me that it could happen to a child in this country in my school’ (NSPCC, 2013b).

One of the few teachers who knew enough about FGM to report her suspicion that a pupil may be a victim had a shocking response: ‘My concerns were dismissed as “unlikely” by the school’s head of child protection.’

As Lisa Harker, head of strategy at the NSPCC, says:

There are young girls in British classrooms who will be subjected to the agony and trauma of FGM and a life of pain. Teachers are on the frontline in the fight against FGM yet they clearly feel unprepared for this role. Schools and [Local Safeguarding Children Boards] must take responsibility for protecting these children by ensuring that teachers have the training, support and confidence they need to help victims of

this barbaric practice, and Government must hold them to account for this. Government guidelines are no good if teachers are unaware they exist or are unable to use them. The secret world of female genital mutilation means that teachers may be the only professionals these children come into contact with. This is why they play such a vital role in raising concerns as part of their responsibility to act on all types of suspected child abuse. (NSPCC, 2013b)

Schools currently play a key role in bringing other forms of child abuse to the attention of the authorities. It is an embarrassing missed opportunity that schools and the Department for Education are not working together with other institutions to tackle FGM systematically and bring those responsible for the crime to account.

Joan Smith, chair of the mayoral Harmful Practices Taskforce, says:

The police say that child abuse allegations usually do not come to them from the child. What [happens] is a teacher will notice a child has got bruised legs or a neighbour will ring and say, 'Look I don't want to be nosy [but] I hear this child crying.' They will [subsequently] ring social services or the police. FGM as an issue is not actually overtly addressed in the education system.

### **Police**

Professionals felt that there was a lack of a robust response from the police in cases of FGM. One professional discussed a case in which a woman had called the police to report a house in her neighbourhood where people were coming and going frequently. She had heard screaming and had seen people unable to walk properly when they left. The police had visited the property and asked whether FGM was being performed there. The occupants said 'no', and the police left.

The police need to apply the important lessons learnt from their handling of domestic violence and other forms of violence against women and girls (VAWG). Campaigning and multi-agency work was (and still is) undertaken to prevent this kind of mistake from happening. There needs to be a robust investigation whenever a report comes in of FGM.

The Metropolitan Police, for instance, has launched 148 investigations into alleged FGM cases since 2010, and yet to date there has not been a single prosecution (still less a conviction). The police have to examine their practice and see what aspects of evidence gathering and investigation are not working, so that they can finally bring those responsible for the crime of FGM to book.

### **Crown Prosecution Service**

The CPS has to make sure that prosecution goes ahead even without the victim as a witness. As previously noted, the CPS could follow similar guidelines to those used in domestic violence cases. These guidelines state that as long as a victim has confirmed the truth of a complaint, the CPS can pursue a case – if it is possible to do so without the victim's evidence, and if it is in the public interest. The gathering of evidence without the victim's involvement is not impossible with intelligence-led policing – for example, using surveillance. Scotland Yard recently pursued two cases using this approach; though they eventually concluded that the suspects were innocent, they did state that they were prepared to launch further covert operations as soon as they received new information about potential perpetrators (Bentham, 2013c).

Similarly when victims of FGM are reluctant to report the abuse or to be a witness in a case involving their own family, the CPS should make sure that the victim is supported in every way while the investigation and prosecution continues. Keir Starmer, the former director of public prosecution has said:

What I want to do is to see whether we can have a prosecution without putting the victim through that [witnessing]. So we were urging more victims to come forward and putting more support around them, that may help, but I think realistically it is going to be a victimless prosecution. I think we are getting closer to that now.<sup>4</sup>

### **Survivors coming forward and the need for appropriate support**

Professionals emphasise the importance of adult survivors/victims of FGM coming forward to report what has happened to them. When professionals come across a woman who was mutilated as a child either in this country or abroad, some mechanism needs to be in place to protect any girls in the family, since the daughters of a woman who has undergone FGM are at heightened risk (though some women who have suffered FGM refuse to allow the same thing to befall their daughters). Currently no system is in place to follow up such cases.

Professionals, however, emphasised that victims could hardly be expected to come forward, report abuse and go through the process of investigation and prosecution without having the necessary support in place. Women and girls who are victims of FGM need the kind of services that are provided to victims of domestic violence, such as shelters. This support should be mainstreamed to other VAWG services, so that women and girls can feel empowered to report that FGM is about to happen to someone close to them or to someone they know. It should never be the case that a child is put back where she is at risk of FGM.

One professional said that she had witnessed a young person at risk of FGM being questioned and then returned to the family unit, where she was at risk. This would never occur if a child had been sexually abused. Agencies such as the police should approach FGM in a way that is consistent with other VAWG approaches to keeping children from harm.

Moreover, if a child who has undergone FGM is returned to the family unit, that is likely to undermine any chance of a prosecution: the girl will be subject to pressure from her family, and, as a child, will be completely disempowered when faced with adult family members. In one case that was cited by a frustrated professional, a prosecution seemed likely, but then the child was returned to her family. After that the girl changed her story twice. The prosecution decided not to proceed with the case, as it was felt that the girl would not make a credible witness.

The lack of prosecutions for FGM in the UK has resulted in a culture of complacency among many professionals and citizens in the UK, as well as a 'green light' for those who wish to commit this crime – be they the parents who facilitate it or the 'cutters' who carry it out. The UK lags behind a number of other European countries in tackling this crime. For this state of affairs to continue would be a further injustice. 

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# 7

## France: a model of best practice

It is estimated that 61,000 women aged 18 and over have undergone FGM in France. This number does not take into account the undocumented population or those aged under 18 who may have undergone (or be at risk of) FGM (European Institute for Gender Equality, 2013b).

In contrast to the United Kingdom, France has long had a commitment to prosecuting cases of FGM. Between 1979 and 2004, a total of 29 cases were brought before criminal courts. Most were from the mid-1990s onwards and involved aggravated offences, like cruelty towards a minor (European Institute for Gender Equality, 2013b).

### Laws

France has no specific legislation on FGM. Instead it relies on existing laws, such as offences against the person and assault or cruelty. General provisions of the penal code have been applied in cases of FGM – in particular those articles that refer to acts of torture and barbarity and those that deal with intentional bodily harm causing permanent infirmity or mutilation. An offence committed against a minor is regarded as an ‘aggravating circumstance’ that increases the penalty imposed. The principle of extraterritoriality is applicable, so that FGM is punishable even if carried out abroad.

In France, general child protection law may be applied in cases of FGM. Social protection measures for persons under the age of 18 are listed in Article 375 of the civil code: in cases where a child suffers psychological or physical abuse at home, a judge can order the child to be placed in a public institution, in a family shelter or under the responsibility of an authorised association. The Domestic Violence Act of 2006 allows perpetrators of violence against children to be evicted from their residence and prevented from having any contact with their victims. The Act Reforming Children’s Protection Provisions of 2007 replaced the idea of children suffering psychological or physical abuse at home with the more inclusive concept of

‘endangered children’. Rather than just stipulating punishment, this Act envisages a more collaborative approach involving parents, on whom it imposes educational measures.

### Policy

The first policy instruments on FGM in France were adopted at a regional level in the mid-1990s, and most were developed after 2004. France focused primarily on criminalising the practice. After the passage of the Domestic Violence Act of April 2006, a number of policy documents were developed that dealt with violence perpetrated by couples against children. These policies consisted of a set of preventive and educational measures at the regional and the national level (in the social, educational and health sectors). Though they do not form a single comprehensive package, the documents are often referred to as the ‘Action Plan on FGM’. FGM was also addressed as part of the National Action Plan on Violence against Women 2008–10.

The subsequent National Action Plan on Violence against Women 2011–13 does contain a specific chapter on FGM, with a detailed set of measures and a budget of EUR 288,500. The measures include dissemination of the findings of a prevalence study; awareness-raising among migrants from countries that practise FGM; training of professionals and officers from embassies and consulates; and improving the protection of girls with refugee status, or who have had ‘subsidiary protection’ granted, and who are at high risk of FGM.

In France, the Mother and Infant Protection Services play a key role in preventing FGM and monitoring girls at risk. They have issued a protocol on FGM, which addresses the genital screening of girls and recommends how to deal with mutilation.

In France, any girl who has been identified as at risk of FGM will be the subject of mandatory intervention from the authorities and children’s social care. As part of this intervention, there will be a compulsory medical examination at the outset

of the investigation, plus annual examinations and an examination when the girl returns to France from abroad. If, while under the management of the authorities, the girl is found to have suffered FGM, the parent or carer could be prosecuted (Carroll, 2010).

**“Some anti-FGM activists in France are appalled that migrants occasionally resort to sending their daughters to Britain to have them mutilated here”**

In fact, some anti-FGM activists in France are appalled that migrants occasionally resort to sending their daughters to Britain to have them mutilated here. In an interview with the BBC, Isabelle Gillett-Faye, an anti-FGM activist in France, recounts the story of two little girls about to board a train for London:

It was a Friday. We heard just in time. They had tickets for the Saturday. A family member tipped us off. We told the police and they were stopped from making the journey. The parents were cautioned. Had they gone ahead with the mutilations and been found out, they would have been imprisoned for up to 13 years.

As she says: ‘In England you are very respectful of your immigrants. It is very different in France. They have to integrate and they have to obey our laws ... We simply will not tolerate this practice’ (Lloyd Roberts, 2012).

### **France: good practice**

Linda Weil-Curiel is a French anti-FGM activist based in Paris. We interviewed her for this report in an attempt to shed some light on what has worked

particularly well in France to combat FGM and prosecute perpetrators. She attributes the success to a range of interventions and measures taken both by the government and by activists.

### **Working with health professionals**

Anti-FGM activists like Linda have made sure that medical professionals, such as doctors, are aware that any failure to report a case of FGM could amount to complicity in a crime. At first this encountered some resistance:

They said ‘It has already been done’ or ‘It’s not our business’ or ‘It’s their culture.’ I would respond: ‘Children should be raised in the best health. If you pretend that once a girl has been cut, that’s it, then you are wrong; if you do nothing, it will mean that you are responsible when the next girl in the family is cut. Besides, what if a girl grows up and blames her doctor and says “Why didn’t you protect me? Is it because I am black?”’

Back in 1984, new legislation came into force that protected professionals who breached patient/doctor confidentiality from being punished, so long as they were reporting harm or potential harm. This made medical professionals more ready to report cases of FGM.

**“In England you are very respectful of your immigrants. It is very different in France. They have to integrate and they have to obey our laws ... We simply will not tolerate this practice’ – Isabelle Gillett-Faye, anti-FGM activist, on the BBC website”**

### **Making professionals responsible**

Linda says that responsibility for identifying and dealing with FGM has shifted. No longer is it the case that the victim is expected to come forward and report the matter; rather it is up to professionals who encounter girls or women who have been mutilated:

In some FGM cases, the victim is a minor and cannot ask for a prosecution. This is why it is so crucial that teachers, nurses, doctors and neighbours report it when they think there is a risk or when it has already been done. Kids always want to protect and defend their parents.

### **Providing compensation**

As well as focusing on criminal prosecution and convictions, France tries to ensure that the victims of FGM are compensated. Fines are imposed and the money collected goes into a separate compensation fund, which the child can access at the age of 18. If the parents have no money, the state steps in – but the parents have to pay the state back eventually. As Linda recalls, in one case a woman who had performed FGM was given a suspended sentence but fined EUR 15,000 per child. She explains:

Once the lawyers have summed up a case, the jurors and judges discuss it. They come back, give a verdict and pass a sentence. Immediately afterwards, proceedings for civil compensation begin and the parents are called to the dock and told how much they need to pay – it hits them where it hurts.

### **Prosecution as a form of prevention**

Linda also stresses the deterrent effect of prosecution. She recalls cases where younger daughters have not been cut because a prosecution was brought over mutilation of the eldest. Besides, older girls tell their sisters not to go to the country of origin on holiday. Linda claims that the issue is not a lack of awareness: 'All the African mothers are very well aware that

FGM is a crime in France. The only thing that deters them from doing it to their daughters is prison.'

She mentions a case involving a family from Guinea that has lived in France for 20 years and has four girls. When the eldest needed medical attention for appendicitis, the surgeon noticed that the girl had undergone FGM. The police were informed and the parents were summoned. It was discovered that the two eldest daughters had undergone FGM. The father was prosecuted and swore that the same would not happen to his two younger daughters. A few years later, however, one of the older daughters called the paramedics, who arrived to find a little girl bleeding. The surgeon found that she had been cut deeply. The police were called, and they discovered the flesh in the bin. The little girl, however, trying to protect her parents, said that she bled when she was 'pushing her poo'. Only later did she tell a nurse that she had been 'taken to a small room and hurt'. All the girls were so frightened that they denied what had happened even in court, until they saw the pictures and heard the doctors' testimony.

### **Victims protected through the process**

In France today, children and victims of FGM have a legal advocate representing them and supporting them throughout a legal case. Since 1989 there has been a special body – 'tutors for minors' – for when minors' interests stand in opposition to those of their parents. The investigating judge, as the prosecutor, will appoint a 'tutor' and the tutor will appoint a legal advocate for the child.

France is a shining example of how, with political will and a firm commitment to one law for all, hurdles can be overcome and prosecutions achieved in cases of FGM, however complex. France decided to ignore the unjust accusations of racism and 'cultural insensitivity' and treat FGM as it would other forms of serious child abuse. The result has been a clear message to the potential perpetrators that this crime will be neither overlooked nor tolerated. 🌟

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# 8

## Conclusion and recommendations

Current official estimates of the prevalence of FGM in the UK are based on out-of-date census information, and fail to take account of the substantial increase in immigration that has occurred over the past 12 years. Through our own research, we have demonstrated that the number of women and girls in the UK who are living with FGM is in the region of 170,000 – almost three times the current official estimate. Furthermore, 65,000 girls aged 13 and under are at risk of mutilation.

These women and girls have been systematically failed. Support for existing victims of FGM and protection for those who may be at risk both rely on a better implemented and more coordinated response across all the institutions – and a commitment to prosecuting those who commit this crime. However, it is also vital that FGM should be recognised for what it is – child abuse and violence against women – and not simply dismissed as a ‘cultural practice’ that is beyond intervention.

### Prosecutions

Nothing would boost the campaign against FGM more powerfully than a few high-profile convictions. That would send out a message loud and clear that the state is taking the problem seriously.

**“Nothing would boost the campaign against FGM more powerfully than a few high-profile convictions”**

We have seen a tidal wave of high-sounding rhetoric, policy initiatives, task forces, protocols and health passports, yet not a single mutilator has been taken to court – never mind put behind bars. Until that happens, all the state’s activities will carry no weight whatsoever. For too long, the Crown Prosecution Service has demonstrated

insufficient determination. Fears about the difficulties involved have had a paralysing effect.

Britain needs to follow the example of France, where a real threat of prosecution and prison has undoubtedly had a deterrent effect.

### Reframe the debate

For too long in Britain, female genital mutilation has been presented as a cultural issue. But it is not: it is an issue of abuse against children and violence against women. All the institutions of the state should be committed to reframing the debate, thereby making FGM wholly unacceptable on any basis in our society. In recent years, we have witnessed transformations in public attitudes to homophobia, domestic violence, drink-driving and child sexual abuse. The same should happen with FGM.

### Better engagement with communities

All agencies working on FGM, whether statutory or non-statutory, have a responsibility to engage more with local communities where FGM is common and to raise awareness across the board about child welfare and protection. Communities and individuals within those communities need to feel well equipped and informed on where to go for help or advice if and when they suspect or know that FGM is happening or is about to happen.

### Publicity

There should be a nationwide anti-FGM public awareness campaign. Posters in health clinics, GP surgeries, schools and other public and community centres should state unambiguously that FGM is a crime, set out the penalties that the crime carries, highlight the health hazards, provide information on services and the support available to victims, and explain how to pass on any relevant information about FGM that has been or is about to be committed.



## Develop a coordinated multi-agency approach

A multi-agency approach to FGM – primarily involving the education, health and local authorities, the police and the CPS – needs to be developed to ensure that all information on suspected FGM cases is shared and communicated appropriately. These institutions need to be able to work together on cases, sharing intelligence to ensure that girls at risk of FGM are not lost in the system, and receive the attention they need. A more joined-up approach within the agencies will improve every stage in bringing an FGM case to court and securing a prosecution.

## Introduce mandatory training for professionals

It is clear that there is a need for mandatory, dedicated, FGM-specific training for all professionals in law enforcement, social services, the health sector and schools who come into contact with girls who may be at risk of FGM or who have already experienced it. Professionals need to possess the ability to recognise and identify those at risk or those who have already undergone FGM, know how to deal with these cases appropriately and be aware of what the next steps should be in terms of recording and reporting the information.

## Enforce mandatory recording, reporting and medical examinations

In order to ensure that all suspected cases reach the police for investigation, there need to be clear guidelines and procedures in place for all professionals to follow if they suspect that a girl is at risk of, or has undergone, FGM. This structured form of recording cases as FGM specific and reporting them needs to be rigorous, consistent and mandatory across all institutions, leaving the decision on how to proceed with the recorded information up to the police and the CPS. All health

professionals in a suspected FGM case should be required to carry out a medical examination to establish whether the individual concerned has undergone FGM – information that can later be used as evidence in court. A medical examination should also be mandatory when a case of suspected FGM is received by the police or the social services.


Medical examinations should be treated as a helpful part of investigations into FGM, rather than as something invasive or unnecessary. If professionals are certain about the FGM status of a potential victim, not only can they provide the necessary medical and emotional support for that victim, but they can also use the information to determine whether other family members may be at risk.

## More support for victims

There is a need for girls at risk of FGM (and their families) to have access to refuges. They need to be able to turn to agencies in time of need and know that they will receive confidential support, advice and accommodation if needed. Those that have already undergone FGM also need access to sensitive

**“It is clear that there is a need for mandatory, dedicated, FGM-specific training for all professionals ... who come into contact with girls who may be at risk”**

psychological support, if required, and to medical centres where reversal surgery can be performed, if the individual so desires.

Support for the victim can and should assist the police and prosecutors in detecting and convicting the criminals responsible for this heinous crime. Nothing less will do. 

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## Appendix A: Survey findings

Figure 1

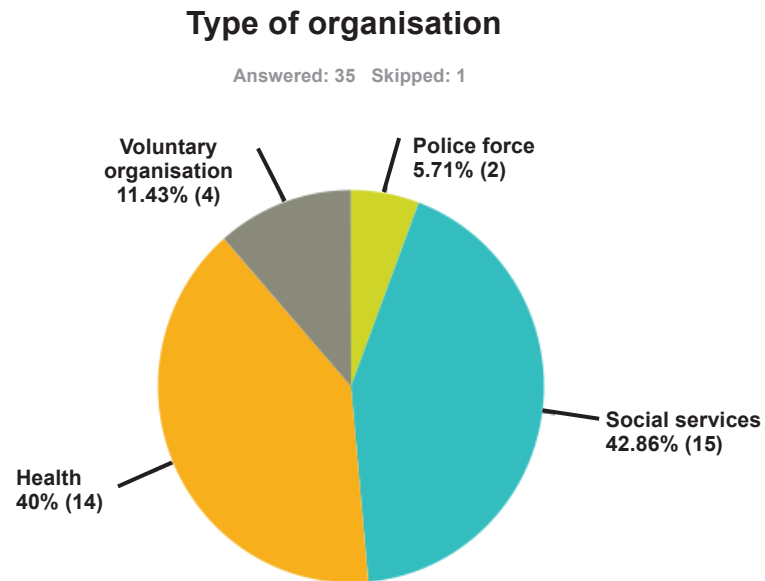


Figure 2

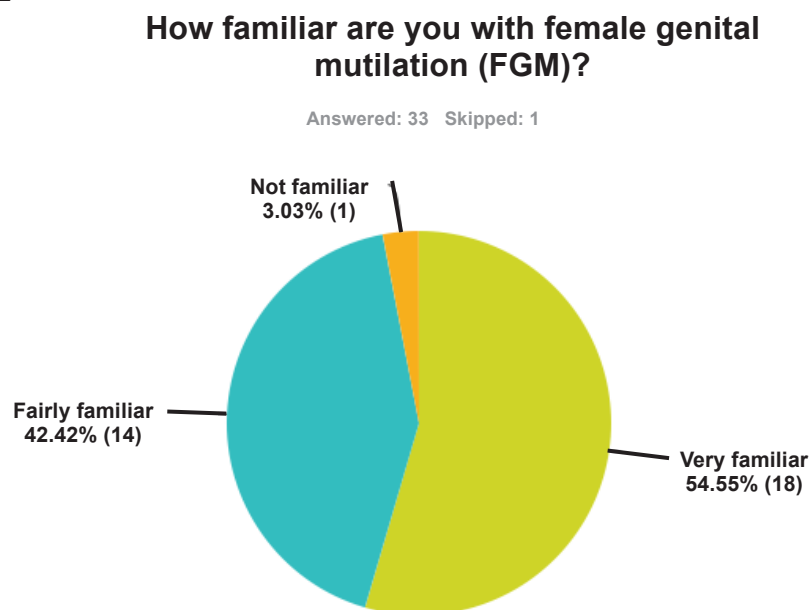


Figure 3

### Have you ever had training on FGM?

Answered: 31 Skipped: 5

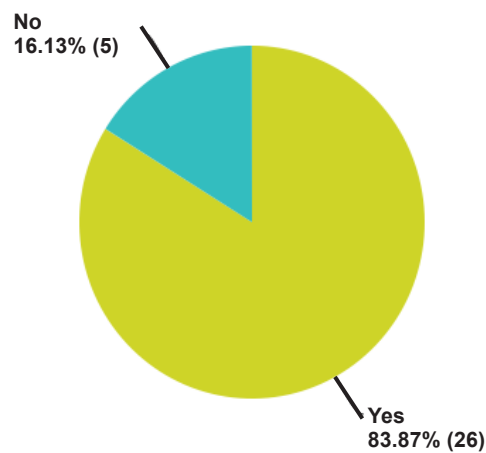


Figure 4

### What do you think best describes FGM? (Please tick all that apply)

Answered: 33 Skipped: 3

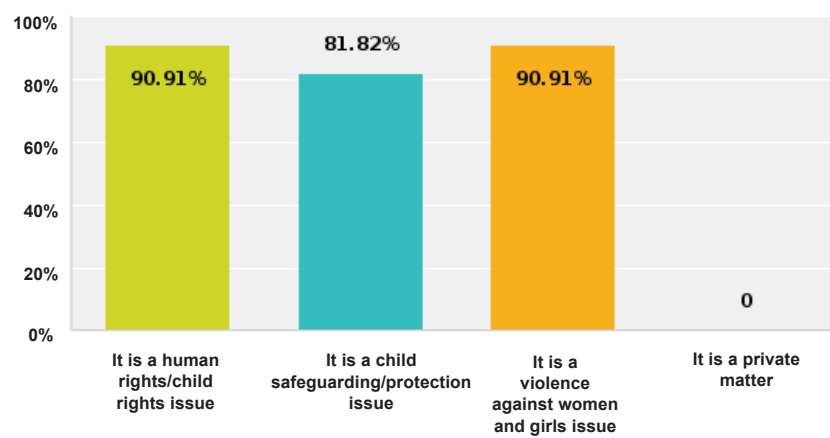


Figure 5

**Did you know that FGM is a criminal offence in the UK (since 1985)?**

Answered: 33 Skipped: 3

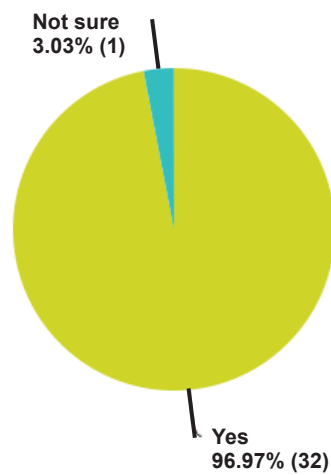


Figure 6

**Which of the following FGM-related acts do you think are criminal offences under UK laws? (Please tick all that apply)**

Answered: 33 Skipped: 3

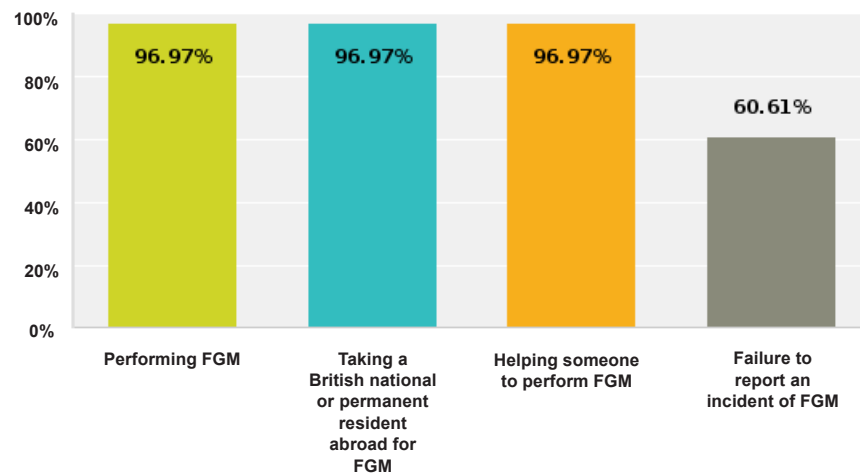


Figure 7

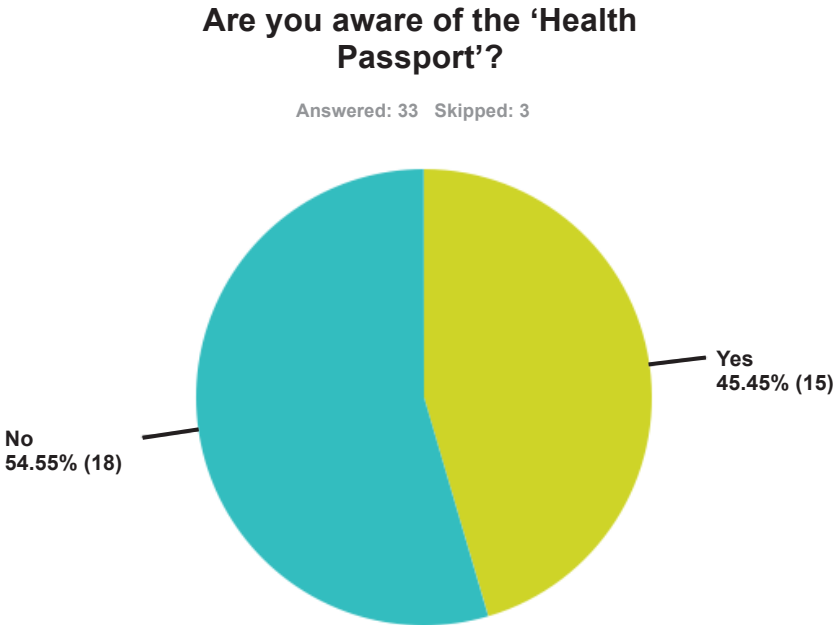


Figure 8

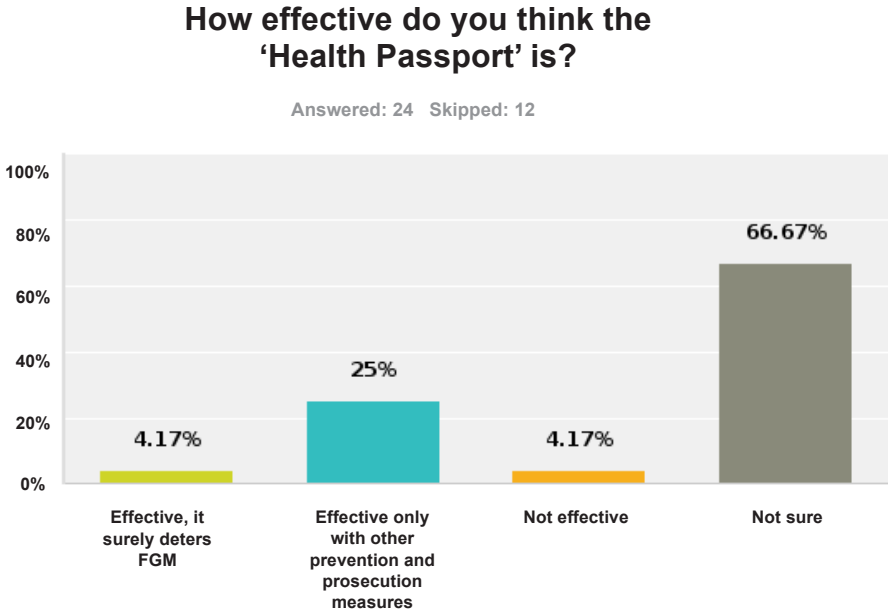


Figure 9

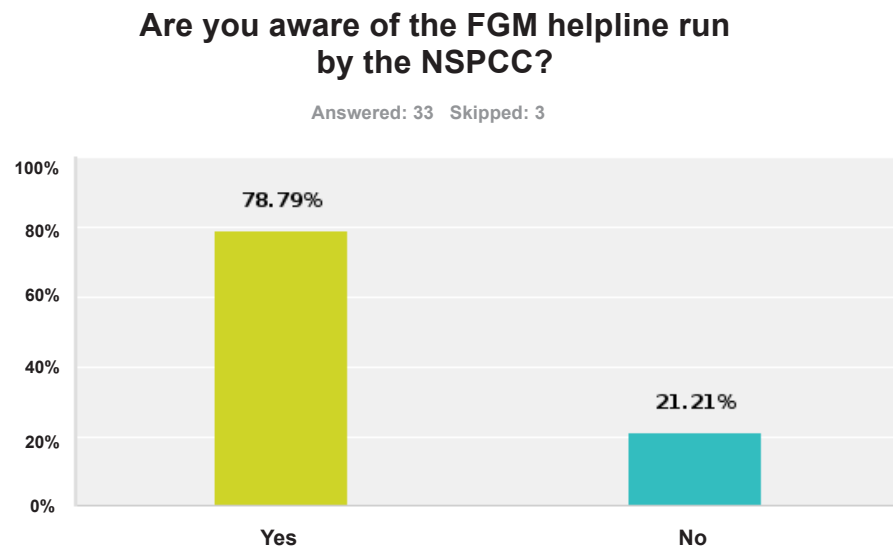


Figure 10

**If you answered 'Yes' to the previous question, have you used the helpline?**

Answered: 26 Skipped: 10

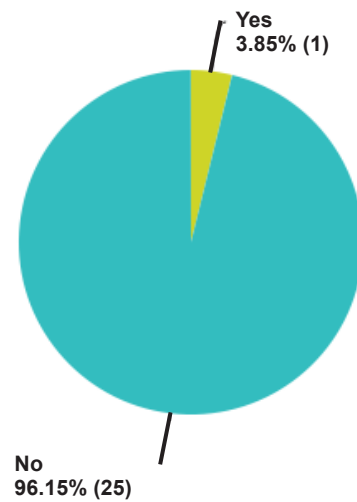


Figure 11

**If you have come across a case of FGM, what measures did you take to deal with the issue? (Please tick all that apply)**

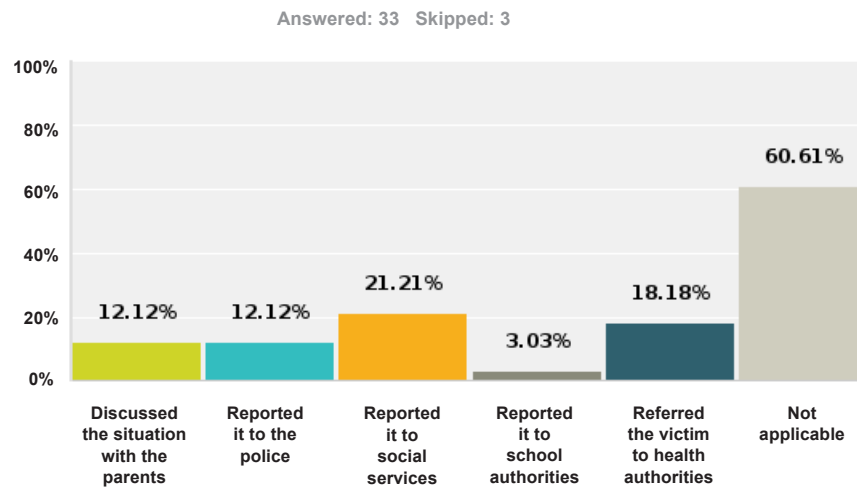


Figure 12

**If you have dealt with a case of FGM, what was the outcome? (Please tick all that apply)**

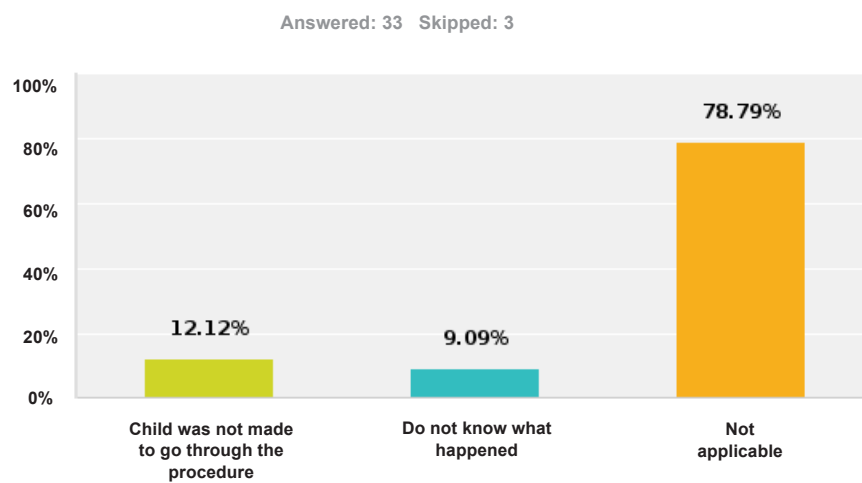


Figure 13

**Does your agency/organisation have any internal guidelines on how to deal with FGM cases?**

Answered: 31 Skipped: 5

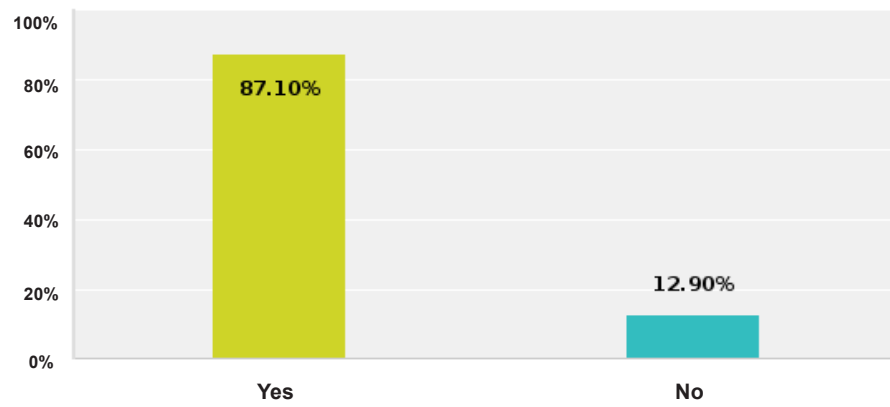


Figure 14

**As an organisation/agency do you use other external guidelines when dealing with FGM cases?**

Answered: 31 Skipped: 5

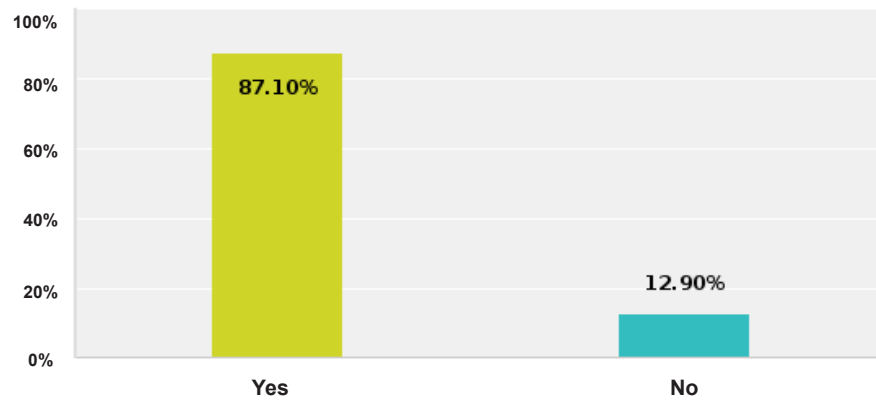




Figure 15

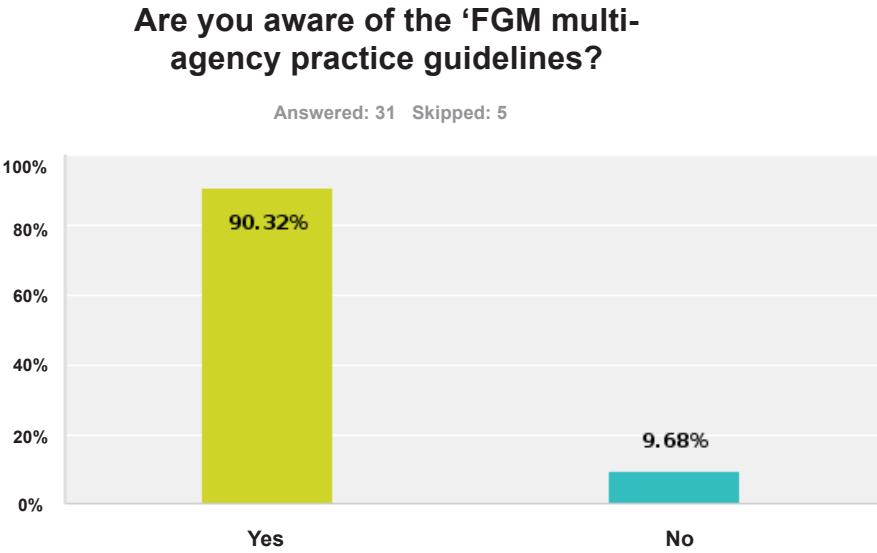


Figure 16

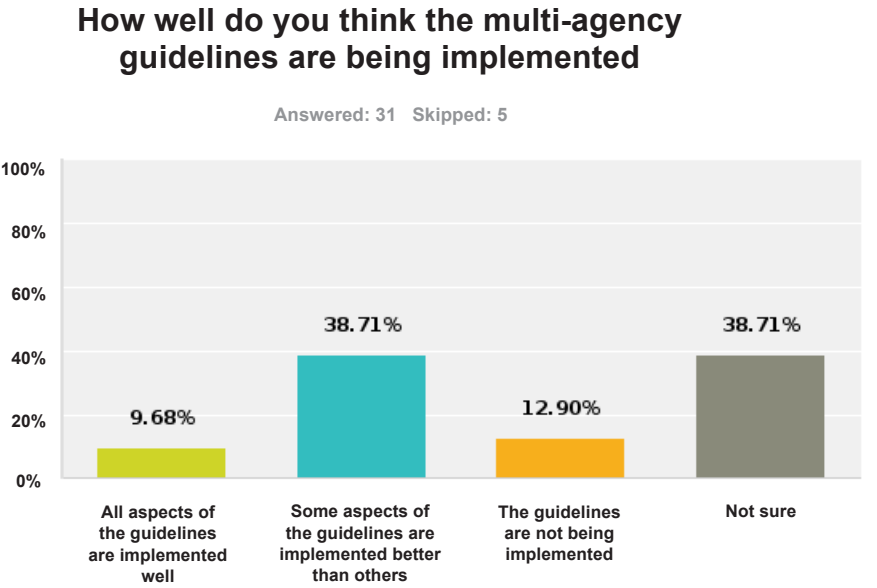
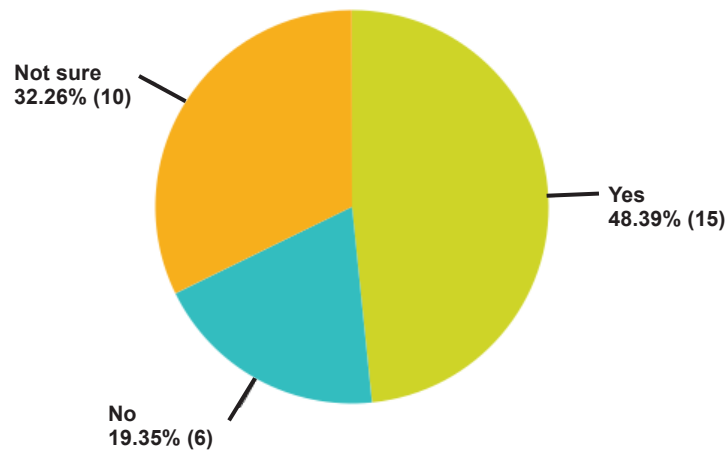


Figure 17

**Does your organisation/agency keep records of women and girls who have undergone FGM or are at risk of FGM?**

Answered: 31 Skipped: 5

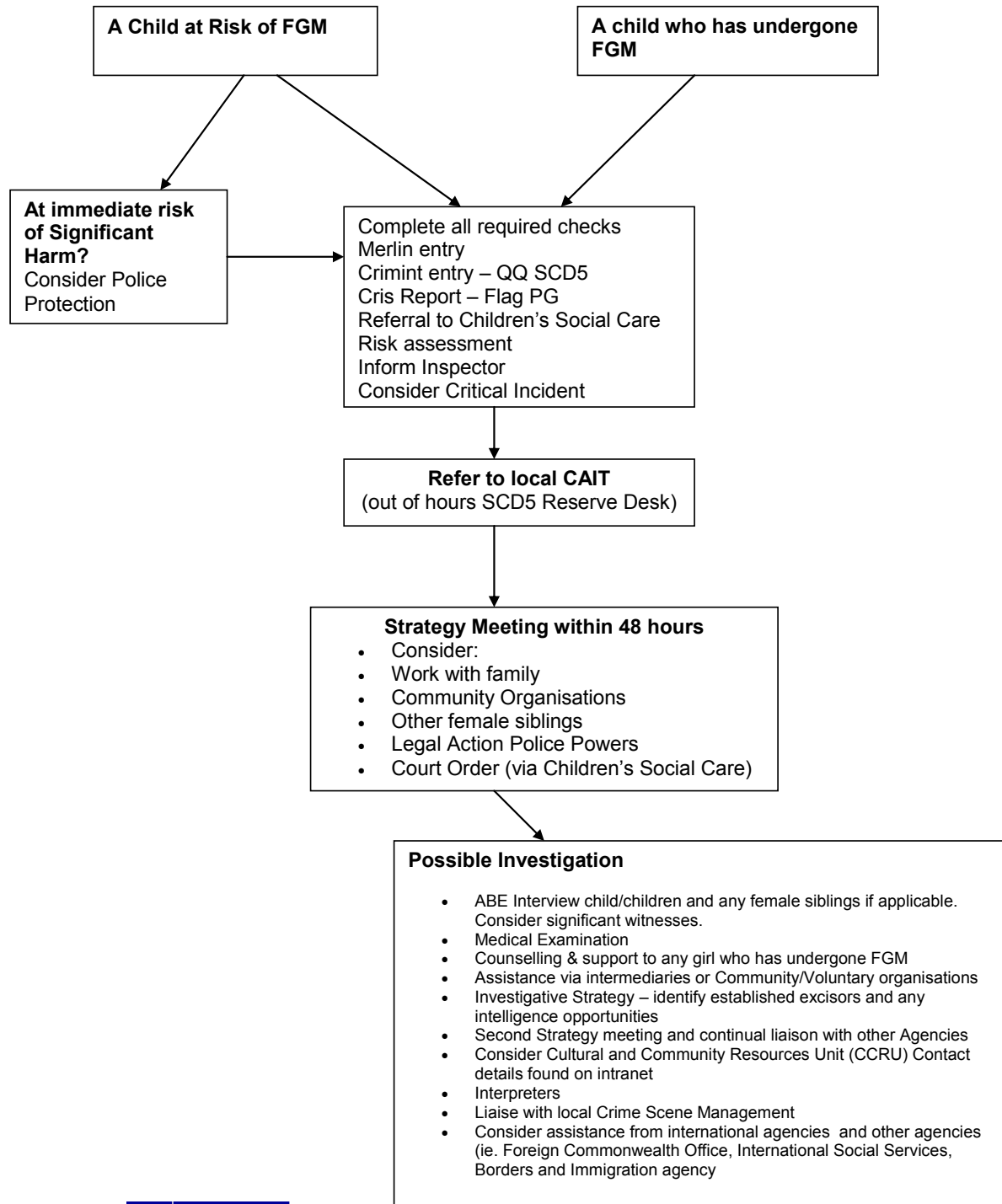


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## Appendix B: Interview questions

1. Do you think using the criminal justice system is an appropriate mechanism to tackle FGM?
2. Why do you think there have not been any convictions so far? In your opinion, where does the problem lie?
  - a. In the community
  - b. The victims (not giving evidence or reporting it in the first place)
  - c. The police not taking up cases and investigating
  - d. The CPS not taking cases on board and prosecuting
  - e. Professionals in health, education, etc. not being able to identify cases or not knowing what to do when they are aware of cases.
3. What ways do you think are best to gather the appropriate evidence and bring perpetrators to account?
  - a. Health checks
  - b. Working with schools to identify those going on holidays or at risk
  - c. Making reporting of the crime mandatory.
4. What do you think is missing in supporting victims and holding perpetrators accountable?
5. In your role, what do you do in terms of identifying, reporting, investigating or prosecuting cases?  
Does your role have such a remit?
6. What is the way forward on this?

## Appendix C: Female genital mutilation – a guide to investigation



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## Appendix D: Methodology

### Introduction

Data from the 2011 UK census was used along with recent data on births to update existing estimates on the number of women living in the UK with female genital mutilation and on the number of girls at risk of FGM. Previous estimates came from FORWARD/Department of Health (2007). The main assumption made in the calculations that follow is that the rates of FGM among groups in the UK are the same as are found back in the mother's country of birth.

### Number of women born in the UK and living with female genital mutilation

A number of countries are known to practise FGM. This paper uses the same list of countries as appeared in FORWARD/Department of Health (2007). The 2011 census gives information on the UK population by country of birth.

For larger population groups (from Kenya, Nigeria and Somalia), the Office for National Statistics (ONS) published data by country of birth and gender. For other countries, the data was only available by country of birth, and an assumption of a 50:50 split in gender had to be made.

This calculation yielded a figure of 406,600 for the number of females living in the UK (in March 2011, at the time of the census) who were born in a country where FGM is practised. This is a rise of 214,000 over the ten years since the 2001 census and suggests that the population of women and girls who were born in countries where FGM is routinely practised grew at an average rate of 21,000 a year.

Many of the women, especially from Somalia, will have come to the UK via the asylum route, either as the main applicant or as a family member. The number of initial asylum claims was higher in the early part of the last decade than in the latter; but these have been followed by further flows, as family members come to join the initial asylum claimant. It is therefore a reasonable assumption that the growth in the number of females born in FGM-practising

countries between March 2011 and the end of 2013 continued at roughly the same rate as in the previous decade. This would add a further 52,500 to the population, giving a total figure of 459,100. It is estimated that of these 94 per cent are aged 15 or over, which means the number of 'adult' women would be 431,500.

The rates of FGM in each country are taken from the Orchid project website (<http://orchidproject.org/fgc-map/>). In most countries, the rates stated are similar to those given in FORWARD/Department of Health (2007), since they often both refer to the same source. The rates of FGM in each country were applied to the number of women born in that country to give a figure of 171,600. This should be rounded, given the uncertainties. Therefore, it is estimated that the number of women living in the UK with FGM is **170,000**.

This figure is likely to be an underestimate, since it does not include women born here, or in another European country, who have already undergone FGM. FORWARD/Department of Health (2007) also recognised this issue. Census information cannot distinguish second-generation migrants by the country of birth of their mothers. In addition, the census is likely to be an undercount, as a proportion of the women living in the UK with FGM will have no legal status to remain and so are unlikely to have responded to the census questionnaire.

### Number of girls living in the UK at risk of female genital mutilation

There are two components to this figure:

1. The number of girls born in the UK to mothers from countries where FGM is practised.
2. The number of girls born in countries where FGM is practised and who then move to the UK.

The first component is the larger of the two.

#### Component 1

The ONS collects data on births to non-UK-born

mothers by country of birth. The data for selected countries is published, while data for other countries had to be requested from the ONS. Children born in 2001 or later will be under the age of 13 at the end of 2013. The sex of the child is not recorded, and so it is assumed that half the births were female. It is estimated that a total of 117,100 girls were born to mothers from countries where FGM is practised.

The FGM rate in the mother's country of birth was applied to the number of girls born to give an estimated **58,200** girls under the age of 13, born in the UK and at risk of FGM (of these around 30,000 have Somali-born mothers).

### **Component 2**

In addition, there are 18,000 girls under the age of 13 who live in the UK but were born abroad, in FGM-practising countries (an estimated 4 per cent of the female population of 459,100).

Again by applying the relevant FGM rates, it can be estimated that there are **7,300** girls under the age of 13 living in the UK but born in FGM-practising countries.

### **Components 1 and 2 combined**

In total, it is therefore estimated that there are some **65,000** girls under the age of 13 and living in the UK who are at risk of FGM. ↪

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