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Female Genital Mutilation and Designer Vaginas in Britain: Crafting an Effective Legal and Policy Framework

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ARTICLES

Female Genital Mutilation and Designer Vaginas in Britain: Crafting an Effective Legal and Policy Framework

*Lisa R. Avalos**

ABSTRACT

The prevalence of female genital mutilation (FGM) in Britain and Europe has grown in recent years as a result of international migration, and European institutions have grown increasingly concerned with eradicating the practice. According to the European Parliament, approximately 500,000 girls and women living in Europe have undergone FGM and are suffering with the lifelong consequences of the procedure, and more than 30,000 girls in Britain are thought to be at risk of future FGM. Although Britain strengthened its law against FGM in 2003, the number of girls at risk continues to grow, and there have been no convictions for FGM in England and Wales. This Article examines Britain's legal and policy approach to FGM, analyzing key gaps in British law that allow girls at risk to go unprotected and giving a range of policy suggestions for closing these gaps.

* Assistant Professor of Law, University of Arkansas School of Law. I would like to thank Naana Otoo-Oyortey, Sharon Foster, William Foster, Rukayah Sarumi, and Stephen Sheppard for their insightful comments on this paper, and Ann Marie Carson and Grace Casteel for superb research assistance. I would also like to thank Susan Deller Ross, Sarah Creighton, Comfort Momoh, Koshuma Mtengeti, Sandra Gulyurtlu, Amina Ali, Victoria Hill, Zahra Ibrahim, and Dexter Dias for sharing their experiences and perspectives with me. This paper was prepared in consultation with the Foundation for Women's Health, Research and Development (FORWARD) as an aid to their advocacy work. FORWARD is an African Diaspora women-led, UK-registered campaign and support charity dedicated to advancing and safeguarding the sexual and reproductive health and rights of African girls and women. They work in the UK, Europe, and Africa to help change practices and policies that affect access, dignity, and wellbeing. They tackle female genital mutilation, child marriage, and related rights of girls and young women.

The Article also gives particular attention to the relationship between FGM and so-called “designer vagina” surgeries, addressing the double standard whereby FGM is prohibited by law while designer vagina surgery has been allowed to flourish. The Article concludes with legal and policy recommendations for increasing protection against FGM and for coordinating the approach to FGM and designer vagina surgery. In particular, it proposes a Model FGM law that is much more robust than Britain’s current FGM law and provides additional opportunities to protect those at risk and to prosecute those who facilitate or carry out FGM.

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I. INTRODUCTION

In March of 2014, Dr. Dhanuson Dharmasena was charged with carrying out female genital mutilation (FGM) on a patient at Whittington Hospital in north London.¹ Less than two months later, a thirty-eight-year-old woman was arrested at Heathrow airport for

1. See Owen Bowcott, *Two Men First to Be Charged in UK Under FGM Act*, GUARDIAN (U.K.) (Mar. 21, 2014, 7:38 AM), <http://www.theguardian.com/uk-news/2014/mar/21/fgm-female-genital-mutilation-men-charged> [<http://perma.cc/89LW-ZCNK>] (archived Jan. 29, 2015).

The World Health Organization (WHO) classifies female genital mutilation into four major types:

1. Clitoridectomy: partial or total removal of the clitoris (a small, sensitive, and erectile part of the female genitals) and, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
2. Excision: partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are 'the lips' that surround the vagina).
3. 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.
4. Other: all other harmful procedures to the female genitalia for nonmedical purposes, e.g., pricking, piercing, incising, scraping, and cauterizing the genital area.

Female Genital Mutilation: Fact Sheet N°241, WORLD HEALTH ORG. [hereinafter *Fact Sheet N°241*], <http://www.who.int/mediacentre/factsheets/fs241/en/> (last updated Feb. 2014) [<http://perma.cc/Z79U-D6YR>] (archived Jan. 29, 2015).

conspiracy to commit FGM.² The woman was a British national who was born in Sierra Leone and had just arrived at Heathrow on a flight from Sierra Leone.³ She was travelling with a thirteen-year-old Sierra Leonean girl who was taken into the care of social services at the time of the woman's arrest.⁴ These actions were Britain's first-ever attempts to prosecute someone for performing FGM despite the fact that FGM has been prohibited by law since 1985. FGM is usually associated with a range of countries, primarily in Africa, but it has become a serious concern in western countries as immigrants from FGM-affected countries have brought the practice with them.

FGM in the West is not an isolated and infrequent occurrence. Approximately 500,000 girls and women living in Europe have undergone FGM and are suffering with the lifelong consequences of the procedure⁵ and more than 30,000 girls in Britain are thought to be at risk of FGM.⁶ Since 2009, nearly 4,000 patients have been treated at hospitals across London for FGM-related complications.⁷ The British Crime Survey has recorded over one hundred instances of FGM annually since it began tracking this crime in early 2008.⁸ In addition to its prevalence, those who speak out against FGM face harassment, intimidation, and even death threats for their actions.⁹ For example,

2. See *Female Genital Mutilation: Woman Arrested at Heathrow*, BBC NEWS (May 9, 2014, 11:49 AM), <http://www.bbc.com/news/uk-england-london-27348776> [<http://perma.cc/XY9S-VZPU>] (archived Jan. 29, 2015).

3. See *id.*

4. See *id.*

5. See Resolution on Combating Female Genital Mutilation in the EU, EUR. PARL. DOC. 2008/2071 (INI) ¶ H (2009).

6. *Communication from the Commission to the European Parliament and the Council: Towards the Elimination of Female Genital Mutilation*, at 5, COM (2013) 833 final (Nov. 25, 2013) [hereinafter *Towards the Elimination of Female Genital Mutilation*]. For an earlier estimate, see EFUA DORKENOO, LINDA MORISON & ALISON MACFARLANE, FOUND. FOR WOMEN'S HEALTH, RESEARCH & DEV. (FORWARD), in collaboration with THE LONDON SCH. OF HYGIENE & TROPICAL MED. & THE DEPT OF MIDWIFERY, CITY UNIV., A STATISTICAL STUDY TO ESTIMATE THE PREVALENCE OF FEMALE GENITAL MUTILATION IN ENGLAND AND WALES 25 & tbl.7 (2007).

7. See *FGM: Thousands of Women Treated in London Hospitals*, GUARDIAN (U.K.) (Mar. 19, 2004, 8:50 AM), <http://www.theguardian.com/society/2014/mar/19/fgm-women-london-hospitals-female-genital-mutilation> [<http://perma.cc/YCH5-MNBS>] (archived Jan. 29, 2015). In particular, women who have undergone Type 3 FGM frequently seek out medical treatment in order to have the seal over the vagina opened so that urine and menstrual blood can pass more freely. Comfort Momoh, a midwife at Guy's and St. Thomas Hospitals, London, has done upwards of three hundred of these procedures annually since 1997. See Interview with Comfort Momoh MBE, Midwife, Guy's and St. Thomas' Hospital, in London, Eng. (Sept. 21, 2012) (on file with author).

8. This figure covers the time period 2008–2011, the latest year for which figures are available. HOME OFFICE STATISTICAL BULLETIN, CRIME IN ENGLAND AND WALES 2010/11, at 42 (Rupert Chaplin, John Flatley & Kevin Smith eds., 2011).

9. See Amelia Hill, *Female Genital Mutilation Campaigners Face Death Threats and Intimidation*, GUARDIAN (U.K.) (May 8, 2013, 4:48 PM), <http://www.theguardian.com/society/2013/may/08/female-genital-mutilation-death-intimidation> [<http://perma.cc/RSK9-QL6A>] (archived Jan. 29, 2015).

Efua Dorkenoo, Senior Advisor to Equality Now on FGM,¹⁰ has received death threats aimed at stopping her from speaking out against FGM.¹¹ Dorkenoo states that the backlash against women who speak out against FGM is getting more extreme: “It’s getting worse for young girls because social media means they can be threatened and harassed by people outside of their community, including by family members back in Africa who are told what they’re doing.”¹² Accordingly, FGM is a serious problem in the UK, and concern is growing over the fact that there has not yet been a prosecution for FGM.¹³

The potential prosecutions described above represent one prong of the British government’s recent efforts to more effectively combat FGM, but prosecutions alone cannot effectively curtail a cultural phenomenon as complex and entrenched as FGM. In December 2013, a parliamentary committee was convened to address what other measures were needed in the fight against FGM in the UK—an action that implicitly recognized that a range of strategies was necessary.¹⁴ At a time when international organizations have heightened efforts to end FGM and countries such as Ireland, Uganda, and Kenya have strengthened their anti-FGM laws,¹⁵ it is critical to consider how Britain’s approach to FGM might be strengthened.

10. *Efua Dorkenoo*, EQUALITY NOW, http://www.equalitynow.org/people/efua_dorkenoo (last visited Feb. 27, 2015) [<http://perma.cc/B452-CUVX>] (archived Jan. 29, 2015).

11. See Hill, *supra* note 9.

12. *Id.*

13. See COMMONS SELECT COMM., *Committee Announce New Inquiry into Female Genital Mutilation*, UK PARLIAMENT (Dec. 18, 2013) [hereinafter *Committee Announcement*], <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/news/131218-new-inquiry-fgm/> [<http://perma.cc/VVU9-L2TT>] (archived Jan. 29, 2015). The Right Honorable Keith Vaz MP, Chair of the Committee, stated,

It is shocking that 28 years on from female genital mutilation first being made a criminal offence, there has not yet been a successful prosecution in the UK. The Committee’s inquiry will seek to find out why this is the case, as well as considering what more needs to be done to protect at risk girls. We would welcome evidence from those affected by this hideous crime as well as those whose responsibility it is to protect them.

Id.; see also Alexandra Topping, *FGM Inquiry Launched to Uncover Reasons for Lack of Prosecution in UK*, GUARDIAN (U.K.) (Dec. 18, 2013, 5:59 PM), <http://www.theguardian.com/society/2013/dec/18/fgm-inquiry-lack-prosecution-uk-female-genital-mutilation> [<http://perma.cc/WQ8M-B5RV>] (archived Jan. 29, 2015).

14. See *Committee Announcement*, *supra* note 13.

15. See Christine Bohan, *Female Genital Mutilation Officially Banned in Ireland*, JOURNAL (IR.) (Mar. 28, 2012, 8:28 PM), <http://www.thejournal.ie/female-genital-mutilation-officially-banned-in-ireland-399707-Mar2012/> [<http://perma.cc/2DMC-QDHP>] (archived Jan. 29, 2015) (describing new legislation in Ireland that prohibits and criminalizes the practice of FGM); Sarah Boseley, *FGM: Kenya Acts Against Unkindest Cut*, GUARDIAN (U.K.) (Sept. 8, 2011, 4:00 PM), <http://www.theguardian.com/society/sarah-boseley-global-health/2011/sep/08/women-africa> [<http://perma.cc/2NAZ-ZLBA>] (archived Jan. 29, 2015) (exploring Kenya’s law that not only makes it illegal “to

This Article analyzes Britain's legal and policy framework on FGM. It examines the key gaps in Britain's approach that allow FGM to continue and gives a range of policy suggestions for closing these gaps. Part II of the Article briefly sets out the legislative context, reviewing British laws that are relevant to FGM as well as resolutions and other materials from the European Union, the Council of Europe, and the United Nations. Part III then identifies specific weaknesses in the existing legal framework and also explores other obstacles to ending FGM in Britain. It particularly examines the need for better research and data collection, and it discusses a range of obstacles to ending FGM, particularly cultural obstacles in communities and barriers that prevent professionals who come into contact with those at risk from intervening effectively.

Part IV explores how Britain can create an enabling policy and legal environment for ending FGM, and it makes a range of recommendations. The recommendations include adopting a national action plan on FGM, using existing domestic violence legislation more effectively, and revising and strengthening the existing law against FGM. With respect to the latter, the Article includes a model FGM law and explains the rationale behind each aspect of the model law. Part IV also includes recommendations for working with communities, building competency among professionals, and coordinating international efforts against FGM.

Part V examines the relationship between FGM and female genital cosmetic surgery (FGCS) or "designer vaginas," considering how legal and policy approaches to these two issues should be coordinated given the similarity in the procedures. The Article concludes with a set of recommendations for strengthening Britain's legal and policy approach to FGM.

II. THE LEGISLATIVE CONTEXT

This section provides a brief overview of the laws, resolutions, and other measures that provide the context for Britain's actions against FGM. It begins with a consideration of how FGM is regarded by international human rights treaties and then examines the positions and actions taken against FGM by Britain, the European Union, the Council of Europe, and the United Nations.

practice or procure [FGM] or take somebody abroad for cutting" but also forbids "derogatory remarks about women who have not undergone FGM"); *Uganda Bans Female Genital Mutilation*, BBC NEWS (Dec. 10, 2009, 6:19 PM), <http://news.bbc.co.uk/2/hi/africa/8406940.stm> [<http://perma.cc/W3K9-LLN7>] (archived Jan. 29, 2015) (noting Uganda's criminalization of female circumcision); see also *infra* note 215 (providing references to each country's FGM law).

A. International Human Rights and FGM

FGM violates the human rights of women and girls as embodied in the British Human Rights Act (HRA), the European Convention on Human Rights (ECHR), the EU Charter on Fundamental Rights, and in international treaties such as Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social, and Cultural Rights (ICESCR), the Convention on the Rights of the Child (CRC), and the Convention Against Torture (CAT). In particular, FGM violates the right to physical and mental integrity;¹⁶ the right to the highest attainable standard of health;¹⁷ the right to freedom from torture and cruel, inhuman, or degrading treatment;¹⁸ and the right to freedom from discrimination based on sex.¹⁹ FGM is a form of torture.²⁰ When FGM results in death, it also violates the right to life.²¹ With respect to the infliction of FGM on children, state parties have an obligation to protect children from all forms of physical and mental violence, abuse, and maltreatment.²² They also have an obligation to take measures to abolish traditional practices that are prejudicial to the health of

16. See Charter of Fundamental Rights of the European Union, art. 3, 2000 O.J. (C 364) 1; European Convention on Human Rights art. 8, Nov. 4, 1950, 312 U.N.T.S. 221 [hereinafter ECHR] (protecting the right to a private life).

17. See Convention on the Rights of the Child art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3 [hereinafter CRC]; International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3.

18. See Human Rights Act, 1998, c. 42, sch.1, art. 3 (U.K.) [hereinafter HRA]; Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment arts. 2, 16, Dec. 10, 1984, 1465 U.N.T.S. 85; International Covenant on Civil and Political Rights art. 7, Dec. 16, 1966, 999 U.N.T.S. 171 [hereinafter ICCPR]; ECHR, *supra* note 16, art. 3.

19. HRA, *supra* note 18, sch. 1, art. 14; CRC, *supra* note 17, art. 2; Convention on the Elimination of All Forms of Discrimination Against Women arts. 2, 15–16, Dec. 18, 1979, 1249 U.N.T.S. 13; ICCPR, *supra* note 18, arts. 2, 26; ECHR, *supra* note 16, art. 14.

20. Special Rapporteur on Violence Against Women, its Causes and Consequences, *Implementation of General Assembly Resolution 60/251 of 15 March 2006 Entitled "Human Rights Council,"* Human Rights Council, ¶ 56, U.N. Doc. A/HRC/4/34 (Jan. 17, 2007) (by Yakin Ertürk) (“[W]e should recognize all those forms of violence against women that entail severe pain or suffering, whether physical or mental – e.g., female genital mutilation – as torture.”); see also Special Rapporteur on Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, *Promotion and Protection of all Human Rights, Civil, Political, Economic, Social and Cultural Rights, Including the Right to Development*, ¶ 53, U.N. Doc. A/HRC/7/3 (Jan. 15, 2008) (by Manfred Nowak) (“It is clear that even if a law authorizes the practice, any act of FGM would amount to torture and the existence of the law by itself would constitute consent or acquiescence by the State.” (emphasis added)).

21. See HRA, *supra* note 18, sch. 1, art. 2; CRC, *supra* note 17, art. 6; ICCPR, *supra* note 18, art. 6; ECHR, *supra* note 16, art. 2.

22. See CRC, *supra* note 17, art. 19.

children.²³ The CEDAW Committee addressed the UK's response to FGM in its most recent Concluding Observations.²⁴ Although the Committee expressed a desire to see prosecutions under the FGM Act, it emphasized that a range of measures against FGM should be adopted, including training for public officials, effective prevention strategies, and "education and awareness-raising programmes involving community and religious leaders, women's organizations, and the general public."²⁵

B. *The Law in England and Wales*

FGM was first criminalized in the UK in 1985, and the law was strengthened in 2003 with the passage of the 2003 Female Genital Mutilation Act (FGM Act).²⁶ Scotland passed a similar law against FGM in 2005.²⁷ The Children Act (1989 and 2004) also provides protective measures that can be used against FGM.²⁸ The FGM Act states that "[a] person is guilty of an offence if he excises, infibulates or otherwise mutilates the whole or any part of a girl's labia majora, labia minora or clitoris."²⁹ It provides exceptions for surgical operations necessary for a girl's physical or mental health and for surgical operations performed in connection with labour or birth, provided that such procedures are performed by registered medical practitioners, which, in the case of labor and birth, include registered midwives.³⁰ The FGM Act prohibits FGM carried out (or arranged) abroad by British nationals or permanent residents, and it extends the maximum penalty to fourteen years in prison.³¹ The Scottish Act is similar but uses a more expansive definition of FGM that includes procedures that harm the vagina.³² The Children Act 1989 provides

23. *See id.* art. 24.

24. *See generally* Rep. of the Comm. on the Elimination of Discrimination Against Women, 40th Sess., Jan. 14–Feb. 1, 2008, 41st Sess., June 30–July 18, 2008, ¶¶ 248–303, U.N. Doc. A/63/38; GAOR, 63d Sess., Supp. No. 38 (2008) [hereinafter CEDAW Report].

25. *Id.* ¶¶ 278–79.

26. *See* Female Genital Mutilation Act, 2003, c. 31 (Eng., Wales, N. Ir.); Prohibition of Female Circumcision Act, 1985, c. 38, § 1 (U.K.).

27. *See generally* Prohibition of Female Genital Mutilation (Scotland) Act, 2005, (A.S.P. 8) (Scot.).

28. *See* Children Act, 1989, c. 41 (U.K.) (including provisions for child assessment orders, orders for emergency protection of children, the power to include exclusion requirements in emergency protection orders, undertakings relating to emergency protection orders, the duration of emergency protection orders, and the removal and accommodation of children by police in cases of emergency); Children Act, 2004, c. 31 (U.K.).

29. Female Genital Mutilation Act, 2003, c. 31, § 1(1) (Eng., Wales, N. Ir.).

30. *See id.* § 1(2)–(3).

31. *See id.* §§ 4–5.

32. *See* Prohibition of Female Genital Mutilation (Scotland) Act, 2005, (A.S.P. 8), § 1 (Scot.) (indicating that it is an offence to excise, infibulate, or otherwise mutilate "in

protective measures that could be used to protect a girl at risk of FGM, including prohibited steps orders, police protection powers, emergency protection orders, and care orders.³³ The Children Act 2004 states that each agency governed by the Act must carry out their functions having regard to the need to safeguard and promote the welfare of children.³⁴

C. European Union Action Against FGM

The European Parliament passed resolutions urging states to take action against FGM in 2001, 2009, and 2012; it also passed a resolution in 2008 addressing the rights of the child.³⁵ Together, these resolutions call upon states to take a range of actions against FGM and to recognize that such actions are necessary in order to fulfil states' obligations under international human rights agreements such as the Convention on the Rights of the Child and CEDAW. These resolutions demand a range of measures against FGM, including a European Union-wide action plan, adequate legislation and law enforcement, adequate research and data collection, education and awareness raising, collaboration with non-governmental organizations and other governments that have FGM-affected populations, recognition of the right of asylum based on FGM, dissemination of information to affected populations upon immigration to EU countries, specific attention to FGM as part of an overall strategy against gender-based violence, and the allocation of appropriate financial resources to address the needs and priorities of girls in vulnerable situations.³⁶

EU measures against FGM have been reinforced by the launch of the European Institute for Gender Equality (EIGE) in June 2010.³⁷ Since then, EIGE has been instrumental in promoting pan-European action against FGM.³⁸ Moreover, the European Commission issued a

relation to the whole or any part of the labia majora, labia minora, prepuce of the clitoris, clitoris or vagina of another person").

33. See Children Act, 1989, c. 41, §§ 8(1), 31–34, 44, 46 (U.K.).

34. See Children Act, 2004, c. 31, § 11 (U.K.).

35. See Resolution on Ending Female Genital Mutilation, EUR. PARL. DOC. 2012/2684 (RSP) (2012) [hereinafter 2012 EP Resolution]; Resolution on Combating Female Genital Mutilation in the EU, EUR. PARL. DOC. 2008/2071 (INI) (2009) [hereinafter 2009 EP Resolution]; Resolution Towards an EU Strategy on the Rights of the Child, EUR. PARL. DOC. 2007/2093 (INI) (2008) [hereinafter 2008 EP Resolution]; Resolution on Female Genital Mutilation, EUR. PARL. DOC. 2001/2035 (INI) (2001) [hereinafter 2001 EP Resolution].

36. See generally 2012 EP Resolution, *supra* note 35; 2009 EP Resolution, *supra* note 35; 2008 EP Resolution, *supra* note 35; 2001 EP Resolution, *supra* note 35.

37. See *A Brief EIGE History*, EUR. INST. FOR GENDER EQUALITY, <http://eige.europa.eu/content/brief-eige-history> (last visited Mar. 8, 2015) [<http://perma.cc/GSE2-4SUG>] (archived Jan. 29, 2015) (describing the circumstances leading to the formation of the EIGE).

38. See *Female Genital Mutilation*, EUR. INST. FOR GENDER EQUALITY, <http://eige.europa.eu/content/female-genital-mutilation> (last visited Mar. 8, 2015) [<http://perma.cc/V8Z8-NYXP>] (archived Jan. 29, 2015) (discussing research and studies

Communication on the elimination of female genital mutilation in November 2013.³⁹ This Communication lays out steps that the European Commission will take to (a) better understand the prevalence of FGM in the EU, (b) promote sustainable change to prevent FGM, (c) support EU member states in prosecuting FGM more effectively, (d) ensure protection for women at risk of FGM on the EU territory, (e) promote the elimination of FGM globally, and (f) implement measures to monitor and evaluate the aforementioned goals.⁴⁰

D. Council of Europe: The Istanbul Convention

The Council of Europe passed a resolution against FGM in 2001⁴¹ and, in 2011, opened for signature the Convention on Preventing and Combating Violence Against Women and Domestic Violence (Istanbul Convention). The Istanbul Convention requires state parties to take a series of actions designed to prevent, protect against, and prosecute violence against women.⁴² The Istanbul Convention was opened for signature on May 11, 2011, and was entered into force on August 1, 2014.⁴³ The Istanbul Convention recognizes FGM as a form of violence against women and calls upon state parties to criminalize FGM as well as any act of pressuring or coercing a person to undergo FGM.⁴⁴ It also requires state parties to raise awareness about FGM across all sectors of society,⁴⁵ calls upon state parties “to provide victims with adequate civil remedies against . . . perpetrator[s]” of violence, including FGM,⁴⁶ and requires state parties to conduct research and collect relevant statistical data on FGM in order to better understand the extent of the problem and craft more effective interventions.⁴⁷

conducted by the EIGE that “support policy makers in their efforts to follow the law . . . and develop strategies for effective elimination of female genital mutilation in Europe”).

39. See *Towards the Elimination of Female Genital Mutilation*, *supra* note 6.

40. See *id.*

41. See Eur. Parl. Ass., *Female Genital Mutilation*, 108th Sess., Doc. No. 1247 (2001).

42. See *The Convention in Brief*, COUNCIL OF EUR., http://www.coe.int/t/dghl/standardsetting/convention-violence/brief_en.asp (last visited Mar. 8, 2015) [<http://perma.cc/5CJB-NFUQ>] (archived Feb. 3, 2015).

43. *Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence*, CETS No.: 210, COUNCIL OF EUR., <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=210&CM=1&DF=&CL=ENG> (last visited Mar. 8, 2015) [<http://perma.cc/M278-5DK7>] (archived Feb. 3, 2015).

44. See Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence art. 38, May 11, 2011, C.E.T.S. No. 210 [hereinafter *Istanbul Convention*].

45. See *id.* arts. 12–17; see also *The Convention in Brief*, *supra* note 42.

46. *Istanbul Convention*, *supra* note 44, art. 29.

47. See *id.* art. 11.

E. United Nations Action Against FGM: The UN FGM Resolution

The United Nations General Assembly passed a resolution banning female genital mutilation in December 2012 (UN FGM Resolution).⁴⁸ The UN FGM Resolution calls upon countries to condemn all forms of FGM and to take all necessary measures toward this goal, including enforcing legislation, implementing awareness-raising, and allocating sufficient resources towards FGM prevention and protection efforts.⁴⁹ “It calls for special attention to protect and support” those affected by FGM, particularly refugees and migrants.⁵⁰ It specifically calls upon states to commit substantial financial resources to eliminating FGM, develop national action plans, and systematically engage in data collection and monitoring.⁵¹ These various measures at the state, regional, and international level demonstrate a growing awareness that FGM is a problem that affects all parts of the world, not just those countries where it originates. The measures also demonstrate an understanding that eliminating FGM requires a multi-pronged approach and a strong commitment to implementing anti-FGM strategies across all sectors of society. The remainder of this Article examines obstacles to ending FGM in the UK and strategies for overcoming these obstacles.

III. OBSTACLES TO ENDING FGM IN THE UK

FORWARD, a key charity working to end FGM in Britain, has long taken the position that the FGM Act is inadequate because it contains certain loopholes that allow individuals committing FGM to avoid prosecution.⁵² More recently, other voices have joined the chorus, calling for reform of the FGM Act. The Association of Chief Police Officers (ACPO), for example, has argued that the law needs to be toughened in order to close a loophole that creates difficulty when trying to prosecute parents who are not permanent UK residents.⁵³

48. See generally Intensifying Global Efforts for the Elimination of Female Genital Mutilations, G.A. Res. 67/146, U.N. Doc. A/RES/67/146 (Dec. 20, 2012) [hereinafter UN FGM Resolution].

49. See *id.* ¶¶ 2, 3, 9, 12, 14.

50. See *United Nations Bans Female Genital Mutilation*, UN WOMEN (Dec. 20, 2012), <http://www.unwomen.org/en/news/stories/2012/12/united-nations-bans-female-genital-mutilation> [http://perma.cc/UR4K-CALM] (archived Feb. 17, 2015) (“It calls for special attention to protect and support women and girls who have been subjected to female genital mutilations, and those at risk, including refugee women and women migrants.”).

51. UN FGM Resolution, *supra* note 48, ¶¶ 3, 7, 13–14.

52. Multiple interviews with Naana Otoo-Oyortey, Executive Director, FORWARD, in London, U.K., June 25, 2012, September 21, 2012 and February 24, 2013.

53. See Rowena Mason, *Female Genital Mutilation Law Must Be Toughened, UK's Top Police Officers Say*, GUARDIAN (U.K.) (Mar. 3, 2014, 1:48 PM),

Barristers Dexter Dias and Felicity Gerry and sociologist Hilary Burrage have also raised concerns about loopholes in the FGM Act.⁵⁴ They would also like to see greater powers given to judges to issue protective orders to shield those at risk.⁵⁵ This Section addresses the loopholes in the FGM Act and then analyzes other obstacles to ending FGM in Britain.

A. Gaps in the Legislation

The FGM Act lacks clarity and leaves several significant gaps in the protection offered by the law. The lack of a definition of FGM in the law is striking. This is problematic because the current law does not criminalize every form of FGM. For example, it is silent on the issue of reinfibulation, which involves re-closing the vulva of a previously infibulated woman. Second, the FGM Act also does not address female genital cosmetic surgery, which can be very similar to FGM in that both procedures involve the removal of healthy genital tissue. Third, the FGM Act restricts protection to those individuals who are UK nationals or permanent residents, which leaves many at-risk individuals unprotected. Fourth, the FGM Act is silent with respect to some issues that should be addressed in light of Britain's obligations under international law—these include mandating the reporting of FGM to the authorities and clarifying UK obligations to asylum seekers. Finally, there are some additional issues with unclear language that should be resolved. This section describes each of these issues in detail, and Part IV of this Article then proposes a Model FGM Act that resolves each issue. The Model FGM Act is available in the Appendix.

1. The Need to Define *Female Genital Mutilation* and Criminalize Reinfibulation
 - a. Adding a Definition of FGM

The law should include a clear definition of FGM in order to ensure that all types of FGM procedures are covered. Section 1(1) of the FGM Act specifies that it is an offense to excise, infibulate, or

<http://www.theguardian.com/society/2014/mar/03/female-genital-mutilation-law-police-acpo-fgm-parents-cutters> [<http://perma.cc/NJ9F-4MQK>] (archived Jan. 29, 2015).

54. See Dexter Dias, Felicity Gerry & Hilary Burrage, *10 Reasons Why Our FGM Law Has Failed – And 10 Ways to Improve It*, Guardian (U.K.) (Feb. 7, 2014, 5:22 AM), <http://www.theguardian.com/commentisfree/2014/feb/07/fgm-female-genital-mutilation-prosecutions-law-failed> [<http://perma.cc/K955-2WEV>] (archived Jan. 29, 2015).

55. See *id.* (“Consider the creation of a new FGM prevention order system where authorities could apply for an order prohibiting the mutilation of a child where there is clear evidence of risk This allows the child to stay at home but puts careers under threat of prosecution.”).

otherwise mutilate the labia majora, labia minora, or clitoris. This wording is underinclusive. For instance, pricking, piercing, scraping, and cauterizing are forms of FGM recognized by the World Health Organization (WHO) but not directly addressed in the law.⁵⁶ Although one can argue that these forms are covered by the phrase “or otherwise mutilate,” a defendant might argue that pricking or piercing the clitoris is not so severe as to qualify as mutilation. In addition, Section 1(1) does not include procedures done to the *vagina*, such as cutting, scraping, or introducing corrosive substances into it.⁵⁷

Section 1(2)(b) is also problematic, stating that no offense is committed if an approved person performs “a surgical operation on a girl who is in any stage of labor, or has just given birth, for purposes connected with the labor or birth.” Nothing in this language indicates that the operation must be necessary for physical or mental health, so this provision could be interpreted as stating that FGM is acceptable as long as it is carried out in connection with labor or birth. In particular, one could argue that a reinfibulation after birth is lawful because it is performed in connection with the birth.

In contrast to the FGM Act, the WHO defines female genital mutilation much more broadly as “compris[ing] all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons.”⁵⁸ Incorporating the WHO definition of FGM into the law would close gaps in protection and entirely eliminate the need for a list of exceptions and approved persons. With its emphasis on “all procedures,” the WHO definition unquestionably covers every conceivable type of FGM, no matter what the procedure is and what part of the genitalia is affected. The definition’s emphasis on procedures performed “for non-medical reasons” eliminates the need to include a cumbersome list of exceptions for permitted surgical operations. As a procedure that is, by definition, *never* medically necessary, FGM is clearly distinguishable from procedures that *are* medically necessary, such as episiotomy, post-childbirth repairs of the perineum, and removal of diseased tissue. With the addition of the WHO definition of FGM, sections 1(2)-(4) and Section 3(3) can be eliminated from the FGM Act, thus removing the source of much confusion. Adopting the WHO definition would clarify that FGM is a range of procedures performed for nonmedical reasons and would introduce greater clarity into the law. In addition to these benefits, it would harmonize the British law with international standards since the WHO definition of FGM is used worldwide.

56. See WORLD HEALTH ORG., ELIMINATING FEMALE GENITAL MUTILATION: AN INTERAGENCY STATEMENT 24, 26–27 (2008).

57. Cf. *id.* (discussing the extensive debate over whether or not pricking should be included in the typology).

58. *Fact Sheet N°241*, *supra* note 1.

b. The Need to Explicitly Prohibit Reinfibulation

Section 1(1) is silent on the issue of reinfibulation, which involves re-closing an infibulated woman's vulva after it has been opened to allow for childbirth. This lack of clarity is a problem because reinfibulation is regularly encountered by health professionals in the UK. Some have reported that women who have been deinfibulated to allow for childbirth are later found to have been reinfibulated when they come for maternity care with later pregnancies.⁵⁹ Some groups that practice infibulation, such as the Sudanese, typically reinfibulate women after the birth of each child.⁶⁰ The recent arrest of Dr. Dharmasena for FGM and the reaction of the medical establishment to his arrest highlight some of the confusion around reinfibulation and its status under the law.

The Dharmasena case involved reinfibulation.⁶¹ Dr. Dharmasena was accused of conducting a post-childbirth repair of "FGM that had previously been performed on the patient."⁶² In so doing, he allegedly carried out FGM himself.⁶³ Post-childbirth repair typically does not involve excising tissue,⁶⁴ so Dr. Dharmasena was accused of carrying out the repair in a way that recreated the seal over the vagina that is typical of infibulation. Accordingly, in order to bring charges against Dr. Dharmasena, the Crown Prosecution Service (CPS) interpreted the FGM Act as prohibiting reinfibulation.

But some health professionals have come to a different conclusion about the law's position on reinfibulation. Although the Royal College of Obstetricians and Gynaecologists (RCOG) interpreted the law as

59. See 30 June 2011, PARL. DEB., H.L. (2011) 1900 (U.K.) ("After giving birth, the women beg those same doctors to stitch them up the way they were in order to please their husbands. Doctors have to explain to women that they will play no part in that practice, but they know that those women return to them with a second pregnancy, and their vagina has been restitched."); ROYAL COLL. OF MIDWIVES, TACKLING FGM IN THE UK: INTERCOLLEGIATE RECOMMENDATIONS FOR IDENTIFYING, RECORDING AND REPORTING 11 (2013) [hereinafter INTERCOLLEGIATE REPORT], available at http://www.equalitynow.org/sites/default/files/Intercollegiate_FGM_report.pdf [<http://perma.cc/4KYA-92ZC>] (archived Mar. 23, 2015) ("[S]ome women who have undergone reversals (de-infibulations) during previous pregnancy care, return to the maternity clinics during subsequent pregnancies, having undergone re-infibulation.").

60. See Els Leye et al., *An Analysis of the Implementation of Laws With Regard to Female Genital Mutilation in Europe*, 47 CRIME L. SOC. CHANGE 1, 5 n.2 (2007).

61. Sandra Laville, *Doctor Found Not Guilty of FGM On Patient at London Hospital*, GUARDIAN (U.K.) (Feb. 4, 2015, 11:29 AM), <http://www.theguardian.com/society/2015/feb/04/doctor-not-guilty-fgm-dhanuson-dharmasena> [<http://perma.cc/JMB2-XC76>] (archived May 22, 2015) (stating that the patient underwent Type 3 FGM—also known as "infibulation"—in Somalia as a child).

62. Bowcott, *supra* note 1, see also Laville, *supra* note 61.

63. Bowcott, *supra* note 1.

64. See, e.g., Hayley Willacy & Colin Tidy, *Episiotomy and Tears*, PATIENT.CO.UK, <http://www.patient.co.uk/doctor/episiotomy-and-tears> (last updated Apr. 14, 2014) [<http://perma.cc/LC4H-WY8R>] (archived Jan. 29, 2015) (outlining the recommended procedure for a routine perineal repair).

prohibiting reinfibulation as recently as 2009,⁶⁵ they, along with the Royal College of Midwives, the Royal College of Nursing, and several other groups, have recently interpreted the law's silence on reinfibulation to mean that the procedure is not covered by the law because reinfibulation does not involve cutting away additional tissue.⁶⁶

But what characterizes infibulation/reinfibulation and distinguishes these procedures from excision is that *they obstruct the vaginal opening by creating a covering or seal out of the labia majora or minora*.⁶⁷ Accordingly, the law's prohibition on infibulation should also cover reinfibulation, which involves *recreating* such a seal after it has been removed to facilitate childbirth. The fact that the CPS and a coalition of health professionals have reached different conclusions about what the law covers illustrates the confusion that exists. Thus, there is a clear need for definitive legal guidance on the status of reinfibulation. The RCOG has already issued *medical* guidance prohibiting reinfibulation, stating that any repair after birth should be sufficient to "control bleeding, but must not result in a vaginal opening that makes intercourse difficult or impossible."⁶⁸ What remains, then, is for the law to expressly prohibit reinfibulation.

2. Female Cosmetic Genital Surgery and the FGM Act

The FGM Act does not differentiate between FGCS and FGM. The FGM Act prohibits the excision, infibulation, or other mutilation of the labia majora, labia minora, or clitoris.⁶⁹ Labial reduction surgery, or labiaplasty, is the most common form of FGCS and typically involves removing a portion of the labia minora.⁷⁰ Since "excision" means the

65. See ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, FEMALE GENITAL MUTILATION AND ITS MANAGEMENT, GREEN-TOP GUIDELINE NO. 53, at 9 (2009), available at https://www.rcog.org.uk/globalassets/documents/guidelines/greentop_53femalegenital_mutilation.pdf [<http://perma.cc/8H9B-HGCG>] (archived Feb. 17, 2015). RCOG's position is consistent with that taken by the World Health Organization, which directs health workers to refuse requests to perform reinfibulation. See DEPT. OF GENDER & WOMEN'S HEALTH, WORLD HEALTH ORG., FEMALE GENITAL MUTILATION: THE PREVENTION AND THE MANAGEMENT OF THE HEALTH COMPLICATIONS 11–12 (2001), available at http://www.who.int/gender/other_health/en/guidelinesnursesmid.pdf [<http://perma.cc/7RDN-ZB2R>] (archived Mar. 10, 2015) ("Health workers must not, under any circumstances, close up (re-infibulate) an opened vulva in a girl or woman with type III FGM in a manner that makes intercourse and childbirth difficult.").

66. See INTERCOLLEGIATE REPORT, *supra* note 59, at 12.

67. See WHO, *FGM Typology*, *supra* note 1 (defining infibulation as the "narrowing of the vaginal opening through the creation of a covering seal . . . formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris").

68. ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, *supra* note 65, at 9.

69. See Female Genital Mutilation Act, 2003, c. 31, § 1(1) (Eng., Wales, N. Ir.).

70. See NS Crouch et al., *Clinical Characteristics of Well Women Seeking Labial Reduction Surgery: A Prospective Study*, 118 BRIT. J. OBSTETRICS & GYNAECOLOGY 1507,

cutting away of tissue, the FGM Act on its face prohibits both FGM and labiaplasty, as well as any form of FGCS that involves the cutting away of tissue. However, genital surgery is allowed under the FGM Act in cases where a medical practitioner determines that the procedure is necessary for the physical or mental health of the person on whom the surgery is performed.

FGCS is growing in popularity, with over two thousand labiaplasties performed by the National Health Service in 2011.⁷¹ These procedures have not led to any prosecutions, so either the physicians are able to justify them all as medically necessary or police and prosecutors are ignoring the activity. In addition to these procedures, there are women seeking hymen restoration surgeries in order to enhance their marriage prospects when cultural norms require them to be virgins prior to marriage.⁷² There is a clear contradiction between prohibiting FGM and allowing very similar procedures to be funded by the National Health Service. These issues will be discussed more fully in Part V below.

3. No Extraterritorial Prosecution of Non-UK Citizens and Permanent Residents Who Have Ties to the UK

The FGM Act prohibits FGM carried out on any person *within* the United Kingdom, regardless of the residency status of the victim or perpetrator. But the law only allows prosecution for acts of FGM committed abroad where the perpetrator is a United Kingdom *national* or *permanent resident*. Accordingly, it is not an offense under the FGM Act to perform FGM outside of the UK where the perpetrator has ties to the UK but is not a UK national or permanent resident—for instance, if he or she is an asylum seeker, a student studying in the United Kingdom, or not yet a permanent resident. In contrast, the Istanbul Convention calls upon states to exercise jurisdiction over perpetrators who maintain their “habitual residence” in the state’s

1507 (2011), available at <http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2011.03088.x/pdf> [<http://perma.cc/4GQW-4Q6U>] (archived Feb. 3, 2015).

71. See Melissa Hogenboom, *The Rise in Women Seeking a Perfect Vagina*, BBC NEWS (July 24, 2012, 2:27 PM), <http://www.bbc.com/news/health-18947106> [<http://perma.cc/4FSY-WVDT>] (archived Jan. 29, 2015).

72. For clinics offering this service, see, for example, *Hymenoplasty or Hymen Repair*, GYNAE CENTRE, <http://www.gynae-centre.co.uk/our-services/hymen-repair/> (last visited Mar. 10, 2015) [<http://perma.cc/4ES5-XKQS>] (archived Jan. 29, 2015) (“[I]n many cultures the hymen is considered a token of virginity and for cultural and religious reasons can be an important factor in a new marriage. In many cases marriages are even annulled if the hymen is torn. Now that hymen repair is available and relatively safe, many women and families are opting for this solution.”); *Hymen Repair*, 111 HARLEY ST. EXCLUSIVE COSMETIC SURGERY, <http://111harleystreet.com/body/genitals/hymen-repair/> (last visited Mar. 10, 2015) [<http://perma.cc/BL48-FLN3>] (archived Jan. 29, 2015) (providing an overview of the hymen repair surgery).

territory.⁷³ Similarly, the 2001 European Parliament Resolution calls upon member states to enact criminal laws that reach every act of FGM committed by *any resident*, even if the offense was committed outside of a country's borders.⁷⁴

The broader language in the Istanbul Convention and 2001 European Parliament Resolution, if adopted in the UK, would increase the UK's ability to effectively address the growing problem of girls being taken abroad for FGM. This is particularly an issue during the summer holidays when there is sufficient time for girls to heal from the procedure without teachers or other authorities noticing their condition.⁷⁵ Although there is no reliable data on the residency and nationality status of persons taking their daughters abroad for FGM, it is likely that a significant number of them are not UK nationals or permanent residents, given their families' ties to their countries of origin and strong motivation to embrace a practice that is illegal the UK.⁷⁶ The National Society for the Prevention of Cruelty to Children (NSPCC) points out that FGM in the UK is associated with first-generation immigrants, refugees, and asylum seekers who come from affected countries.⁷⁷ It makes no sense for a law prohibiting FGM to fail to reach the very people who are most likely to perpetrate the crime.

In keeping with the Istanbul Convention, the law should be revised to create an offense out of removing from the UK any person habitually resident there for FGM, regardless of the citizenship or residency status of the person. It should also be revised to extend jurisdiction over any perpetrator of FGM abroad when that person is *habitually resident* in the UK. Whether a person is habitually resident in the UK could be determined by a court of competent jurisdiction through school records, health care records, social service records, or testimony of relatives, friends, neighbors, or other witnesses.

73. See Istanbul Convention, *supra* note 44, art. 44.

74. See 2001 EP Resolution, *supra* note 35, ¶ 11.

75. Cf. *Female Genital Mutilation: Signs, Symptoms and Effects*, NAT'L SOC'Y FOR THE PREVENTION OF CRUELTY TO CHILD., <http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/signs-symptoms-and-effects/> (last visited Mar. 10, 2015) [<http://perma.cc/E66M-LREL>] (archived Mar. 10, 2015) (listing information on the signs, symptoms, and effects of FGM and offers advice for keeping children safe from the practice).

76. See *Female Genital Mutilation: Who is Affected*, NAT'L SOC'Y FOR THE PREVENTION OF CRUELTY TO CHILDREN [hereinafter *Who is Affected*], <http://www.nspcc.org.uk/preventing-abuse/child-abuse-and-neglect/female-genital-mutilation-fgm/who-is-affected/> (last visited Mar. 10, 2015) [<http://perma.cc/229A-282E>] (archived Mar. 10, 2015); see also HOME OFFICE, GUIDANCE: FEMALE GENITAL MUTILATION: RESOURCE PACK (U.K.), available at <https://www.gov.uk/government/publications/female-genital-mutilation-resource-pack/female-genital-mutilation-resource-pack#overview> [<http://perma.cc/5Z88-GMSA>] (archived Feb. 3, 2015).

77. See *Who is Affected*, *supra* note 76 (noting that the UK government has identified victims of FGM from several foreign countries).

4. No Professional Duty to Report FGM

The FGM Act does not include a provision requiring any category of professional to report suspected cases of FGM to the police. More generally, there are no specific laws in the UK requiring mandatory reporting of suspected child abuse or maltreatment to the authorities,⁷⁸ although such mandatory reporting regimes are in place in other developed countries⁷⁹ and can be of great assistance in bringing cases of abuse to the attention of the authorities.

The 2009 European Parliament Resolution on FGM called on member states to make it compulsory for medical personnel to report cases of FGM to health authorities and the police.⁸⁰ This objective has clearly not yet been met in the UK. Northern Ireland could be said to meet the objective indirectly in that there, “it is an offence not to report an arrestable crime to the police,” and this “includes crimes against children.”⁸¹ Since FGM is an arrestable crime, it would be an offense for a person to not report it, but it may be difficult for individuals with knowledge of FGM occurring to make the connection to the reporting requirement since the relevant reporting requirement is not specific to FGM.

The Multi-Agency Practice Guidelines on FGM also indicate that health professionals themselves should not conduct inquiries into possible criminal offenses; rather, health professionals should be sure to refer cases of suspected FGM to the police or social care so that these entities can carry out the necessary investigations.⁸²

78. See NAT'L SOC'Y FOR THE PREVENTION OF CRUELTY TO CHILD., CHILD ABUSE REPORTING REQUIREMENTS FOR PROFESSIONALS: AN NSPCC FACTSHEET 1 (2013) [hereinafter NSPCC Factsheet], available at <http://www.nspcc.org.uk/globalassets/documents/information-service/factsheet-child-abuse-reporting-requirements-professionals.pdf> [<http://perma.cc/U9J7-KCTV>] (archived Feb. 4, 2015) (“There are no specific mandatory regulations in the UK requiring professionals to report suspicions about child abuse to the authorities.”)

79. For example, every state in the United States requires certain persons to report suspected child maltreatment to an appropriate agency. For a state-by-state guide to these laws, see CHILD WELFARE INFORMATION GATEWAY, MANDATORY REPORTERS OF CHILD ABUSE AND NEGLECT 5–65 (2013), available at <https://www.childwelfare.gov/pubPDFs/manda.pdf#page=5&view=Summaries%20of%20State%20Laws> [<http://perma.cc/6K6R-57Z8>] (archived Feb. 4, 2015).

80. See 2009 EP Resolution, *supra* note 35, ¶ 21.

81. NSPCC Factsheet, *supra* note 78, at 1.

82. See DEPT. OF HEALTH, HM GOVERNMENT, MULTI-AGENCY PRACTICE GUIDELINES: FEMALE GENITAL MUTILATION 26–27 (2011) [hereinafter PRACTICE GUIDELINES], available at <https://www.gov.uk/government/publications/female-genital-mutilation-multi-agency-practice-guidelines> [<http://perma.cc/83LA-465H>] (archived Feb. 4, 2015) (explaining the powers police officers and children's social care have to protect girls at risk of FGM).

5. Lack of Clarity With Respect to FGM and Asylum Protection

A person who “has been compelled to undergo, or who is likely to be subjected to, FGM can qualify for refugee status under the 1951 Refugee Convention.”⁸³ The 2001 European Parliament Resolution recognized the right of asylum of women and girls at risk of being subjected to FGM, and the 2009 Resolution reaffirmed this principle.⁸⁴ These are determinations that must be made by the courts, and United Kingdom courts have decided many FGM-based claims. However, there is room for legislation to streamline the adjudication process by clarifying that facing a risk of FGM is indisputably a valid grounds for asylum. This position is in harmony with the condemnation of FGM that is contained in the FGM Act as well as in a number of sources of international law, including the 2006 House of Lords *Fornah* decision and the 2001 and 2009 European Parliament Resolutions mentioned above.⁸⁵

In addition, the European Council and Parliament issued an asylum qualification directive in November 2011 that provides clearer and more harmonized standards for identifying persons in need of international protection.⁸⁶ The directive includes a reference to the importance of taking into account traditions and customs, including genital mutilation, when considering an applicant’s well-founded fear of persecution based on “membership of a particular social group.”⁸⁷ The FGM Act currently offers no guidance with respect to FGM-related asylum claims in the United Kingdom. Legislative clarification on the status of FGM as grounds for asylum can help to focus the attention of asylum seekers and adjudicators squarely on the particulars of each applicant’s specific case rather than on arguing aspects of the law that are actually well-settled. As a result, each asylum seeker will be better positioned to devote her resources to demonstrating her own credibility and the details of her particular case.

83. UN High Commissioner for Refugees (UNHCR), Guidance Note on Refugee Claims Relating to Female Genital Mutilation 4 (May 2009), available at <http://www.refworld.org/docid/4a0c28492.html> (last visited Mar. 10, 2015) [<http://perma.cc/HR3S-3E5Q>] (archived Feb. 4, 2015).

84. See 2009 EP Resolution, *supra* note 35, ¶ 3 (stressing the need to examine asylum requests from parents who refuse to submit their daughters to FGM on a case by case basis); 2001 EP Resolution, *supra* note 35, ¶ 14.

85. See, e.g., *Fornah (FC) v. SSHD*, [2006] UKHL 46 [8] (appeal taken from Eng.) (“FGM has been condemned as cruel, discriminatory and degrading by a long series of international instruments . . .”).

86. See generally Directive 2011/95/EU, of the European Parliament and of the Council of 13 December 2011 on Standards for the Qualification of Third-Country Nationals or Stateless Persons as Beneficiaries of International Protection, for a Uniform Status for Refugees or for Persons Eligible for Subsidiary Protection, and for the Content of the Protection Granted, 2011 O.J. (L 337).

87. See *id.* ¶ 30.

6. Additional Examples of Confusing Language

a. The Need to Clarify the “Aiding and Abetting” Provision

Section 2 of the FGM Act creates confusion because it is framed around the idea of a girl procuring someone to perform FGM on her. It reads as follows: “Offence of assisting a girl to mutilate her own genitalia: A person is guilty of an offence if he aids, abets, counsels or procures a girl to excise, infibulate or otherwise mutilate the whole or any part of her own labia majora, labia minora or clitoris.”⁸⁸

Girls do not typically arrange to have FGM performed on themselves, so the framing of this provision sets up an obstacle to prosecuting someone who aids or abets, as the prosecution is unlikely to be able to prove that the perpetrator was assisting a girl to perform FGM on *herself*. The provision should be revised to clarify that the unlawful activity is the *aiding, abetting, counseling, or procuring*. The issue of whether or not the girl herself is involved in the planning should not be relevant to the offense. For suggested wording, see the Model FGM Act in the Appendix.

b. Changing “Girl” to “Person”

References to “girl” should be changed to “any person” throughout the Act since FGM can be performed at any age. There is no benefit to using the more restrictive term “girl.”

B. Additional Obstacles to Ending FGM in Britain

A strong anti-FGM law, by itself, is not enough to end FGM in the UK. In addition to the gaps in protection that exist in the current law, policy-makers must be aware of a number of other obstacles to ending FGM that must be addressed as part of a holistic strategy. These obstacles include an overemphasis on achieving a prosecution, a lack of scientific data on the prevalence of FGM, cultural obstacles within communities that perpetuate the practice, and professionals’ lack of preparedness for responding effectively to FGM. Each of these issues is addressed below.

1. Overemphasis on Achieving a Prosecution

The British media has repeatedly called attention to the fact that no prosecutions have been brought under the FGM Act despite the fact

88. Female Genital Mutilation Act, 2003, c. 31, § 2 (Eng., Wales, N. Ir.).

that FGM has been specifically prohibited by statute since 1985.⁸⁹ Prosecution of cases under the FGM Act is very important, but prosecution is no magic bullet. The media is currently doing a great deal to shape the debate around FGM and raise questions about the lack of prosecutions, but policy around FGM must be holistic and not dictated by media concerns. In November 2012, the CPS introduced an Action Plan to Improve Prosecutions of FGM.⁹⁰ Although this is a promising development, prosecution is just one of many strategies in the fight to eliminate FGM.

Some in the media have compared Britain to France, where there have been roughly one hundred convictions of parents and circumcisers for FGM over the last three decades.⁹¹ This comparison is misplaced because of differences between the French and Anglo-Saxon legal systems. In particular, the French system allows a civil society organization to play a significant role as a civil party in a criminal proceeding, with the result that successful prosecution is not as heavily dependent on the actions and initiative of the public prosecutor as in Anglo-Saxon countries.⁹² It is important to keep in mind the

89. See, e.g., Bowcott, *supra* note 1; *Female Genital Mutilation Action Plan Launched*, CROWN PROSECUTION SERV. (U.K.) (Nov. 23, 2012) [hereinafter *FGM Action Plan*], http://cps.gov.uk/news/latest_news/female_genital_mutilation_action_plan_launched/ [<http://perma.cc/QH4J-YH23>] (archived February 4, 2015) (detailing the launch of an action plan designed to get FGM offenders into court and improve prosecutions of the practice); Tracy McVeigh, *Female Circumcision Growing in Britain Despite Being Illegal*, GUARDIAN (U.K.) (July 24, 2010, 7:06 PM), <http://www.theguardian.com/society/2010/jul/25/female-circumcision-health-child-abuse> [<http://perma.cc/H3SR-9W99>] (archived Feb. 4, 2015) (explaining that schoolgirls are most at risk to become victims of FGM during the summer months because this is when they can be “cut” without their absence being alarming); Tracy McVeigh & Tara Sutton, *British Girls Undergo Horror of Genital Mutilation Despite Tough Laws*, GUARDIAN (U.K.) (July 10, 2010, 7:06 PM), <http://www.theguardian.com/society/2010/jul/25/female-circumcision-children-british-law> [<http://perma.cc/ES4T-5KWU>] (archived Feb. 4, 2015) (describing FGM in the United Kingdom).

90. See *FGM Action Plan*, *supra* note 89.

91. See, e.g., John Lichfield, *The French Way: A Better Approach to Fighting FGM?*, INDEPENDENT (Dec. 13, 2013), <http://www.independent.co.uk/news/world/europe/the-french-way-a-better-approach-to-fighting-fgm-9006369.html> [<http://perma.cc/88RJ-MJ92>] (archived Feb. 4, 2015); see also Megan Rowling, *France Reduces Genital Cutting With Prevention, Prosecutions – Lawyer*, THOMSON REUTERS FOUND. (Sept. 27, 2012, 10:51 AM), <http://www.trust.org/item/?map=france-reduces-genital-cutting-with-prevention-prosecutions-lawyer/> [<http://perma.cc/H7DB-W7WK>] (archived Feb. 4, 2015) (attributing France’s reduction in FGM to its prevention efforts and prosecutions); Rhona Scullion, *FGM First UK Prosecution Follows French Example*, LIBERTY VOICE (Mar. 22, 2014), <http://guardianlv.com/2014/03/fgm-first-uk-prosecution-follows-french-example/> [<http://perma.cc/8KYP-EYCN>] (archived Feb. 4, 2015) (“France has been undeniably successful in preventing and deterring the practice of FGM and has been extremely vocal in its approach.”).

92. See *Commission for the Abolition of Sexual Mutilations (Commission pour l’abolition des mutilations sexuelles)*, EUR. INST. FOR GENDER EQUALITY [hereinafter EIGE, CASM], <http://eige.europa.eu/content/commission-for-the-abolition-of-sexual-mutilationscommission-pour-1%E2%80%99abolition-des-mutilation> (last visited Mar. 11, 2015) [<http://perma.cc/YQT4-4ELH>] (archived Feb. 4, 2015) (noting that France

observation of the CEDAW committee that a range of measures against FGM is necessary as part of a comprehensive strategy.⁹³ It would be a mistake to allow a singular focus on prosecution to eclipse the need for the more holistic strategy as outlined in this Article.

2. Lack of Robust Statistical Data on FGM

A lack of data on the prevalence of FGM in the UK as well as in Europe is a barrier to fully implementing the law and effectively tackling the problem.⁹⁴ According to the European Institute for Gender Equality, there is currently no ongoing, systematic data collection in place that is harmonized across countries and would allow for accurate estimates of the exact extent of FGM in Europe or of the number of females living in Europe who are at risk of FGM.⁹⁵ Very little systematic research tracking the prevalence of FGM and its consequences has been done, and the most reliable study conducted in the UK was completed back in 2007.⁹⁶ The European Parliament and the Istanbul Convention both recognize the urgent need for more robust data collection with respect to FGM. The 2009 European Parliament Resolution called upon member states to “quantify the number of women who have undergone FGM or are at risk in individual countries, taking into account the fact that there are as yet no figures available for many countries, which likewise do not have harmonized data-gathering systems.”⁹⁷ The Istanbul Convention similarly calls upon state parties to collect “relevant statistical data at regular intervals” with respect to all forms of violence covered by the Convention and to support research into the such violence including

permits civil society organizations like the Commission for the Abolition of Sexual Mutilations to participate in FGM prosecutions); *see also* Sophie Poldermans, *Combating Female Genital Mutilation in Europe: A Comparative Analysis of Legislative and Preventative Tools in the Netherlands, France, the United Kingdom, and Austria* 39 (July 14, 2006) (unpublished master’s thesis, University of Vienna), *available at* <http://www.stopfgm.net/wp-content/uploads/vor2013/grundlagen/SPoldermansFGMinEurope.pdf> [<http://perma.cc/CQS4-3F7P>] (archived Feb. 4, 2015).

93. *See* CEDAW Report, *supra* note 24, ¶ 278–79 (urging the United Kingdom to increase its efforts to develop and implement targeted prevention strategies, raise awareness, and educate the public).

94. *See Prevalence in Europe*, END FGM IN EUR. CAMPAIGN, <http://www.endfgm.eu/en/female-genital-mutilation/fgm-in-europe/prevalence-in-europe/> (last visited Mar. 11, 2015) [<http://perma.cc/KT4S-8E2L>] (archived Feb. 4, 2015); *see also* Mona Chalabi, *Female Genital Mutilation: How Prevalent Is It?*, *GUARDIAN* (U.K.) (June 24, 2013, 9:18 AM), <http://www.theguardian.com/news/datablog/2013/jun/24/female-genital-mutilation-prevalence-uk> [<http://perma.cc/9RAV-PXGB>] (archived Feb. 4, 2015).

95. *See* ELS LEYE ET AL., *EUR. INST. FOR GENDER EQUAL., FEMALE GENITAL MUTILATION IN THE EUROPEAN UNION AND CROATIA* 25 (2013).

96. *See* DORKENOO, MORISON & MACFARLANE, *supra* note 6, at 25 & tbl.7 (estimating the number of women then residing in England and Wales who were at risk of or had already undergone FGM).

97. 2009 EP Resolution, *supra* note 35, ¶ 8.

the “root causes and effects, incidences and conviction rates, as well as the efficacy of measures taken to implement this Convention.”⁹⁸

Consequently, there are a number of critical questions concerning FGM in the UK for which reliable statistical data is not available. Data is not available on the following issues: (a) prevalence, morbidity, and mortality by type of FGM procedure and the ethnic origin of the practicing groups; (b) the extent to which at-risk girls living in the UK are subjected to FGM *within* the UK as opposed to being *taken abroad* for FGM; (c) the number of girls living in the UK who are subjected to FGM abroad *legally* each year because they are not UK citizens or permanent residents when they are taken abroad for FGM; (d) which types of FGM are carried out *within* the UK and, in particular, how women manage to become reinfibulated after childbirth; (e) the extent to which the UK is a *destination country* for people wishing to have FGM performed in Europe (there is some evidence that girls are brought to the UK for FGM from other EU countries in order to take advantage of lax enforcement of the FGM law in the UK);⁹⁹ (f) how attitudes towards FGM are shifting and evolving among various ethnic group and age cohorts within the UK; and (g) the citizenship and residency status of girls taken out of the UK for FGM—what percentage of these individuals are UK nationals, permanent residents, and nonpermanent residents? In addition, there is a lack of data on why FGM prosecutions have not moved forward in light of the fact that police recently investigated more than one hundred suspected cases of FGM.¹⁰⁰

98. See Istanbul Convention, *supra* note 44, art. 11.

99. See Hazel Barrett, *UK Letting Down Victims of Female Genital Mutilation*, THE CONVERSATION (June 13, 2013, 1:46 AM), <https://theconversation.com/uk-letting-down-victims-of-female-genital-mutilation-14867> [<http://perma.cc/NG77-RFEB>] (archived Feb. 5, 2015) (noting the absence of FGM data in most countries and reporting that “the UK [is] a destination for many families who . . . believe the law isn’t applied [t]here”); Sue Lloyd-Roberts, *Migrants From Europe Bringing Girls to Tolerant Britain for Genital Mutilation*, INDEPENDENT (July 23, 2012), <http://www.independent.co.uk/news/uk/home-news/migrants-from-europe-bringing-girls-to-tolerant-britain-for-genital-mutilation-7965148.html> [<http://perma.cc/X3FP-Y2GT>] (archived Feb. 5, 2015); Kim Willsher, *France’s Tough Stance on Female Genital Mutilation Is Working, Say Campaigners*, GUARDIAN (U.K.) (Feb. 10, 2014, 3:00 PM), <http://www.theguardian.com/society/2014/feb/10/france-tough-stance-female-genital-mutilation-fgm> [<http://perma.cc/3R5N-CHSF>] (archived Feb. 5, 2015); see also HAZEL BARRETT ET AL., REPLACE: RESEARCHING FEMALE GENITAL MUTILATION INTERVENTION PROGRAMMES LINKED TO AFRICAN COMMUNITIES IN THE EU 14 (2011), available at http://www.replacefgm.eu/documents/content/toolkit/replace_toolkit.pdf [<http://perma.cc/XHQ7-MMAE>] (archived Feb. 6, 2015) (“[M]any FGM practicing communities in the EU do not take the law seriously, or take their daughters to other EU countries, where it is perceived that the law is less rigorously applied, in order to have their daughters subjected to FGM.”).

100. See Hugh Muir, *Female Genital Mutilation Laws Need to Be Toughened Against Families*, GUARDIAN (U.K.) (July 22, 2011, 1:17 PM), <http://www.theguardian.com/lifeandstyle/2011/jul/22/female-genital-mutilation-laws-families> [<http://perma.cc/Y3HE-U7TM>] (archived Feb. 5, 2015).

Reliable data on the prevalence of FGM among various groups in the UK is essential in order to have effective intervention and prosecutions. Prevention, awareness-raising, and educational strategies must be tailored to the various types of FGM and the particular health and social consequences that surround each type. For instance, infibulation—the most severe form of FGM—carries particularly catastrophic, chronic health consequences,¹⁰¹ many of which can be alleviated by reversal surgery, also known as deinfibulation. But there is a lack of even basic data on the number of women in the UK who have been infibulated and where these procedures were carried out. This data is essential in order to track morbidity and mortality among these women, as well as reach affected individuals with information about the availability of deinfibulation. Women have complained that they want deinfibulation but do not know where to go to have the procedure done.¹⁰²

In addition, evidence from health care practitioners indicates that some women from affected communities ask for reinfibulation after childbirth.¹⁰³ Even when physicians refuse this request, women have returned, infibulated, when they are expecting their next child.¹⁰⁴ There is currently no data gathering system set up to track the prevalence of reinfibulation and the means by which these procedures are taking place. The taboo nature of discussing FGM in many communities means that data collection efforts must be carefully designed and culturally sensitive.

101. In addition to problems associated with childbirth, infibulation results in severe day-to-day problems including slow, painful urination, frequent urinary tract infections, and accumulation of menstrual blood in the vagina. See NORWEGIAN MINISTRIES, ACTION PLAN FOR COMBATting FEMALE GENITAL MUTILATION 2008–2011 7 (2008), available at https://www.regjeringen.no/globalassets/upload/hod/dokumenter-fha/kjonnslemlestelse/handlingsplan_kjonns1_eng_net.pdf [<http://perma.cc/FZ5X-JB56>] (archived on Feb. 6, 2015); see also DEPT. OF GENDER & WOMEN'S HEALTH, *supra* note 65, at 11 (discussing several of the health consequences of infibulation and reinfibulation).

102. For example, one woman in the FORWARD study stated, "She asks the local nurse where she can get the sewing opened and they always tell her they don't know where she can get it done and to ask somewhere else. This has gone on for years." KATE NORMAN, JOANNE HEMMINGS, EIMAN HUSSEIN & NAANA OTOO-OYORTEY, FGM IS ALWAYS WITH US: EXPERIENCES, PERCEPTIONS AND BELIEFS OF WOMEN AFFECTED BY FEMALE GENITAL MUTILATION IN LONDON 38 (2009) [hereinafter PERCEPTIONS AND BELIEFS].

103. See Interview with Comfort Momoh, *supra* note 7; INTERCOLLEGIATE REPORT, *supra* note 59, at 12 (explaining that, for the purposes of the FGM Act, reinfibulation after childbirth is not considered FGM); see also DEPT. OF GENDER & WOMEN'S HEALTH, *supra* note 65, at 11 (noting that healthcare providers may be asked to re-stitch a vulva and equating reinfibulation with the original act of FGM).

104. See Interview with Comfort Momoh, *supra* note 7; see also 30 June 2011, PARL. DEB., H.L. (2011) 1900 (U.K.), *supra* note 59.

3. Cultural Obstacles Within Communities that Perpetuate FGM

Female genital mutilation is a practice with strong social significance. Women in affected communities must undergo it in order to be viewed as accepted, adult members of their communities.¹⁰⁵ By submitting to FGM, women gain social legitimacy and become marriageable.¹⁰⁶ Accordingly, understanding the social importance of FGM is key to eliminating it. Community-wide discussion about, and rejection of, FGM is critical because women (and their parents) who reject FGM need to be certain that they (and their daughters) will still have meaningful and fulfilling futures.¹⁰⁷ Eliminating FGM must involve (a) breaking through the silence around the issue that is imposed by many communities, (b) ensuring that those in affected communities have access to reliable information on the physical reality of FGM and its health consequences, and (c) addressing head-on the strong community pressure that enforces the practice of FGM.

a. Silence

FGM-affected communities have strong taboos against discussing the procedure, even amongst themselves. According to Sarah McCullough of the Agency for Culture Change Management UK, “a code of silence in Britain’s African communities has allowed circumcisions to continue and has prevented arrests.”¹⁰⁸ “It is something they simply do not discuss—if they do they’d be seen as betraying their family and their community and culture, she said.”¹⁰⁹ The experience of Nimko Ali, a British-Somalian woman who founded the charity Daughters of Eve, corroborates McCullough’s observations. Ali has stated that she “never told anyone I had FGM, not even my best friend, because I saw what happened to women in the UK who did speak out and I saw it as a warning sign.”¹¹⁰ She has suffered consequences for speaking out, including a former friend offering to kill her for £500 and a man throwing liquid in her face, making her fear

105. See HANNY LIGHTFOOT-KLEIN, *SECRET WOUNDS* 57 (2002).

106. See *id.* at 61 (“[A] girl who has not been circumcised is regarded as foul, unmarriageable and deserving only of pity.” (footnote omitted)); see also PERCEPTIONS AND BELIEFS, *supra* note 102, at 11–12, 21–22.

107. See generally Abdi A. Gele, Bernadette Kumar, Karin Harsløf Hjelde & Johanne Sundby, *Attitudes Toward Female Circumcision Among Somali Immigrants in Oslo: A Qualitative Study*, 4 INT’L J. WOMEN’S HEALTH 7, 11–17 (2012), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3271810/> [<http://perma.cc/Q7QL-VQBA>] (archived Feb. 5, 2015) (explaining that cultural and social pressure has changed the perception of FGM in some Somali immigrant communities in Norway).

108. Richard Kerbaj, *Thousands of Girls Mutilated In Britain*, TIMES (U.K.) (Mar. 16, 2009, 12:00 AM), <http://www.thetimes.co.uk/tto/health/article1964473.ece> [<http://perma.cc/7JUM-TG3R>] (archived Feb. 5, 2015) (subscription required).

109. *Id.*

110. Hill, *supra* note 9.

that it was acid.¹¹¹ She said, “He was screaming that I was ‘a slag’ and needed to learn some shame.”¹¹²

Community members may also face severe sanctions for discussing FGM with people outside the FGM-affected community. For instance, in March 2012, Liberian journalist Mae Azango received death threats for publishing an article about FGM in Liberia.¹¹³ The article stated, among other things, that individuals “who experience complications from [FGM] . . . do not seek [medical attention] until they are in dire condition, because they have taken an oath to keep secret what happens in the Sande bush. The promised punishment for speaking out . . . is death.”¹¹⁴

In January 2008, the Daily Mail reported that “[i]n Norway, . . . a young Somali woman was . . . beaten, almost to death, for talking to TV documentary” producers about FGM.¹¹⁵ The Daily Mail also interviewed a fifteen-year-old British-Somali girl in East London who was “plainly terrified” to speak to them about FGM. “Promise no one will ever know that I’ve spoken to you? If people in my community find out, they’ll say that I’ve betrayed them and I’ll have to run away,” she implored.¹¹⁶ As these examples indicate, FGM is often not a subject open for discussion, even within affected communities.

As a result of the culture of silence surrounding FGM and community pressure to acquiesce to the practice, it is extremely difficult for affected individuals to discuss FGM with outsiders and particularly with people in positions of authority, such as the police. Individuals are understandably reluctant to report family members to

111. *See id.*

112. *Id.*

113. *See* Public Statement, Amnesty Int’l, *Liberian Police Must Take Immediate Action to Protect Journalist*, AI Index No. AFR 34/001/2012 (Mar. 13, 2012), available at <http://www.amnesty.org/en/library/asset/AFR34/001/2012/en/e8a58660-e392-4296-847e-55dfe250c12f/af340012012en.html> [<http://perma.cc/BM5G-MT2S>] (archived Feb. 5, 2015); Hajer Naili, *Liberian Journalist Threatened for FGM Coverage*, WOMEN’S ENEWS (Dec. 27, 2012), <http://womensenews.org/story/journalist-the-month/121226/liberian-journalist-threatened-fgm-coverage#U5DtUvmwJcQ> [<http://perma.cc/FW8L-WNKV>] (archived Feb. 5, 2015); Wade C.L. Williams, *Sande Bush Fallout: World Outcry Over Death Threats Against Liberian Journalist*, FRONT PAGE AFRICA ONLINE (Mar. 15, 2012, 10:10 PM), <http://www.frontpageafricaonline.com/old/politics/42-politics/2734-sande-bush-fallout-world-outcry-over-death-threats-against-liberian-journalist.pdf> [<http://perma.cc/WN2K-3SRF>] (archived Feb. 6, 2015).

114. Mae Azango, *Growing Pains: Sande Tradition of Genital Cutting Threatens Liberian Women’s Health*, FRONT PAGE AFRICA ONLINE (Mar. 8, 2012, 6:46 PM), <http://www.frontpageafricaonline.com/old/health/54-health-matters/2691-growing-pains-sande-tradition-of-genital-cutting-threatens-liberian-womens-health.html> [<http://perma.cc/U4QB-ZBPE>] (archived Feb. 6, 2015).

115. Jo-Ann Goodwin & David Jones, *The Unspeakable Practice of Female Circumcision That’s Destroying Young Women’s Lives in Britain*, DAILY MAIL (U.K.) (Jan. 3, 2008, 11:57 AM), <http://www.dailymail.co.uk/femail/article-505796/The-unspeakable-practice-female-circumcision-thats-destroying-young-womens-lives-Britain.html> [<http://perma.cc/T8PN-SZWK>] (archived Feb. 6, 2015).

116. *Id.*

the police when doing so means that those family members may face criminal prosecution. Such a prosecution can have a dramatic impact on the lives of the victims. A daughter who reports otherwise loving parents for FGM could find herself being placed into care, her parents sent to prison, and her family losing its economic livelihood. These adverse consequences would naturally be a very strong disincentive for persons with knowledge of FGM to come forward.¹¹⁷

A 2009 FORWARD study found that certain perceptions about the FGM Act circulated among members of affected communities and contributed to a reluctance to report FGM to the police, even when the beliefs were not accurate. For instance, one participant in the FORWARD study “said she knew a woman who is now in jail [in Britain] because she had her daughters circumcised.”¹¹⁸ At least two other study participants said that they had heard of incidents in which parents took their daughters overseas for FGM, and upon return to the UK, their daughters were taken away from them.¹¹⁹ These claims are not factually accurate, but their circulation reveals that inaccurate beliefs about the consequences of reporting FGM can silence people.¹²⁰

A Danish case demonstrates, however, that formidable obstacles to reporting can, in fact, be overcome. In that case, two girls chose to come forward because they felt that it was the only way to protect their younger sister. The two girls were aged ten and twelve when their Eritrean mother took them to Sudan in 2003 to undergo FGM. Later, when their mother was in the process of planning another trip to Sudan to have FGM performed on the girls’ six-year-old sister, the two older girls alerted other adults to their mother’s plans. In 2009, a Danish court sentenced the mother to two years in prison for having FGM carried out on the two older girls. The father was acquitted of all charges, claiming he had no idea what was happening. This prosecution was the first one in which a Danish court handed down a jail sentence in an FGM case.¹²¹

117. See PRACTICE GUIDELINES, *supra* note 82, at 23 (“For many people, prosecuting their family is something they simply will not consider.”).

118. PERCEPTIONS AND BELIEFS, *supra* note 102, at 51.

119. See *id.*

120. The claims are not accurate because there has never been a prosecution for FGM in Britain. Therefore, no parents or circumcisers have been imprisoned. See, e.g., *id.*; COMMONS SELECT COMM., *Committee Announce New Inquiry Into Female Genital Mutilation*, UK PARLIAMENT (Dec. 18, 2013), <http://www.parliament.uk/business/committees/committees-a-z/commons-select/home-affairs-committee/news/131218-new-inquiry-fgm/> [<http://perma.cc/N4D9-KPYP>] (archived Feb. 6, 2015) (questioning the efficacy of existing efforts to raise FGM awareness and inviting the public to submit ideas on how to combat the practice).

121. See Marcus Oscarsson, *Sweden, Denmark and Norway Try to Stop Genital Mutilation Among Immigrants at Home and Abroad*, MINN POST (Sept. 21, 2009), <http://www.minnpost.com/global-post/2009/09/sweden-denmark-and-norway-try-stop-genital-mutilation-among-immigrants-home-and-> [<http://perma.cc/XFJ6-SLAL>] (archived Feb. 6, 2015).

b. Lack of Education and Awareness Around FGM Leads to the Normalization of Severe Health Problems

Some FGM-affected communities practice a taboo of silence around FGM, such that people do not discuss FGM even with close family members. In such contexts, it is difficult or impossible to have open discussion about the health problems caused by the procedure. In addition, the fact that FGM is generally carried out before puberty and the onset of menstruation contributes to community members lacking the awareness that FGM has serious health consequences.

Instead, women may develop the perception that the health consequences they experience are simply a normal part of being female. This is particularly so because such problems are likely experienced by the majority of women in the community.¹²² For instance, infibulated women typically report that their periods are extremely painful and that blood tends to accumulate in the vagina, but they do not necessarily know that these difficulties are a consequence of FGM when they have not experienced menstruation any other way and when other women in the community have similar experiences. These accounts, from the 2009 FORWARD study, are representative:

Her neighbour was circumcised so tightly that even her urine comes out drop by drop, and her menses stayed for 10 or 15 days.¹²³

After her first child she bled so much for 40 days, they thought they had forgotten something during the delivery inside her, so much blood and it looked like fleshy fatty tissue coming out, and they said it was because she had been circumcised and the blood had not been able to escape properly. Her other friends say that it happened to them too, *it is normal because of the FGM*.¹²⁴

Some people are taken to hospital when they cannot pass urine. There is a story about a lady in Sudan who got infection and was not able to pass urine. She had fever because the opening was very small and so she kept getting infections and had bad smelling discharge. She had to go to Cairo for medical help and they told her it was because of FGM. The Doctor asked her if she would like to be opened up but she refused because she was not married and did not want her to lose her virginity.¹²⁵

[Circumcision leaves] only a very small opening which might cause lots of problems during the menstrual cycle, as the blood comes out with

122. See LIGHTFOOT-KLEIN, *supra* note 105, at 63 (2002) (“Because the rituals [FGM] saturate entire regions and are performed for the most part on small girls, no basis for comparison with intact women exists for its practitioners and therefore, the cause and effect relationship between the procedures and their devastating consequences to women’s physical and emotional health later on in life is not understood by the populace. Failure to make this connection is absolutely crucial to continuation of the practices.” (footnote omitted)).

123. PERCEPTIONS AND BELIEFS, *supra* note 102, at 37.

124. *Id.* at 38 (emphasis added).

125. *Id.* at 37.

difficulty from the opening, usually with the monthly cycle there is a lot of pain and discomfort.¹²⁶

The majority if not all have some or all of these health problems – if everyone has it done, and everyone feels pain on sex, *then that is what is normal for women.*¹²⁷

These testimonies illustrate that women from affected communities may tend to view the highly debilitating health complications of infibulation as normal experiences rather than as the life-threatening and preventable problems that they actually are. Accurate information about the health effects of FGM can help communities make the necessary linkages between FGM and poor health and understand the health benefits of abandoning the practice.

c. Community Pressure to Accept FGM is Intense

Affected communities exert extremely strong pressure on their members to accept and perpetuate FGM. Families can be stigmatized and marginalized if they refuse to accept FGM, and parents worry that their daughters will not be able to get married if they have not undergone FGM. According to the 2009 FORWARD study,

Female circumcision is thus a socially prescribed act in these women's countries of origin. Not participating in the practice, or in the accompanying social event, is seen by the wider social group as a rejection of shared values and identity.¹²⁸

In fact, the pressure to conform can be so great that girls sometimes want to undergo FGM against their parents' wishes in order to be accepted among their peers. In 2006, a fifteen-year-old Kenyan girl bled to death after attempting to perform FGM on herself because she wanted to fit in with her peers. Her mother had refused to allow her to undergo the procedure.¹²⁹

It can be extraordinarily difficult for parents to stand up to this pressure. The decision to circumcise is not simply made at one point in time—if a mother decides against it at one point, the community will keep pressuring her for years until she gives in. The FORWARD study found that mothers have to be highly motivated and assertive to resist the ongoing pressure.¹³⁰ Women who decide against circumcising their daughters may face ongoing internal doubts, especially if they plan to return to live in their original country.¹³¹

126. *Id.*

127. *Id.* at 38 (emphasis added).

128. *Id.* at 20.

129. *See Kenya Shocked at Mutilation Death*, BBC NEWS (June 23, 2006, 11:49 AM), <http://news.bbc.co.uk/2/hi/africa/5109094.stm> [<http://perma.cc/BP96-LWLR>] (archived Feb. 6, 2015).

130. *See PERCEPTIONS AND BELIEFS*, *supra* note 102, at 12.

131. *See id.*

In addition, extended family members have been known to have FGM performed on girls against the wishes of, and without the knowledge of, the parents.¹³² Participants in the 2009 Forward study made the following statement about mothers traveling to Sudan on holiday:

When people go back to Sudan on holiday, always the grandmothers pressurise them to have their daughters circumcised.

Grandmothers pressurise their children into circumcising their daughters, but most mothers either avoid going to Sudan if the pressure is too much until their children get older. Or if they go, they do not leave their girls alone . . . as the grandmother or aunts might circumcise the girls even despite the mother's refusal.¹³³

In a case reported in *The Times*, a father in Britain reportedly said that his wife became eager to circumcise their two young daughters when she took them on holiday to Somalia and felt pressured by her own mother. He claimed that he was only able to protect the girls by telling his mother-in-law that he would kill his wife if they carried out the procedure.¹³⁴

Many FGM-affected communities have social structures that afford women few or even no economic options outside of marriage. Consequently, the idea that a woman could be economically self-sufficient without marriage may be an unfamiliar and unacceptable concept to many people from such communities and one that they do not want to embrace for their daughters.¹³⁵ Efforts to end FGM must involve and engage entire communities since the procedure has a strong significance to these communities as a whole, and parents and girls can experience very strong social pressure to accept FGM. With these cultural components reinforcing FGM—lack of economic options for women outside marriage, a perceived shortage of men willing to marry women who have not been through FGM, and stigma applied to families who refuse to conform—it will be very difficult to effect lasting change by focusing on one individual at a time.

132. See *id.* at 26; see also IRIN, *Burkina Faso: I Saw the Knife and Knew: One Girl Recalls her Circumcision*, in RAZOR'S EDGE: THE CONTROVERSY OF FEMALE GENITAL MUTILATION 16, 16–17 (2005), available at <http://www.irinnews.org/pdf/in-depth/fgm-irin-in-depth.pdf> [<http://perma.cc/BE7P-X3LW>] (archived Feb. 6, 2015) (recounting the story of a young girl visiting her grandmother expecting a normal weekend, who was forced to undergo FGM at her grandmother's behest).

133. PERCEPTIONS AND BELIEFS, *supra* note 102, at 32.

134. Richard Kerbaj, *Case Study: Female Circumcision, the Husband*, *TIMES* (London) (Mar. 16, 2009, 12:00 AM), <http://www.thetimes.co.uk/tto/health/article1964475.ece> [<http://perma.cc/B2YE-ZZQC>] (archived Mar. 12, 2015) (subscription required).

135. See, e.g., PERCEPTIONS AND BELIEFS, *supra* note 102, at 19 (noting while many women feel they have more options outside of marriage in the United Kingdom than in their home countries, others felt burdened by them).

4. The Practical Impact of the FGM Statutory Regime on Women and Girls in the UK
 - a. Results from the 2009 FORWARD Study

Although the lack of data on FGM is a significant obstacle to tackling the problem, the 2009 FORWARD study, *FGM is Always With Us*, offers key data on the practical impact that the FGM Act has had on affected communities in the UK. The study gathered data from affected communities through the use of trained peer responders who conducted interviews with women from these communities. The study found that people believe the FGM Act has had some deterrent effect (although it is also frequently misunderstood) and that some members of affected communities persist in taking their daughters overseas to have FGM performed despite the law. This study is a good starting point for understanding the impact the current law and approach to FGM has had on affected communities thus far.

- b. People Are Aware of the Law Prohibiting FGM But Do Not Have a Good Grasp of the Law's Details and Nuances

The study found that people generally know that FGM is prohibited in the United Kingdom, but they do not know what the specific impact of this prohibition means. There is evidence that people hold inaccurate beliefs about the law that could contribute to reluctance to reporting information to the authorities. For instance, some people had heard that a child could be taken away from her parents because of FGM, or that the parents could lose their jobs.¹³⁶

The law is not clear - even those who have heard of it do not know what it will actually mean for the families.¹³⁷

People have heard there is a reward being given to someone who tells the police about people who are doing FGM. They have heard they put people in prison but do not know for how long.¹³⁸

People in the community know that the U.K. government has prohibited female circumcision but they don't know about the sentences and the fines.¹³⁹

- c. Inaccurate Perceptions of the Law May Interfere with Women's Access to Health Care

These inaccurate beliefs may also be related to another finding of the study: women are reluctant to volunteer information about their

136. See *id.* at 32–34.

137. *Id.* at 33.

138. *Id.* at 34.

139. *Id.*

experience to health care practitioners, with the result that they may not get the specialized care that they need.¹⁴⁰

Now health professionals have some understanding of FGM but even so, the women themselves do not inform them of the problems they might face, especially when related to their genitalia as they are shy to talk about it and fear that they will not be understood.¹⁴¹

As long as people mention it (that they are circumcised) early enough they can get the help they need. But many don't - maybe they are shy or maybe they think it is not important to mention it.¹⁴²

Many women avoid the cervical smear test as they do not want to be examined¹⁴³

People do not want to inform the health services about their experiences and think it is their own secret.¹⁴⁴

Given the prevalence of misinformation about the law, women's reluctance to volunteer information about FGM could also be out of concern that they could somehow get in trouble with the law if they disclose that FGM has been carried out on them. If this is the case, the FGM prohibition, coupled with poor dissemination of the law's details and inadequate information about specialist health services for FGM survivors, could be preventing those affected by FGM from accessing the services they need.

d. The Law Has Had Some Deterrent Effect, But FGM Still Persists

According to the 2009 study, women believe that perceptions of the FGM law, even when inaccurate, have been important in deterring the practice of FGM, especially in discouraging people from taking daughters to be circumcised in their families' countries of origin. For instance, there were reports that some women effectively used the UK law to combat extended family pressure to circumcise when visiting relatives overseas:

Those who do have information on the law have not circumcised their girls and some have even informed their families in Sudan that their daughters cannot be circumcised, especially when they take them on holiday. They tell them that they are living outside of Sudan and do not need to circumcise, and that if this is done they will be taken to prison.¹⁴⁵

The study concluded that "[t]he UK law gives families support in resisting social pressure to circumcise, even when they are in another country."¹⁴⁶ There was also contrasting evidence, however, that others

140. *See id.* at 43.

141. *Id.*

142. *Id.*

143. *Id.* at 44.

144. *Id.* at 43.

145. *Id.* at 33.

146. *Id.*

do not see the law as a deterrent and persist in taking their daughters overseas to have FGM performed despite the law.¹⁴⁷ A number of women reported that such “people resent the law and see it as interfering with their tradition and culture.”¹⁴⁸

e. Desire to See the Law Enforced

Other study participants took the view that the law needs to be enforced—they felt that examples should be made, “while taking care that these examples come from various communities.”¹⁴⁹

If the law had actually been acted on for a few communities they might have been more fearful of it, but up until now it is just words, with no action!¹⁵⁰

If there were examples of people having been penalised here in the UK, or seeing and examining the daughters, and from each of the different cultures here, from different communities, that would really change things a lot.¹⁵¹

In sum, the most important findings from this data are that (1) there is a strong need for dissemination of accurate, detailed information about the law prohibiting FGM and (2) while the existence of the law appears to have had at least some deterrent effect, active enforcement of the law could potentially have a much stronger effect in deterring FGM.

f. Lack of Funding for FGM Prevention Work and Specialist Health Services

The FGM Act does not make any provision for funds to be used for any sort of prevention work or specialist health services related to FGM. There are substantial needs in the areas of education and awareness-raising within affected communities as well as among healthcare professionals. The 2009 FORWARD study revealed that there is a strong desire for access to information about the harmful effects of FGM within affected communities. The study also revealed significant unmet needs for physical and psychological aftercare.¹⁵²

All of these areas require funding commitments. The UN FGM Resolution notes “a tremendous gap in resources” with respect to funding for FGM prevention efforts and notes that this gap “has severely limited the scope and pace of” efforts to eliminate FGM.¹⁵³ It

147. *See id.*

148. *Id.*

149. *Id.*

150. *Id.*

151. *Id.*

152. *See id.* at 40–44.

153. UN FGM Resolution, *supra* note 48, pmb1.

therefore calls upon states to “allocate sufficient resources to the implementation of policies and programmes and legislative frameworks aimed at eliminating [FGM].”¹⁵⁴ It also invites the “international community, the relevant United Nations entities and civil society[,] and international financial institutions to continue to actively support, through the allocation of *increased financial resources* and technical assistance, targeted comprehensive programmes that address the needs and priorities of women and girls at risk of or subjected to [FGM].”¹⁵⁵

Less than three months after the UN issued this resolution, the UK government pledged £35 million to help eliminate FGM within a generation.¹⁵⁶ This commitment is a start, but it is too early to say how effective this commitment will be, and it is important that funding commitments be sustained over the long term. In April 2014, the Special Rapporteur on Violence Against Women, Ms. Rashida Manjoo, completed a sixteen-day mission to the United Kingdom. Her report expressed concern that government austerity measures were having a negative and disproportionate impact on the provision of services meant to combat violence against women.¹⁵⁷ She noted that cuts to legal aid were an obstacle to women being able to access the justice system, and she also noted that “[i]t is important to recognize that the reduction in the number and quality of specialized services for women does impact health and safety needs of women and children . . .”¹⁵⁸ Programs meant to eliminate FGM will not thrive in an environment where other services meant to reduce violence against women are suffering. All such programs require sustained funding commitments over the long term.

154. *Id.* ¶ 14.

155. *Id.* ¶ 17 (emphasis added).

156. See Liz Ford, *UK Funds Aim to End Female Genital Mutilation ‘in a Generation,’* GUARDIAN (U.K.) (Mar. 6, 2013, 6:51 AM), <http://www.theguardian.com/global-development/2013/mar/06/uk-funds-female-genital-mutilation-generation?guni=Article:in%20body%20link> [<http://perma.cc/A7KZ-H629>] (archived Feb. 17, 2015).

157. See Rashida Manjoo, Special Rapporteur on Violence Against Women, United Nations Office of the High Comm’r for Human Rights, Special Rapporteur on Violence Against Women Finalizes Country Mission to the United Kingdom and Northern Ireland and Calls for Urgent Action to Address the Accountability Deficit and Also the Adverse Impacts of Changes in Funding and Services (Apr. 15, 2014), *available at* <http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=14514&LangID=E> [<http://perma.cc/RPB6-XQ5E>] (archived Feb. 17, 2015).

158. *Id.*

5. Professionals' Lack of Preparedness to Appropriately Intervene in FGM Cases

The training of professionals to respond appropriately to FGM cases is a priority area for funding. Frontline professionals who have regular contact with children are in an ideal position to identify suspected cases of FGM and report them to the relevant authorities. But for professionals to fulfill this function, they must be aware of FGM and be knowledgeable about how to properly respond to those cases. The little research that is available indicates that health care professionals and teachers are not yet properly equipped to identify and take action in cases of FGM.

a. Health Professionals

Three recent studies have examined attitudes towards, and awareness of, FGM among health professionals, and they show poor levels of awareness. A 2007 study surveyed forty-five respondents at a teaching hospital.¹⁵⁹ It found significant deficiencies in knowledge about FGM and lack of adherence to clinical guidelines on FGM issued by the Royal College of Obstetricians and Gynaecologists (RCOG).¹⁶⁰ A 2012 study surveyed seventy-nine health professionals and found only slight improvement over the 2007 study.¹⁶¹ For example, "less than 25% of respondents had received formal training in recognising or managing [FGM]," and 10 percent of respondents "thought that medicalising, and therefore making FGM legal . . . would make the practice more open and safe."¹⁶²

Although both of these studies had small sample sizes, a 2010 study conducted by the Royal College of Midwives was much larger, reporting the views of over 1,700 midwives.¹⁶³ This study found similar deficiencies in knowledge about FGM. For instance, only 15 percent of respondents had received formal training in recognising or managing FGM, just 58 percent reported an awareness of the UK law against

159. See generally N. Zaidi, A. Khalil, C. Roberts & M. Browne, *Knowledge of Female Genital Mutilation Among Healthcare Professionals*, 27 J. OBSTETRICS & GYNAECOLOGY 161 (2007).

160. See *id.* at 161–63.

161. See Sophie Relph, Rekash Inamdar, Hardeep Singh & Wai Yoong, Letter to the Editor, *Re: Female Genital Mutilation: The Role of Health Professionals in Prevention, Assessment, and Management*, BRIT. MED. J. (Mar. 30, 2012), <http://www.bmj.com/content/344/bmj.e1361/rr/576570> [<http://perma.cc/NAH5-JU44>] (archived Feb. 17, 2015).

162. *Id.*

163. JANINE STOCKDALE & JANET FYLE, THE ROYAL COLLEGE OF MIDWIVES, FEMALE GENITAL MUTILATION: REPORT OF A SURVEY ON MIDWIVES' VIEWS AND KNOWLEDGE 8 (2012) [hereinafter MIDWIVES' VIEWS], available at <http://www.bava.org.uk/wp-content/uploads/Midwifery-survey-in-to-views-on-FGM-Survey-FINAL.pdf> [<http://perma.cc/G8SS-7BVQ>] (archived Feb. 17, 2015).

FGM, and only 21 percent knew that reinfibulation following childbirth was considered illegal by the RCOG.¹⁶⁴

The findings of these studies are particularly timely given Dr. Dharmasena's arrest in March 2014 for allegedly performing FGM after a birth in November 2012.¹⁶⁵ Dharmasena's arrest followed an incident where the thirty-one-year-old doctor was confronted, for the first time, with a Somali patient who had been infibulated as a child and was in the late stages of labor.¹⁶⁶ Dharmasena stated at his trial that he had never received training in how to properly respond to FGM.¹⁶⁷ Although he was charged, under the FGM Act, with performing a procedure that was not medically necessary, he told the court that the post-childbirth stitching he performed was in fact medically necessary to stem bleeding after the birth.¹⁶⁸ The jury agreed with him, deliberating for less than thirty minutes before delivering a "not guilty" verdict.¹⁶⁹ But the prosecution came at heavy cost to Dharmasena. He was suspended from the medical register when the prosecution was announced, and he also endured death threats¹⁷⁰—a significant price to pay for a young doctor who had not been trained to handle the situation in which he found himself. The scenario described here could easily happen to any doctor or midwife who is unfamiliar with FGM and has patients affected by infibulation. Consequently, medical professionals' lack of awareness of FGM is a critical problem and could land them in legal trouble.

The midwife study described above offers further evidence that health professionals are ill-equipped to handle FGM adequately. The great majority of respondents in the midwife study—85 percent—indicated that they were not familiar with available resources related to FGM and did not know where to refer women with FGM for specialist services.¹⁷¹ The study also found that many midwives were not aware of the resources available to them, such as the RCOG clinical guidelines¹⁷² and the government's 2011 Multi-Agency Guidelines on FGM.¹⁷³ This study made a number of recommendations for improving training. Most importantly, it noted that midwives do, in fact, have a strong interest in receiving more training on how to care for women with FGM, particularly women in labor who present with FGM. The study concluded by stating that the midwives' lack of preparedness was

164. See *id.* at 14, 15, 17.

165. See Bowcott, *supra* note 1.

166. See Laville, *supra* note 61.

167. *Id.*

168. *Id.*

169. *Id.*

170. *Id.*

171. STOCKDALE & FYLE, *supra* note 163, at 16, figs. 2 & 3.

172. STOCKDALE & FYLE, *supra* note 163, at 11; see also ROYAL COLL. OF OBSTETRICIANS & GYNAECOLOGISTS, *supra* note 65 (providing background information on FGM and the RCOG Guidelines for clinical professionals).

173. See generally PRACTICE GUIDELINES, *supra* note 82.

worrying because it supports some of the communities' assertion that professionals are not always aware of what to do when a patient presents with FGM.¹⁷⁴

It is indeed the case that women with FGM have complained about inappropriate reactions from health professionals, such as revulsion or disgust. In one case that a Somali community leader shared with me, a woman went to the doctor for FGM-related health problems, having specifically requested a female gynecologist in the hopes that she would be familiar with FGM. But this particular doctor had never seen a case of FGM before and reacted with shock and horror. She compounded the patient's discomfort by calling in several of her colleagues to come and look at the woman's genitalia, since none of them had ever seen genitals in such condition before. The patient was mortified and did not get the care she needed.¹⁷⁵

Women with FGM have also noted an inability among health professionals to provide referrals to specialist clinics that can provide deinfibulation or other services.¹⁷⁶ According to midwife Comfort Momoh, who runs a specialist FGM clinic at a central London hospital, many of the clinic's patients indicate that it took them months to find the clinic because physicians do not know about it and do not know where to refer them, despite the fact that the clinic has been open since 1997.¹⁷⁷ As a result of these difficulties, women with FGM have complained of insensitive treatment. Consequently, they may avoid seeking gynecological care.¹⁷⁸

Lack of preparedness among health professionals is a missed opportunity. Health professionals are currently ill-equipped to break the silence around FGM with affected women. They are not in a position to support women in resisting community pressure to circumcise daughters, and they are not providing accurate and accessible information on the health consequences of FGM because they themselves do not yet have the knowledge to enable them to fulfill these functions. But health professionals *can* be one of the most crucial entry points into affected communities in the fight against FGM. Therefore, there is a need to raise awareness among health professionals around FGM *and* help them understand how to respond to FGM with the utmost sensitivity and care.

174. See STOCKDALE & FYLE, *supra* note 163, at 18.

175. Interview with Zahra Ibrahim, Coordinator, Barking and Dagenham Somali Women's Association, in Barking, Eng. (June 25, 2012) (on file with author).

176. See Interview with Comfort Momoh, *supra* note 7.

177. See *id.*

178. See PERCEPTIONS AND BELIEFS, *supra* note 102, at 40–44.

b. Teachers

With respect to teachers, even less data is available, but a recent NSPCC survey found that 80 percent of teachers surveyed had not had child protection training on FGM.¹⁷⁹ This survey also found that 16 percent of teachers did not know that FGM is illegal in the UK, where nearly the same proportion did not regard FGM as child abuse, and 68 percent indicated that they are not aware that there is Government guidance on FGM.¹⁸⁰ These are disturbing figures given that teachers have a legal duty to safeguard children at risk of FGM.

In addition, anecdotal evidence indicates even greater deficiencies in knowledge and awareness of FGM among teachers than among health professionals. For instance, one social worker in east London indicated that she had dealt with situations where teachers had given detention to students with urinary tract infections resulting from FGM because these students had been going to the toilet too frequently.¹⁸¹ A teacher in the NSPCC study cited above stated that when she attempted to report that a pupil was possibly a victim of FGM, her “concerns were dismissed as ‘unlikely’ by the school’s head of child protection.”¹⁸² Teachers are very well positioned to help break community silence around FGM and provide accurate information about the practice, but they need proper training in order to fulfill this role.

The European Institute for Gender Equality has also pointed out that teachers have perhaps the most crucial role in FGM prevention because they are the professionals with “the most consistent, regular, and on-going interaction with young people.”¹⁸³ Teachers are in the best position to detect warning signs that FGM may occur. In addition, they are well placed to be a resource to young people seeking help, and they may notice behavioral changes, such as going to the toilet frequently, that may indicate that FGM has occurred. Accordingly, comprehensive FGM training for teachers should receive great priority.

179. See Nat'l Soc'y for the Prevention of Cruelty to Children, *Teachers' Efforts to Tackle Female Genital Mutilation Hampered: Lack of Training on the Warning Signs Identified as a Barrier to Alerting Authorities*, CRIME PREVENTION WEBSITE (Mar. 26, 2013, 11:47 AM) [hereinafter *Teachers' Efforts*], <http://thecrimepreventionwebsite.com/b/336/crime-prevention-news/2013/mar/26/teachers-efforts-to-tackle-female-genital-mutilation-hampered/> [<http://perma.cc/YS7S-WEMW>] (archived Feb. 17, 2015) (finding that four out of five teachers of the 1,000 teachers surveyed had not had training about girls at risk of FGM).

180. *Id.*

181. Interview with Victoria Hill, Domestic Violence Strategic Implementation Lead, Barking and Dagenham Primary Care Trust, in Barking, Eng. (July 3, 2012) (on file with author).

182. *Teachers' Efforts*, *supra* note 179.

183. LEYE ET AL., *supra* note 95, at 15.

c. Law Enforcement

As indicated above, there has not been any study examining why cases reported to the police have not resulted in prosecution, and collecting such data will be an important next step. Fortunately, the Home Affairs Select Committee launched a major inquiry into FGM in late 2013.¹⁸⁴ This inquiry attempted to determine why there has been no FGM prosecution in the nearly three decades since the law against female circumcision first took effect in 1985. It is possible that law enforcement investigations fail because officers are afraid of being perceived as culturally insensitive, or because they are unwilling to intervene in a matter that community leaders (particularly male community leaders) insist is private and should be addressed within the community.

In addition, in cases where the police succeed in identifying a girl who has been subjected to FGM, it can be difficult to proceed to prosecution if the family insists that the procedure was done before the family immigrated to the UK. Even where a girl was removed from the UK and taken overseas for FGM, a family may convince the authorities that the procedure was done before they immigrated, and FGM community workers shared with me accounts of this occurring.¹⁸⁵ Families can succeed at this deception because once the girl is fully healed, it is usually not possible to determine from the physical evidence exactly when the procedure took place.¹⁸⁶

d. Review of the Crown Prosecution Service Guidance on FGM

The Crown Prosecution Service (CPS) offers legal guidance on FGM.¹⁸⁷ This guidance is very effective and thorough and should therefore help prosecutors explore all charging possibilities when reviewing a case of possible FGM. In addition to defining FGM and setting out the relevant law, the CPS guidance states that FGM should be approached using an overall framework of human rights and of violence against women.¹⁸⁸ This means, among other things, that prosecutors should keep in mind that victims may also have been subjected to other crimes classified as violence against women, such as rape, forced marriage, or other sexual offenses.¹⁸⁹

184. Topping, *supra* note 13.

185. Interview with Amina Ali, FGM Outreach and Advocacy Worker, Black Women's Health and Family Support, in London, Eng. (July 6, 2012) (on file with author).

186. See Interview with Comfort Momoh, *supra* note 7.

187. See generally *Female Genital Mutilation Legal Guidance*, CROWN PROSECUTION SERV., http://www.cps.gov.uk/legal/d_to_g/female_genital_mutilation/ (last visited Mar. 14, 2015) [<http://perma.cc/AN5C-87QF>] (archived Feb. 17, 2015).

188. See *id.*

189. See *id.*

The guidance also urges prosecutors to consider the full ambit of charges in a particular case, especially when it is not possible to apply the FGM Act (such as when the perpetrator is not a UK citizen or permanent resident and the FGM took place outside the UK).¹⁹⁰ Other charges in FGM cases could include child cruelty, assault, and conspiracy, among others.¹⁹¹ The CPS guidance also discusses evidential considerations, such as reluctant victims, and they encourage prosecutors to consider moving a prosecution forward in the public interest.¹⁹²

Multi-Agency Practice Guidelines are available and provide guidance on dealing with FGM to all relevant agencies; however, these guidelines are limited in their effectiveness due to the fact that they are not statutory guidance and are therefore nonbinding.¹⁹³

IV. CREATING AN ENABLING LEGAL AND POLICY ENVIRONMENT FOR ADDRESSING FGM

FGM has been practiced for thousands of years and has proven to be a custom with tremendous staying power.¹⁹⁴ Consequently, ending it will require a planned, concerted effort accompanied by funding commitments that are commensurate with the seriousness of the task. Although members of the House of Lords and other policy makers have roundly condemned FGM, outrage over the practice is not enough to bring it to an end in the UK.¹⁹⁵ The announcement in March 2013 that the UK government has committed to spend £35 million to campaign against FGM is a step in the right direction,¹⁹⁶ but this level of commitment must be sustained over the long term if the efforts are to be successful.

A. A United Kingdom National Action Plan to End FGM

Given the complexity of these tasks, a national action plan for ending FGM is central to success. Such plans have been established in a number of other European countries in conjunction with the End FGM in Europe Campaign. Countries that have developed national

190. See *id.*

191. See *id.*

192. See *id.*

193. See PRACTICE GUIDELINES, *supra* note 82, at 6.

194. See Nawal M. Nour, *Female Genital Cutting: A Persisting Practice*, 1 REVS. OBSTETRICS & GYNECOLOGY, no. 3, 2008, at 135, 135–37, available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2582648/> [<http://perma.cc/38PF-B9TR>] (archived Feb. 17, 2015) (describing the origins and persistence of the practice of FGM).

195. For examples of outrage, see 30 June 2011, PARL. DEB., H.L. (2011) 1893–94 (U.K.).

196. See Ford, *supra* note 156.

action plans on FGM include, for example, Norway, Finland, Ireland, and Austria.¹⁹⁷ Other countries have incorporated action against FGM in their national action plans on gender-based violence and/or gender inequality.¹⁹⁸ In addition, the UN FGM Resolution urges the adoption of comprehensive and multidisciplinary action plans.¹⁹⁹

A national action plan for ending FGM provides the “big picture” and, accordingly, serves a number of purposes. A national action plan provides a way for the government to *coordinate* all anti-FGM efforts across sectors and ensure that all stakeholders are included in planning. It also provides a system for *disseminating* best practices across sectors and organizations, while allowing stakeholders to *avoid duplication of effort*. Also, given that national action plans against FGM and gender-based violence are being developed in several EU member states, these plans provide a way of allowing countries to compare initiatives, share best practices, and work together to end FGM. FGM is a complex problem, and a national action plan provides a mechanism for coordinating the range of responses that the problem requires.

Each country’s national action plan should be tailored to its specific needs, but such plans tend to have certain common elements. They tend to focus primarily on (a) legal measures, including ensuring strong legislation and effective enforcement of legislation, (b) working with communities on FGM-abandonment through education and knowledge transfer, (c) equipping professionals with the education and resources they need to effectively intervene, (d) specialist health services for FGM survivors, and (e) the coordination of international efforts against FGM. A strong anti-FGM action plan in the UK should address each of these areas. This Article elaborates on areas of emphasis within each of these five areas below.

197. See generally EUROPEAN INST. FOR GENDER EQUAL., CURRENT SITUATION OF FEMALE GENITAL MUTILATION IN AUSTRIA 3 (2012), available at http://eige.europa.eu/sites/default/files/documents/Current%20situation%20and%20trends%20of%20female%20genital%20mutilation%20in%20Austria_EN.pdf [<http://perma.cc/V6FP-373E>] (archived Mar. 14, 2015); MINISTRY OF SOC. AFFAIRS AND HEALTH, ACTION PLAN FOR THE PREVENTION OF CIRCUMCISION OF GIRLS AND WOMEN 2012–2016 (Fin.) (FGM) (2012), available at http://www.stm.fi/en/publications/publication/-/_julkaisu/1822114 [<http://perma.cc/6LZ8-7LXY>] (archived Feb. 17, 2015); NAT’L STEERING COMM., IRELAND’S NATIONAL PLAN OF ACTION TO ADDRESS FEMALE GENITAL MUTILATION (2008), available at http://www.ifpa.ie/sites/default/files/documents/media/fgm_plan_of_action_report.pdf [<http://perma.cc/T6ZL-FZ3R>] (archived Feb. 17, 2015); NORWEGIAN MINISTRIES, *supra* note 101.

198. See EIGE’s Study on Female Genital Mutilation Yields the First EU-Wide Map on the Situation of FGM, EUR. INST. FOR GENDER EQUALITY (Nov. 7, 2012, 4:00 PM), <http://www.eige.europa.eu/content/news-article/eige-study-on-female-genital-mutilation-yields-the-first-EU-wide-map-on-the-situation-of-FGM> (last visited Mar. 14, 2015) [<http://perma.cc/P3VT-8YJT>] (archived Feb. 17, 2015).

199. UN FGM Resolution, *supra* note 48, ¶ 7.

B. Legal Measures

Legal measures that the UK should consider include examining the possible range of approaches to prosecutions, strengthening the FGM Act, and determining whether other existing legislation could augment efforts to prosecute FGM.

1. Two Approaches to Prosecuting FGM: General Versus Specific Criminal Laws

a. Does the Approach Taken Make a Difference?

Experience in other European countries indicates that a specific law prohibiting FGM is not essential to prosecuting such cases. France, the leader in European FGM prosecutions, has prosecuted at least thirty-seven FGM cases.²⁰⁰ France relies on provisions of its general criminal code to criminalize FGM, as do many other European countries, including Germany, the Netherlands, Finland, Greece, and Luxembourg.²⁰¹ Switzerland has prosecuted two FGM cases under its general criminal law, and Spain prosecuted three cases under its general criminal law before introducing a specific FGM law in 2003.²⁰² The United Kingdom criminalizes FGM via a specific statute, as do nine other European countries, including Austria, Belgium, Cyprus, Denmark, Italy, Norway, Portugal, Spain, and Sweden.²⁰³ There have been a few prosecutions in these countries as well, including two in Sweden and one in Denmark, but, notably, none in the United Kingdom.²⁰⁴ The 2009 European Parliament Resolution “[c]alls on [m]ember [s]tates to *either* adopt specific legislation on FGM *or* [use] their existing legislation to prosecute each person who conducts genital mutilation.”²⁰⁵

Although criminalizing FGM explicitly is not essential to successful prosecution, direct criminalization of FGM may be helpful

200. United Nations Div. for the Advancement of Women & United Nations Economic Comm’n for Afr., Expert Group Meeting on Good Practices in Legislation to Address Harmful Practices Against Women, Addis Ababa, Eth., May 25–28, 2009, *Overview of Legislation in the European Union to Address Female Genital Mutilation: Challenges and Recommendations for the Implementation of Laws*, § 3, U.N. Doc. No. EGM/GPLHP/2009/EP.09 (May 11, 2009) (by Els Leye & Alexia Sabbe) [hereinafter Leye & Sabbe], available at http://www.un.org/womenwatch/daw/egm/vaw_legislation_2009/Expert%20Paper%20EGMGPLHP%20_Els%20Leye_.pdf [<http://perma.cc/P5FC-S2GQ>] (archived Mar. 25, 2015).

201. Leye et al., *Analysis*, *supra* note 60, at 4.

202. Leye & Sabbe, *supra* note 200, § 3.

203. INT’L CTR. FOR REPRODUCTIVE HEALTH, GHENT UNIVERSITY, RESPONDING TO FEMALE GENITAL MUTILATION IN EUROPE: STRIKING THE RIGHT BALANCE BETWEEN PROSECUTION AND PREVENTION 12 (Els Leye & Alexia Sabbe eds., 2009).

204. Leye & Sabbe, *supra* note 200, § 3.

205. 2009 EP Resolution, *supra* note 35, ¶ 22 (emphasis added).

in clarifying that the act of genital mutilation is a human rights violation that will not be tolerated in the name of culture, tradition, or any other reason. Therefore, the UK should continue to maintain a statute specifically criminalizing FGM, but it should consider (a) whether the existing FGM Act could be made more robust and (b) whether it might be advantageous to also employ other existing legislation to prosecute FGM.

More important than the form the law takes, however, is a country's commitment to enforcing the law and designing and implementing strategies for educating the public about FGM, detecting cases, and publicizing prosecutions.

b. Why France Has Been Successful in Prosecuting FGM

France chose to prohibit FGM through the general criminal law because a working group appointed to research this issue determined that a specific statute would have been too narrow, would have merely been symbolic, and would risk stigmatizing the particular ethnic groups that practice FGM.²⁰⁶ The main elements of France's success in prosecuting FGM include their practice of prosecuting these cases in the country's highest criminal court,²⁰⁷ the fact that civil society organizations can play a key role in prosecutions, such that prosecutions are not wholly dependent on the public prosecutor,²⁰⁸ and France's policy of affording FGM cases substantial publicity in order to make examples out of certain perpetrators.²⁰⁹

One civil society organization—the Commission for the Abolition of Sexual Mutilations (CAMS)—has been particularly involved in the prosecution of FGM in France. CAMS' director, attorney Linda Weil-Curiel, has played a direct role in all but two of the one hundred FGM convictions that have been achieved in France.²¹⁰ Her dedication to the

206. See Poldermans, *supra* note 92, at 36 (noting that the working group was appointed by the Minister of Women's Rights in 1981); see also MARIA CATERINA LA BARBERA, MULTICENTERED FEMINISM: REVISITING THE "FEMALE GENITAL MUTILATION" DISCOURSE 127 (2009) (indicating that application of a general criminal law would be preferable to a special legislation, which could be seen as accusatory).

207. See Poldermans, *supra* note 92, at 38.

208. See *id.* at 39.

209. See Comm. on the Elimination of Discrimination Against Women, *Consideration of Reports Submitted by States Parties Under Article 18 of the Convention on the Elimination of All Forms of Discrimination Against Women: Third Report of States Parties—France*, 55, CEDAW/C/FRA/3 (Oct. 18, 1999), available at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/N00/221/04/PDF/N0022104.pdf?OpenElement> [<http://perma.cc/Z3BW-X3SQ>] (archived Mar. 14, 2015) ("It has been recognized that the publicity given to the trials of female practitioners of circumcision, and of the parents, has made the doctors, social interest groups and families involved more aware of the need to end the practice of sexual mutilation.").

210. See EIGE, *CASM*, *supra* note 92 (stating that "Weil-Curiel . . . has been part of every FGM criminal procedure initiated," with the exception of two early cases); Profile of Linda Weil-Curiel, TRUST WOMEN, <http://www.trustwomenconf.com/profile/linda->

cause of prosecuting FGM may be the most significant factor distinguishing FGM prosecutions in France from those in other western countries.²¹¹

In addition to France's efforts to prosecute FGM, the country also focuses on prevention through strong educational and awareness campaigns.²¹² Some physicians, for instance, display the relevant provisions of the criminal code in their offices. In addition, the French approach involves routine genital exams as part of normal preventive health care for children through age six.²¹³ Critics of France's practice of routine genital exams argue that conducting such exams simply causes families to delay the age at which FGM is carried out.²¹⁴ However, one answer to this argument is that if the age of FGM is delayed, affected girls are more likely to be in a position to oppose the practice and take measures to protect themselves or seek help. To help address the problem of families taking daughters overseas for FGM, French authorities and school officials use educational campaigns at the start of the summer vacation season to warn parents of the risk of prosecution if they have FGM performed on their daughters overseas.²¹⁵

Weil-Curiel maintains that the French approach is still going strong despite the lack of a new prosecution in the last several years: "We have a triple approach, preventing through education, shaming with publicity and punishing. It seems to work . . . We see girls who are cut before they come to France, but we have not seen anyone cut in France for a while."²¹⁶

weil-curiel/ (last visited Mar. 14, 2015) [<http://perma.cc/W69W-6RYH>] (archived Feb. 17, 2015) (crediting Weil-Curiel with involvement in more than one hundred FGM convictions in France).

211. See Sylvia Poggioli, *French Activists Fight Female Genital Mutilation*, NAT'L PUB. RADIO (Jan. 26, 2008, 1:00 AM), <http://www.npr.org/templates/story/story.php?storyId=18376776> [<http://perma.cc/VG47-PEL6>] (archived Feb. 17, 2015).

212. See Comm. on the Elimination of Discrimination Against Women, *supra* note 209, at 55 (describing the Department of Women's Rights provision of various resources, available in five African languages, and funding for organizations focused on eliminating sexual mutilation).

213. See Poldermans, *supra* note 92, at 47–48; see also Leye & Sabbe, *supra* note 200, § 3; Unicef, *Legislative Reform to Support the Abandonment of Female Genital Mutilation/Cutting* 29–30 (2010), available at http://www.unicef.org/policyanalysis/files/UNICEF_-_LRI_Legislative_Reform_to_support_the_Abandonment_of_FGMC_August_2010.pdf [<http://perma.cc/C7GQ-JWZ3>] (archived Feb. 17, 2015).

214. See Poldermans, *supra* note 92, at 49.

215. Interview with Linda Weil-Curiel, Attorney, conducted by Anne Marie Carson, in Paris, Fr. (Aug. 7, 2012); see also Alice Onwordi, *The Cutting Season: Female Genital Mutilation and the UK*, NEW HUMANIST (Oct. 27, 2011), <http://rationalist.org.uk/articles/2673/the-cutting-season-female-genital-mutilation-and-the-uk> [<http://perma.cc/7F6R-PA8F>] (archived Mar. 14, 2015) (reporting that French schoolchildren are given letters to take home explaining to parents that FGM is against the law).

216. Willsher, *supra* note 99.

2. Revising the FGM Act

As Section II demonstrated, there are loopholes in the FGM Act that limit its effectiveness. In addition, European Parliament resolutions on FGM have called on member states to take legislative measures against FGM that go beyond those contained in the FGM Act. For instance, the 2012 European Parliament Resolution states that FGM legislation should not only prohibit all forms of FGM and provide for effective sanctions against perpetrators, but also “mandate a full range of prevention and protection measures, including mechanisms to coordinate, monitor and evaluate law enforcement, and should improve the conditions permitting women and girls to report cases of female genital mutilation.”²¹⁷

The 2009 European Parliament Resolution also calls upon member states to take measures that go beyond the FGM Act, including (a) making it compulsory for physicians and other health care professionals to report cases of FGM to the police, (b) adopting measures enabling judges or public prosecutors to take precautionary or preventive measures if they are aware of specific persons at risk of undergoing FGM, (c) prosecuting and punishing any resident (not just any citizen or *permanent* resident) who commits FGM, even if the act was committed extraterritorially, and (d) fostering proper awareness of FGM among the entire range of professionals (e.g., social workers, teachers, police forces, and health professionals) who may encounter it so that they will recognize such cases and intervene appropriately.²¹⁸

In addition to this guidance from the European Parliament, it is also helpful to consider FGM laws recently enacted in Ireland (2012), Kenya (2011), and Uganda (2010), all of which are more robust than the FGM Act because they incorporate measures criminalizing a range of acts that facilitate FGM.²¹⁹ The approach taken by these newer laws expands the range of prosecutable offenses, giving prosecutors more opportunities to win FGM-related convictions.

This section of the Article presents a Model FGM Act that incorporates guidance from the European Parliament and the Istanbul Convention as well as several aspects of the more recent statutes from Ireland, Kenya, and Uganda. This Model FGM Act, if adopted, would

217. 2012 EP Resolution, *supra* note 35, ¶ 4.

218. 2009 EP Resolution, *supra* note 35, ¶¶ 20, 21, 28.

219. See generally Criminal Justice (Female Genital Mutilation) Act 2012 (Act No. 11/2012) (Ir.), available at <http://www.irishstatutebook.ie/2012/en/act/pub/0011/> [<http://perma.cc/5H77-N4Y8>] (archived Feb. 17, 2015); The Prohibition of Female Genital Mutilation Act, (2011) Cap. 62B (Kenya), available at <http://www.kenyalaw.org:8181/exist/kenyalex/actview.xql?actid=CAP.%2062B> [<http://perma.cc/4EVN-6G8M>] (archived Feb. 17, 2015); The Prohibition of Female Genital Mutilation Act, 2010 (Act No. 5) (Uganda), available at http://www.ulii.org/files/ug/legislation/act/2010/5/the_prohibition_of_female_genital_mutilation_pdf_10616.pdf (last visited Mar. 14, 2015) [<http://perma.cc/DWS3-W39T>] (archived Mar. 14, 2015).

expand the potential for prosecution and strengthen the protection afforded to potential FGM victims under the law. The proposed Model FGM Act is included in the Appendix. The remainder of this section briefly explains the provisions in the proposed Model FGM Act.

a. The Model FGM Act (Model Act)

The Model Act incorporates several suggestions enumerated in Section II above with respect to strengthening the FGM Act. In particular, the Model Act uses the World Health Organization's definition of FGM—including the idea that FGM is a set of procedures performed for *nonmedical* reasons—which, in turn, eliminates the need for language allowing exceptions for permitted medical procedures. The Model Act also incorporates a provision extending extraterritorial protection and prosecution to anyone *habitually resident* in the UK, not just citizens and permanent residents. Further, it relies on the more comprehensive phrase “any person” rather than the more restrictive term “girl.” These drafting choices achieve greater clarity and conform the law to international standards on FGM.

Part One of the Model Act is preliminary and proceeds in two sections. Section 1 defines female genital mutilation using the well-known World Health Organization definition. Uganda's 2010 law also uses this definition.²²⁰ For the sake of clarity, the Model Act also defines *infibulation*, *reinfibulation*, and *child*. Section 2 states that FGM is child abuse. This is to provide clarity so that relevant professionals will understand that all legislation preventing and punishing child abuse also applies to FGM.

Part Two of the Model Act describes offenses involving female genital mutilation in Sections 3–10. The offense of female genital mutilation, as well as of aiding and abetting for FGM, are defined in Section 3. These provisions are similar to sections in the FGM Act, except that they are more streamlined here. The use of the WHO definition of FGM means that it is not necessary to include any exceptions for medically necessary procedures. This approach greatly increases clarity and eliminates the possible argument that the law permits FGM if it is carried out in connection with childbirth.

Section 4 creates an offense of aggravated FGM for cases where FGM results in death, disability, HIV infection, or for cases where the offender is a health care professional, parent, or other person with authority or control over the victim. It treats perpetrators more severely when FGM results in extremely serious consequences or when the perpetrator is someone who has a safeguarding obligation toward the victim. A similar provision is currently in effect in Uganda.²²¹

220. See The Prohibition of Female Genital Mutilation Act, 2010 (Uganda), § 1.

221. See *id.* § 3.

Sections 5 and 6, respectively, criminalize the use of a person's premises for the purpose of FGM and the possession of tools for the purpose of FGM. These provisions expand the range of charging options available to law enforcement, thus increasing the possible approaches for prosecuting FGM-related offenses. Similar provisions are now in effect in Kenya.²²² Kenya goes even farther by providing that a law enforcement officer may enter any premises without a warrant for the purpose of ascertaining whether there has been any violation of the FGM law within the premise.²²³

Section 7 criminalizes discrimination or harassment of any kind when it is directed at a person who resists or refuses FGM or her close family members. Similar provisions are in effect in both Kenya and Uganda.²²⁴ This provision addresses the strong cultural pressure brought to bear on members of FGM-affected communities. It creates a remedy for those who face harsh treatment for rejecting FGM and simultaneously sends the message that harassment and discrimination against those who reject FGM will not be tolerated. Uganda goes even farther and also criminalizes the participation in events, such as coming-of-age ceremonies, that lead to FGM.²²⁵ Section 7 also criminalizes acts of harassment directed at those who speak out against FGM. The Guardian recently reported that women in the United Kingdom "have received death threats, been publicly assaulted, and who have had to move house after speaking out about FGM . . ."²²⁶ These news reports demonstrate Section 7's relevance to the UK context.

Section 8 criminalizes the act of arranging for another person—whether a potential perpetrator or a potential victim—to enter the UK for the purpose of either performing or receiving FGM, while Section 9 criminalizes the removal from the UK of a girl or woman for the purpose of enabling her to undergo FGM outside the UK. These provisions address the fact that FGM is a cross-border problem. Accordingly, criminalizing the facilitation of FGM through travel arrangements expands opportunities to bring a prosecution. Ireland and Kenya have both enacted similar provisions.²²⁷

Section 10 creates extraterritorial liability for the acts described in Sections 3–9 when those acts are committed by a UK national, permanent resident, or person who is habitually resident in the UK. Ireland, Kenya, and Uganda all include extraterritorial provisions in

222. See The Prohibition of Female Genital Mutilation Act (Kenya) §§ 22–23.

223. *Id.* § 26.

224. See *id.* § 25; The Prohibition of Female Genital Mutilation Act, 2010 (Uganda), §§ 11–12.

225. See The Prohibition of Female Genital Mutilation Act, 2010 (Uganda) § 7.

226. Hill, *supra* note 9.

227. See Criminal Justice (Female Genital Mutilation) Act (Ir.), § 3; The Prohibition of Female Genital Mutilation Act, § 21 (Kenya).

their FGM laws,²²⁸ as do several other European countries. The Irish law extends liability to perpetrators who are “ordinarily resident” in Ireland in addition to Irish citizens. It defines *ordinarily resident* as having lived in Ireland “for the period of 12 months immediately proceeding . . . the offense.” However, this approach effectively gives those newly arrived to Ireland a green light to remove their daughters from Ireland for FGM within a year of their arrival, so the Model Act does not include a time requirement in the definition of *habitually resident*. Uganda allows for extraterritorial prosecution when the *victim* is “ordinarily resident” in Uganda;²²⁹ it does not address the nationality or residency status of *perpetrators* outside Uganda.

Part Three of the Model Act describes prohibited defenses and penalties for offenses in Sections 11–13. Sections 11 and 12, respectively, state that neither the consent of the victim nor culture or religious reasons can be a defense to female genital mutilation. Section 13 describes penalties for offenses. The penalty for the offense of FGM under Section 3 is the same as under the FGM Act, but the maximum penalty for aggravated FGM is greater—up to life in prison. The maximum penalty for removing a person from the UK for FGM (Section 9) is the same as the penalty for committing FGM under Section 3, while somewhat lesser penalties are provided for acts committed under Sections 5–8.

Part Four of the Model Act describes obligations to report FGM to the authorities and penalties for failure to report in Sections 14–15. Section 14 states that *any* adult person with knowledge that FGM has occurred or will occur must report that information to the police or other authority within twenty-four hours. It specifies a penalty of a fine or up to six months in prison for failing to report. Both Kenya and Uganda have enacted similar provisions.²³⁰

Section 15 spells out the safeguarding obligations of those who work with children and responds to the 2009 European Parliament Resolution’s call for states to compel health care professionals to report FGM to the proper authorities.²³¹ Section 15 states that professionals working with children, upon becoming aware of a suspected case of FGM affecting a child, must follow the child protection procedures mandated in cases of child abuse. This section does not specify a penalty for failure to comply with this section, but a professional who fails to act could be prosecuted for failure to report under Section 14. Section 15 also requires any professional who becomes aware of a case

228. Criminal Justice (Female Genital Mutilation) Act (Ir.), §§ 4(1)(c), 4(4); The Prohibition of Female Genital Mutilation Act, § 28 (Kenya); The Prohibition of Female Genital Mutilation Act (2010) (Act No. 5) § 15 (Uganda).

229. The Prohibition of Female Genital Mutilation Act (2010) (Act No. 5) § 15 (Uganda).

230. See The Prohibition of Female Genital Mutilation Act, §§ 24, 29 (Kenya); The Prohibition of Female Genital Mutilation Act (2010) (Act No. 5) § 16 (Uganda).

231. See 2009 EP Resolution, *supra* note 35, ¶ 21.

of FGM affecting a child to report the case to the relevant health care authorities. These health care authorities are then obligated to make arrangements to ensure that the affected child has access to appropriate aftercare, including deinfibulation (if needed) as well as other appropriate physical and mental health care.

Part Five of the Model Act addresses court orders and jurisdiction in Sections 16–18. Sections 16 and 17 fulfill requirements of the Istanbul Convention to provide victims of gender-based violence with compensation and civil remedies.²³² Uganda has enacted provisions similar to Sections 16 and 18.²³³

Section 16 empowers courts to order that a perpetrator pay compensation to a victim, with the amount to be determined by the court after considering the victim's injuries as well as medical and other expenses. Any such compensation would be in addition to other penalties provided under the Act.

Section 17 provides victims with civil remedies in cases of FGM so that they may recover damages and attorneys' fees from perpetrators.

Section 18 empowers courts to issue an order of protection when the court becomes aware of a person who is at risk of being compelled to undergo FGM.

Part Six of the Model Act sets out, in Sections 19 and 20, additional measures that the government must take towards eliminating FGM. These provisions are responsive to measures called for in the UN FGM Resolution and the 2009 European Parliament Resolution.²³⁴

Section 19 sets out obligations to provide education on FGM both to the general public and to professionals who may work with those affected. It also mandates the provision of specialist health services to FGM victims. Kenya has enacted a similar measure.²³⁵

Section 20 is modeled on a provision of United States law.²³⁶ It provides that the United Kingdom Border Control Agency shall make available to immigrants from FGM-affected groups information about the severe harm caused by FGM and the potential legal consequences of allowing a child to undergo FGM. The Model Act ends with certain miscellaneous provisions that are consistent with the FGM Act.

The Model Act provides a more robust framework for prosecuting FGM than the current FGM Act. It expands the number of offenses available to prosecutors, and it enhances the extraterritorial protection so that anyone habitually resident in the UK can be protected from FGM (or prosecuted, as the case may be), even if that person is not a

232. See Istanbul Convention, *supra* note 44, arts. 29–30.

233. See The Prohibition of Female Genital Mutilation Act (2010) (Act No. 5) §§ 13–14 (Uganda).

234. Cf. 2009 EP Resolution, *supra* note 35, ¶¶ 5, 7, 20, 30, 31; UN FGM Resolution, *supra* note 48, ¶¶ 5, 6, 9, 15.

235. See The Prohibition of Female Genital Mutilation Act, § 27 (Kenya).

236. See 8 U.S.C. § 1374 (2006).

citizen or permanent resident. It also eliminates confusing language so that the law is easier to understand.

b. Mandatory Reporting Duty for Professionals Who Work with Children

The 2009 European Parliament Resolution on FGM called on member states to make it compulsory for medical personnel to report cases of FGM to health authorities and the police.²³⁷ The Model Act includes a mandatory reporting duty in Section 15 but extends it to include not just medical personnel but any person who works with children and would therefore be in a position to know if a child is at risk. Such a duty is particularly important because, as with cases of child abuse and neglect, it is unrealistic to expect that girls who undergo FGM will report their parents to the police and risk being placed into care and separated from otherwise loving parents. Rather, the law should explicitly set out an obligation for professionals who have contact with children to report cases of FGM to the authorities.

The UK government may want to consider the Norwegian approach whereby its FGM legislation sets out penalties for mandatory reporters who deliberately refrain from trying to prevent an act of genital mutilation.²³⁸ In Norway, “[a] fine or a prison sentence of up to one year may be imposed” in this instance.²³⁹ Mandatory reporting of FGM in Norway is part of a larger child protection scheme whereby public authorities and certain categories of health professionals are obligated to report suspected cases of child mistreatment, including gross neglect.²⁴⁰ Genital mutilation in Norway is regarded as a form of gross neglect for purposes of these reporting requirements.²⁴¹

3. FGM Prosecution Under the Domestic Violence, Crime and Victims Act of 2004 (DVCV Act)

The Domestic Violence, Crime and Victims Act of 2004 establishes a duty of care for adults in a household in relation to children or vulnerable adults in that same household. It creates an offense of causing or allowing the death of a child or vulnerable adult in situations where there is a *significant risk* that a *household member's unlawful actions* could cause *serious physical harm* to the victim.²⁴² This offense was originally designed to be used in situations “where it [is] clear that one of a number of adults in a household [is] responsible

237. See 2009 EP Resolution, *supra* note 35, ¶ 21.

238. See NORWEGIAN MINISTRIES, *supra* note 101, at 12.

239. *Id.*

240. *See id.*

241. *Id.*

242. See Domestic Violence, Crime and Victims Act, 2004, c. 28, § 5(1) (Eng., Wales, N. Ir.).

for the death of a child or vulnerable adult in that household but it [cannot] be proved which” adult is responsible.²⁴³ The DVCV Act does not require a prosecutor to prove which household member was responsible for the death; the prosecutor need only prove that the person charged either caused the death or was aware (or ought to have been aware) of a foreseeable risk to the victim and failed to take steps to protect the victim.²⁴⁴ In 2012, the DVCV Act was amended to cover instances of serious physical harm to a victim in addition to death.²⁴⁵ The DVCV Act entered into force on July 2, 2012.²⁴⁶

The DVCV Act is a promising avenue to prosecute FGM because it enables prosecutors to bring charges against parents who fail to protect their daughters from FGM, even if the parents do not carry out the FGM procedure themselves. A prosecution would be successful if the prosecutor can show that (a) a girl faced a significant risk of FGM, (b) the risk of FGM was foreseeable to the parent charged, and (c) the parent charged (i) was aware, or ought to have been aware, of the risk to the girl and (ii) failed to take steps to protect the girl from the risk. In contrast, prosecutions under the FGM Act must show that the person charged either carried out the FGM him- or herself or aided or abetted another person in carrying out the FGM.²⁴⁷

The DVCV Act also has certain limitations with respect to prosecuting FGM. First, it is only applicable to instances of serious bodily harm occurring on or after the date of enactment—July 2, 2012. Second, the maximum sentence possible for a person charged under the DVCV Act is only ten years if the victim suffers serious bodily harm but not death,²⁴⁸ whereas the maximum sentence under the FGM Act is fourteen years.²⁴⁹ If the victim dies, however, the maximum penalty under the DVCV Act is fourteen years.²⁵⁰

Third, in order to successfully prosecute a parent or other household member under the DVCV Act, the unlawful act that leads to the serious bodily harm or death of the victim must be committed by

243. Domestic Violence, Crime and Victims (Amendment) Act, Explanatory Notes, 2012, c. 4, ¶ 4 (Eng., Wales); *see also* Domestic Violence, Crime and Victims Act, 2004, c. 28, § 5(1) (Eng., Wales, N. Ir.).

244. *See* Domestic Violence, Crime and Victims (Amendment) Act, Explanatory Notes, 2012, c. 4, ¶ 8 (Eng., Wales).

245. *See* Domestic Violence, Crime and Victims (Amendment) Act, 2012, c. 4, § 1 (Eng., Wales), available at http://www.legislation.gov.uk/ukpga/2012/4/pdfs/ukpga_20120004_en.pdf [<http://perma.cc/MZ4K-NZL9>] (archived Mar. 14, 2015).

246. Domestic Violence, Crime and Victims (Amendment) Act 2012 (Commencement) Order, 2012, c. 54, § 2 (Eng., Wales), available at http://www.legislation.gov.uk/uksi/2012/1432/pdfs/uksi_20121432_en.pdf [<http://perma.cc/PWU9-DULB>] (archived Mar. 16, 2015).

247. *See* Female Genital Mutilation Act, 2003, c. 31, §§ 1–3 (Eng., Wales, N. Ir.).

248. *See* Domestic Violence, Crime and Victims (Amendment) Act, 2012, c. 4, § 1(6) (Eng., Wales).

249. *See* Female Genital Mutilation Act, 2003, c. 31, § 5(a) (Eng., Wales, N. Ir.).

250. *See* Domestic Violence, Crime and Victims Act, 2004, c. 28, § 5(7) (Eng., Wales, N. Ir.).

another household member.²⁵¹ In the FGM context, this would likely mean that another household member engaged in an activity that would constitute an offense under the FGM Act—either carrying out FGM, procuring someone to perform FGM, or aiding or abetting that person. There would be no liability for a parent or other household member if the child was subjected to FGM through the unlawful act of a person outside of the household.

Finally, the DVCV Act is silent as to whether it covers serious bodily harm that takes place outside of the UK, so it is unclear whether the Act could be used to prosecute parents who arrange to have FGM performed on their daughters overseas.

C. Working with Communities

Communities are integral to the success of anti-FGM measures. The European Commission has noted that ending FGM must include implementing measures that promote *sustainable social change*. The Commission has stated that legal measures against FGM are necessary but not sufficient to ensure that FGM is abandoned. Rather, “[c]hanges in attitudes and beliefs among relevant communities are needed.”²⁵² As Norway observes in its national action plan, “[i]t is a considerable challenge and it can take time for both women and men to abandon a practice they have personally regarded as positive.”²⁵³ But these communities also contain many members who disapprove of FGM, and such people can be very instrumental in the push to end it. As the Finnish national action plan observes, “[p]ersons who are themselves of immigrant origin can make the most valuable contributions, because they can discuss the difficult issues related to female circumcision in their native language. They can also reach out to people otherwise not encountered by public services.”²⁵⁴ Accordingly, the British government can greatly enhance its efforts against FGM by creating partnerships with members of FGM-affected communities. The government can, and should, work collaboratively with communities to develop strong initiatives that educate and encourage vocal opposition to FGM.

Community-based prevention and education efforts on FGM can take a very wide range of approaches, a number of which are discussed below. This Article does not recommend particular approaches because those decisions are best left to activists familiar with the needs of each community. What is important, however, is that adequate funding be made available in order to ensure that a wide range of strategies can

251. See *id.* § 5(1)(a); Domestic Violence, Crime and Victims (Amendment) Act, Explanatory Notes, 2012, c. 4, ¶ 8 (Eng., Wales).

252. *Towards the Elimination of Female Genital Mutilation*, *supra* note 6, at 6.

253. NORWEGIAN MINISTRIES, *supra* note 101, at 22.

254. MINISTRY OF SOC. AFFAIRS AND HEALTH, *supra* note 197, at 32.

be explored and then evaluated for effectiveness. Those that are most effective should be expanded, as appropriate, for use in as many communities as possible. The Female Genital Mutilation Initiative, as discussed below, aims to support innovations in preventing FGM. In addition, in March 2013 the UK government pledged £35 million to combat FGM, and it has also started a telephone helpline and piloted a health passport. These efforts are discussed in the sections that follow, along with this Article's proposal to create a national FGM advisory board.

1. The Female Genital Mutilation Initiative (Initiative)

Many anti-FGM efforts at the community level are currently supported by the Female Genital Mutilation Initiative—a major anti-FGM initiative largely funded by the private sector with the goal of eliminating FGM across the UK.²⁵⁵ This effort began in January of 2010 when three organizations—the Esmée Fairbairn Foundation, Trust for London, and Rosa (the UK Fund for Women and Girls)—announced a three-year, £1 million initiative to fund fourteen projects focusing on community-based FGM prevention.²⁵⁶ The Initiative entered its second phase in February 2013 when the original three funding organizations were joined by a fourth—Comic Relief—and the groups together announced an additional £1.6 million to fund anti-FGM efforts over an additional three years.²⁵⁷ The second phase of the Initiative will provide funds to twelve projects across the UK.²⁵⁸

The projects funded by the Initiative bring a wide range of approaches and have adapted their strategies to the particular community contexts in which they operate. The Initiative issued Interim Reports in October 2011 and September 2012 assessing the projects' progress;²⁵⁹ it also issued a final report on the first phase—

255. See *Female Genital Mutilation Initiative*, ESMÉE FAIRBAIRN FOUND., <http://esmeefairbairn.org.uk/what-we-fund/funding-partnerships/female-genital-mutilation-initiative> (last visited Mar. 14, 2015) [<http://perma.cc/DP3R-QMR3>] (archived Feb. 18, 2015).

256. *Id.*

257. *Id.*

258. *Id.*

259. See generally ELEANOR BROWN, OPTIONS UK, THE FGM INITIATIVE SECOND INTERIM REPORT (2012), available at <http://esmeefairbairn.org.uk/what-we-fund/funding-partnerships/female-genital-mutilation-initiative/female-genital-mutilation-initiative-evaluation-and-reports> [<http://perma.cc/M5JA-TLVY>] (archived Feb. 18, 2015) (providing access to the 2011 Interim Report); JOANNE HEMMINGS, OPTIONS UK, THE FGM INITIATIVE INTERIM REPORT (2011), available at <http://esmeefairbairn.org.uk/what-we-fund/funding-partnerships/female-genital-mutilation-initiative/female-genital-mutilation-initiative-evaluation-and-reports> [<http://perma.cc/M5JA-TLVY>] (archived Feb. 18, 2015) (providing access to the 2012 Interim Report).

2010 to 2013—in July 2013. ²⁶⁰ Much of the work thus far has addressed a number of the needs identified by the 2009 FORWARD study. For instance, the FORWARD study revealed that communities wanted more information on the health consequences of FGM and the prevalence of these consequences but that such information was difficult to access because of the taboo nature of speaking about FGM.²⁶¹ The FORWARD study found that women linked increasing education and exposure to accurate information about FGM with opposition to the practice. It concluded that education was therefore a crucial step in facilitating the abandonment of FGM.²⁶²

The Initiative indicates that funded projects have enjoyed high levels of success in communicating information about the negative health consequences of FGM.²⁶³ In addition, they have succeeded in breaking some of the silence around FGM and creating community spaces to discuss FGM, its negative effects, and reasons for abandoning the practice.²⁶⁴ The final report on the first phase of the Initiative drew attention to the following key findings. First, communities are increasingly rejecting FGM in places where community-based prevention work is taking place.²⁶⁵ Second, “[w]orking with younger women to empower them to speak out and make decisions has been more effective than trying to change the often deeply entrenched attitudes of older people.”²⁶⁶ Third, “[a]wareness of FGM is rising, and” the Initiative has increased the number of safe spaces where people can “discuss FGM in an informed and balanced way.”²⁶⁷ And finally, there is increasing support within affected communities for British authorities to take a more interventionist stance against FGM.²⁶⁸

As the work has progressed, the Initiative has also identified challenges that must be addressed going forward, in particular the following:

FGM as a religious requirement. Many projects have found that the people in affected communities widely hold the belief that FGM is

260. See generally ELEANOR BROWN & JOANNE HEMMINGS, OPTIONS UK, THE FGM INITIATIVE: EVALUATION OF THE FIRST PHASE (2010–2013) (2013), available at <http://www.trustforlondon.org.uk/wp-content/uploads/2013/07/The-FGM-Initiative-Final-Report-2013.pdf> [<http://perma.cc/H5RC-2LF9>] (archived Mar. 15, 2015).

261. See PERCEPTIONS AND BELIEFS, *supra* note 102, at 16–17.

262. See *id.* at 30.

263. See BROWN, *supra* note 259, at 14 (“Health-related counter-arguments are some of the more effective, easy to understand and to deliver messages. . . . The strength of health-related arguments provide strong support for countering pro-FGM arguments. . . .”).

264. See BROWN & HEMMINGS, *supra* note 260, at 7, 36. See generally BROWN, *supra* note 259; HEMMINGS, *supra* note 259.

265. See BROWN & HEMMINGS, *supra* note 260, at 7, 45.

266. *Id.* at 7.

267. *Id.* at 7.

268. *Id.* at 7.

a religious requirement.²⁶⁹ Some groups have been successful in forming relationships with religious leaders who are willing to speak out against FGM, but there appears to be much more work to be done in this arena.²⁷⁰ Activists see a need to build deeper cooperative relationships with religious leaders and communities.²⁷¹

Type 4 FGM widely embraced. Groups have found that as more people turn away from more severe forms of FGM, many view Type 4 FGM (often involving pricking or piercing) as more acceptable than other forms.²⁷² Anti-FGM groups have found this stance to be a challenge for two reasons. First, Type 4 FGM is often described as “sunna,”²⁷³ thus tying its practice to the religious issue identified above. Second, although community members have been receptive to health arguments against FGM, they often argue that the health arguments do not apply as strongly to less severe forms of FGM.²⁷⁴ The argument that Type 4 FGM is “sunna” and therefore acceptable is very compelling to many in affected communities and is a significant barrier to eliminating FGM.²⁷⁵

Confusion about FGM versus female cosmetic genital surgery. Groups working against FGM have asked for clarification regarding the legal position of procedures on the genitals carried out for reasons of custom or ritual, versus those carried out for cosmetic reasons.²⁷⁶ This issue will be discussed more fully in Part V.

Educating physicians and building referral networks. Groups have reported mixed success in approaching physicians.²⁷⁷ Physicians should play a key role in the fight against FGM because they are in a position to refer individuals at risk as well as those who have been through FGM to specialist health services. However, not all physicians have been receptive to the overtures of anti-FGM groups.²⁷⁸ Making inroads with physicians is important because evidence from domestic violence work suggests that physicians are more likely to refer women to relevant social services when they have familiarity with the issue and with a specific organization that takes referrals.²⁷⁹

The need to incorporate a human rights-based framework. Anti-FGM groups are increasingly framing arguments against FGM in

269. See BROWN, *supra* note 259, at 16; HEMMINGS, *supra* note 259, at 6, 10–11, 27.

270. See BROWN, *supra* note 259, at 16–18, 22.

271. See *id.* at 22; BROWN & HEMMINGS, *supra* note 260, at 10, 23, 25–26.

272. See HEMMINGS, *supra* note 259, at 39.

273. Several of the informants I spoke with used this term to refer to something that is recommended and rewarded, but which a person is not punished for if s/he does not do it.

274. See HEMMINGS, *supra* note 259, at 42.

275. See *id.* at 4, 39, 42.

276. See *id.* at 7.

277. See BROWN, *supra* note 259, at 19.

278. See *id.*

279. See *id.*

terms of a human rights framework.²⁸⁰ Grounding arguments against FGM in human rights, rather than in terms of health, allows activists to make more expansive arguments. Adopting this framing is being embraced by an increasing number of anti-FGM groups, but the shift still has a long way to go.

In addition to the challenges highlighted above, the Initiative has noted that “[t]here is no effective national policy on the role of local authorities in tackling FGM.”²⁸¹ This finding supports the need for a national action plan on FGM. It is also striking how frequently the Initiative’s Interim Reports draw attention to the importance of “confidence” with respect to community members’ willingness to speak out against FGM.²⁸² Projects note that women (and men) have to build confidence and become more assertive in their stance against FGM before they are able to speak out publicly against the practice.²⁸³ This emphasis on the need for confidence demonstrates the continued need for expanded opportunities to talk openly about FGM; it also demonstrates the ongoing pressure in affected communities to continue to practice FGM.

The government has a crucial role to play in creating an enabling environment for community-based anti-FGM initiatives. It must ensure adequate levels of funding, in keeping with the mandate from the UN General Assembly, “to allocate sufficient resources to the implementation of policies and programmes and legislative frameworks aimed at eliminating [FGM].”²⁸⁴ Efforts to eliminate FGM should benefit from public sector funds; the burden should not be on the private sector to sustain these important initiatives. The government also should facilitate community organizations’ efforts to build relationships with key individuals and groups in other sectors—in particular the statutory sector—and with relevant professionals from the health, education, and social services sectors.

2. Telephone Helpline for FGM

The NSPCC children’s charity established a free, twenty-four-hour FGM telephone helpline in June 2013.²⁸⁵ Within its first three

280. See *id.* at 14, 18 (arguing for the “integration of rights-based approaches” into arguments against FGM); HEMMING, *supra* note 259, at 42 (“Prevention projects need to develop compelling arguments that engage with the emotional and collective elements of support for FGM . . .”).

281. BROWN & HEMMING, *supra* note 260, at 8.

282. See BROWN, *supra* note 259, at 3, 9, 15; HEMMING, *supra* note 259, at 5, 17, 19, 21, 22.

283. See BROWN, *supra* note 259, at 3, 9; HEMMING, *supra* note 259, at 5, 17, 21, 22.

284. UN FGM Resolution, *supra* note 48, ¶ 14.

285. See NSPCC Launch Female Genital Mutilation (FGM) Helpline, SAFE NETWORK, http://www.safenetwork.org.uk/news_and_events/news_articles/pages/

months of operation, the helpline received ninety-three calls, coming from members of affected communities “as well as from education and healthcare professionals seeking advice.”²⁸⁶ By early September 2013, the helpline had “referred 34 potential cases of [FGM] to the Metropolitan police.”²⁸⁷ John Cameron, the head of the helpline, has said that “[t]he calls show[] the ‘need for a single anonymous point of contact for information.’”²⁸⁸ This rate of reporting represents an increase compared to the 186 *total* referrals received by the Metropolitan police since they began keeping track in 2009.²⁸⁹ Although this is a very new initiative and information about its effectiveness is limited, the helpline does appear to be a useful way of increasing referrals to the police as well as providing information to those affected by FGM. It also fulfills the Istanbul Convention’s call to establish twenty-four-hour telephone helplines for those affected by gender-based violence.²⁹⁰

3. The Health Passport

The UK government issued a “health passport” in November 2012 on a one-year trial basis.²⁹¹ Modeled on an approach used in the Netherlands, the health passport is a passport-sized booklet that explains the FGM Act and is available in eleven languages. It is designed to be used by members of FGM-affected communities who are traveling abroad to visit family in their countries of origin. The health passport is an additional tool that such families can use to protect their daughters from FGM being carried out abroad. When faced with pressure from families abroad who want FGM to be done, UK persons can use the health passport to explain that FGM is illegal under UK law, that this law protects UK girls when they travel abroad, and that the UK parent or guardian could be prosecuted upon their return to the UK if FGM is carried out abroad.

There is not yet data on the effectiveness of the health passport or response from communities who have used it when traveling, but FGM

female-genital-mutilation-helpline.aspx (last visited Mar. 15, 2015) [<http://perma.cc/6CUV-JPG2>] (archived Mar. 15, 2015).

286. Jane Martinson, *Female Genital Mutilation Helpline Uncovers 34 Potential Cases*, GUARDIAN (U.K.) (Sept. 5, 2013, 3:01 PM), <http://www.theguardian.com/society/2013/sep/05/female-genital-mutilation-helpline-cases> [<http://perma.cc/9HV8-JJJD>] (archived Feb. 18, 2015).

287. *Id.*

288. *Id.*

289. *See id.*

290. *See* Istanbul Convention, *supra* note 44, art. 24.

291. *See generally* HM GOVERNMENT, A STATEMENT OPPOSING FEMALE GENITAL MUTILATION (2014), available at <https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation> [<http://perma.cc/236T-CBTS>] (archived Feb. 18, 2015) (providing a definition of FGM, outlining the legislation and penalties involved, and noting the help and support available).

advocacy groups such as FORWARD and the Wonder Foundation have suggested ways to strengthen the health passport and make the information more accessible to communities.²⁹² First, a key concern is that the health passport uses the term “female genital mutilation” rather than “female circumcision” or “female genital cutting.” The latter terms would be perceived as more neutral by affected communities, which could cause people to be more receptive to the message. Some community members might also find the term “female genital mutilation” to be alienating; they might even fail to see the relevance of the law if they do not view the practice as “mutilation.” In particular, one study found that many members of FGM-affected communities only view one type of FGM—infibulation—as mutilation.²⁹³ They view less severe types of FGM as “sunna” and, therefore, acceptable.²⁹⁴ The Netherlands uses the more neutral term “female circumcision” in their health passport, and FORWARD recommends this approach in order to reach the widest audience possible.²⁹⁵

Second, the health passport relies on the language contained in the FGM Act, which, as discussed in Part IV, is confusing and unclear. Much of this language could be replaced with simpler language that would be more accessible to a wider audience. In addition, the Wonder Foundation has recommended the use of diagrams, as they could be more helpful for the large number of women from affected communities who may be functionally illiterate.²⁹⁶ Finally, the health passport would be even more effective if it included an explanation of the health consequences of FGM, in addition to the legal consequences.²⁹⁷ The Dutch health passport uses this approach, including a paragraph entitled “Female circumcision is extremely damaging,” which explains

292. Interview with Naana Otoo-Oyortey, Executive Director, FORWARD, in London, UK (Dec. 7, 2013) (on file with author); see also WONDER FOUNDATION, FGM PASSPORT REVIEW: WONDER RESPONSE (Spring 2013) (on file with the author).

293. See BARRETT ET AL., *supra* note 99, at 59 (noting that some communities only view Type III as FGM).

294. See *id.*

295. See generally STATE SEC'Y OF HEALTH, WELFARE AND SPORT (NETH.), STATEMENT OPPOSING FEMALE CIRCUMCISION (2011), available at http://www.pharos.nl/documents/doc/pp5056-verklaring-uk-2011_definitief.pdf [<http://perma.cc/YG5X-V5RU>] (archived Mar. 25, 2015).

296. WONDER FOUNDATION, FGM PASSPORT REVIEW: WONDER RESPONSE (Spring 2013) (on file with the author).

297. The Health Passport was revised in February 2014 to incorporate a very brief statement on the health consequences of FGM: FGM “is an extremely harmful practice with devastating health consequences for girls and women. Some girls die from blood loss or infection as a direct result of the procedure. Women who have undergone FGM are also likely to experience difficulty in childbirth.” HM Government, A STATEMENT OPPOSING FEMALE GENITAL MUTILATION (2014), <https://www.gov.uk/government/publications/statement-opposing-female-genital-mutilation> [<http://perma.cc/236T-CBTS>] (archived Feb. 18, 2015).

some of the major health consequences of FGM.²⁹⁸ Revising the UK FGM health passport with these recommendations in mind would likely make it an even more useful tool for families traveling abroad.

4. Establish a National Advisory Board Comprised of Individuals from Affected Communities

In addition to the community-based approaches discussed above, another key step towards eliminating FGM in the UK is the creation of a national advisory board on FGM. Norway has incorporated the use of a national advisory board into their national FGM strategy in order to ensure that affected communities are influential in shaping the national campaign's approach to ending FGM.²⁹⁹ Such an approach is inclusive and helps to ensure that affected communities support and endorse government-sponsored initiatives to end FGM. Members of affected communities are also able to identify and understand individuals who still embrace FGM and will likely have the best sense of what strategies will work best with these groups. A UK national advisory board would ideally be comprised of women and men from a range of FGM-affected communities. One of the most promising strategies for recruitment would be to identify suitable candidates from the network of organizations currently receiving funding from the FGM Initiative.

Although community organizations are best positioned to develop educational and other strategies to discuss and prevent FGM in affected communities, a national advisory board could serve as a liaison between these groups and other stakeholders—such as statutory agencies, health professionals, teachers, and government agencies—and could help to ensure cooperation and communication among these entities. For instance, organizations participating in the FGM Initiative have reported obstacles in gaining access to schools for the purpose of anti-FGM awareness training and difficulty in getting physicians on board with anti-FGM training and referring FGM survivors for specialist health services.³⁰⁰ A national advisory board could help to facilitate these efforts and could also advocate for adequate levels of public sector funding for anti-FGM work.

D. Competency Building Among Relevant Professionals

As the Zaidi study discussed above demonstrates, health care, social care, and education professionals need much more extensive training in the detection and prevention of FGM than they have

298. STATE SEC'Y OF HEALTH, WELFARE AND SPORT (NETH.), *supra* note 295.

299. See NORWEGIAN MINISTRIES, *supra* note 101, at 22.

300. See BROWN, *supra* note 259, at 19, 20–21.

generally received thus far.³⁰¹ The European Institute for Gender Equality recommends that FGM training for professionals should be mandatory and systematic, with adequate funding for such training guaranteed.³⁰²

As a preliminary matter, the Multi-Agency Practice Guidelines on Female Genital Mutilation,³⁰³ issued by the Government in 2011, should be distributed much more widely, and appropriate measures should be taken to ensure that all relevant professionals are familiar with the guidelines and their corresponding responsibilities. For instance, professional associations could be encouraged or required to issue guidelines for their members on training and awareness of FGM and on how to respond appropriately when cases are detected. Professional associations should also be encouraged to work with groups that specialize in anti-FGM work to ensure that the training they offer is not only culturally sensitive and appropriate, but also framed around the goal of ensuring the health and human rights of women and girls.

The National Health Service website gives an excellent overview of female genital mutilation. This website is a high-quality first resource for any professional with little or no familiarity with FGM.³⁰⁴ A range of professional organizations would do well to direct their members to this website for accurate information on FGM. The website explains FGM and its legal status in the UK, lists where to access FGM-related health services, describes the FGM telephone helpline that was implemented in July 2013, and provides several videos that give a range of information on FGM. The website is also helpful to English-speaking members of affected communities, but is not currently available in other languages.

1. Teachers

The European Institute for Gender Equality has pointed out that teachers have perhaps the most crucial role in FGM prevention because they are the professionals with “the most consistent, regular, and on-going interaction with young people.”³⁰⁵ They are in the best position to pick up on warning signs that FGM may occur, they are well

301. See Zaidi, Khalil, Roberts & Browne, *supra* note 159, at 161–64 (discussing the results of a study suggesting a stark “deficiency in knowledge among healthcare professionals” pertaining to FGM).

302. See LEYE ET AL., *supra* note 95, at 69.

303. See generally PRACTICE GUIDELINES, *supra* note 82.

304. See *FGM Health Services: Providing FGM Health Services for Women*, NHS CHOICES (Oct. 28, 2014) [hereinafter NHS CHOICES], <http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-health-services-for-women.aspx> [<http://perma.cc/6G5G-Y4UY>] (archived Feb. 2, 2015) (providing a general overview of FGM and information about available FGM services).

305. LEYE ET AL., *supra* note 95, at 57.

placed to be a resource to young people seeking help, and they may notice behavioral changes—such as going to the toilet frequently—that may indicate that FGM has occurred.³⁰⁶ Accordingly, comprehensive FGM training for teachers should receive great priority.

2. Health Professionals

With respect to health care professionals, the 2012 Interim Report from the Female Genital Mutilation Initiative indicates that anti-FGM projects have had the most success in working with midwives, and that general practitioners (GPs) have been much less responsive.³⁰⁷ In looking for ways to increase the engagement of GPs with FGM, the report notes that in a similar area—responding to domestic violence—GPs have been found to increase their “identification and referrals of [such] women . . . when [they] know where to refer to, and when they have developed a trusting relationship” with referral partners.³⁰⁸ Accordingly, the report suggests working with GPs to strengthen these referral pathways for women and girls affected by FGM.³⁰⁹ Both Comfort Momoh, in her capacity as a midwife delivering specialist health services to FGM survivors, and the 2009 FORWARD study reveal that it is all too common that women affected by FGM have great difficulty accessing the specialist care that they need because physicians do not know where to refer them.³¹⁰

The NHS FGM Health Services website states that there are several specialist FGM clinics available in London and in many other large UK cities and that “[m]ost clinics are run by specially trained doctors, nurses or midwives who can understand why you have had FGM and are able to treat most of the medical problems caused by it.”³¹¹ However, the website also notes that most of these specialist clinics require a referral from a GP.³¹² This referral requirement is likely a barrier to specialist services for many women because GPs who are unaware of FGM and the need for these types of medical services may be reluctant to refer women to them; this problem could be exacerbated by any language barrier between the patient and the GP. All health care professionals should be prepared to have these conversations with women from affected communities, and specialist FGM clinics should consider making their services available without referral.

306. *See id.*

307. *See* BROWN, *supra* note 259, at 19.

308. *Id.*

309. *See id.*

310. *See* Interview with Comfort Momoh, *supra* note 7; *see also* PERCEPTIONS AND BELIEFS, *supra* note 102, at 17–18, 40–44.

311. NHS CHOICES, *supra* note 304.

312. *See id.*

3. Other Professionals

Training on FGM should not be limited to teachers and health professionals. It should encompass all professionals who regularly work with children or have child abuse reporting obligations, including social workers, law enforcement personnel, and others.

4. Cultural Sensitivity and Human Rights

All types of professionals who receive training on FGM will need guidance on navigating the tension between respect for other cultures, on the one hand, and upholding the human rights of individuals, on the other. It can be tempting for professionals who are unfamiliar or uncomfortable with FGM to ignore the practice by rationalizing that it is a cultural matter and, therefore, not something that requires intervention. Such professionals can gain the confidence they need to intervene appropriately when FGM is framed in terms of universal human rights. When viewed through a human rights lens, failure to intervene in a situation where a girl is at risk of FGM would result in a human rights violation—for example, violation of the right to be free from inhuman or degrading treatment under Article 3 of both the British Human Rights Act and the European Convention on Human Rights.³¹³ Such a failure would also be a violation of the right to nondiscrimination under the International Covenant of Civil and Political Rights because the principle of nondiscrimination requires respect for every individual's human rights—even the most marginalized—particularly when confronting situations involving harmful cultural practices.³¹⁴ When professionals become adept at framing FGM as a human rights issue, they will be more able to intervene appropriately and effectively in situations involving FGM-related human rights violations.

E. Provision of Specialist Health Services to FGM Survivors

The UN FGM Resolution calls on member states to, among other things, “develop[] social and psychological support services and care” for women and girls living with FGM and “take measures to improve their . . . sexual and reproductive health.”³¹⁵ The UK has some policies that are in keeping with these objectives but should work to expand these efforts. In particular, specialist health services for FGM survivors currently exist but could be strengthened, and psychological support services still need to be developed.

313. See HRA, *supra* note 18, sch. 1, art. 3; ECHR, *supra* note 16, art. 3.

314. See ICCPR, *supra* note 18, art. 2.

315. UN FGM Resolution, *supra* note 48, ¶ 5.

According to the National Health Service website, currently fourteen specialist clinics across the UK offer specialist health services for FGM survivors, including deinfibulation or reversal of Type 3 FGM.³¹⁶ Most of these clinics are located in London, while others are located in Birmingham, Bristol, Liverpool, Middlesex, and Nottingham.³¹⁷ There is no data on whether the number of clinics and their services are adequate to meet the demand for FGM specialist health services in the UK. This question should be explored through appropriate research with plans and funding made available for expansion of these services as needed.

In addition, the UK does not currently offer any specialist health services involving reconstructive surgery in relation to the clitoris. Such procedures are available in France, and they can restore a woman's sexual functioning and sensation in many cases.³¹⁸ In a recent study of nearly three thousand women who had such surgery after FGM, the procedure was associated with a reduction in pain for the vast majority of patients, as well as with an increase in clitoral pleasure and the achievement of orgasm for many.³¹⁹ The authors of the study recommend that this procedure be made more readily available by training more surgeons.³²⁰ This service should be a funding priority in the UK.

There has been comparatively less attention paid to the provision of psychological support services for women and girls who have experienced FGM. For instance, the National Health Service website mentions psychological problems as a possible long-term consequence of FGM and indicates that counseling is available, but it does not offer detailed information on the specific types of psychological problems likely present after FGM, nor does it indicate whether any counselors are trained specifically to assist FGM survivors.³²¹ The European

316. See NHS CHOICES, *supra* note 304 (noting that surgery can be performed to reverse FGM and providing information on the clinics that specialize in FGM).

317. See NAT'L HEALTH SERV., NHS SPECIALIST SERVICES FOR FEMALE GENITAL MUTILATION (2014), available at <http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Documents/List%20of%20FGM%20Clinics%20Mar%2014%20FINAL.pdf> [<http://perma.cc/ANF6-HMTW>] (archived Feb. 4, 2015) (listing locations of FGM clinics found within England).

318. See Eliza Barclay, *Surgery Restores Sexual Function In Women With Genital Mutilation*, NAT'L PUB. RADIO (June 13, 2012, 4:48 PM), <http://www.npr.org/blogs/health/2012/06/13/154924715/surgery-restores-sexual-function-in-women-with-genital-mutilation> [<http://perma.cc/385P-5QKN>] (archived Feb. 4, 2015).

319. See Pierre Foldès, Béatrice Cuzin & Armelle Andro, *Reconstructive Surgery After Female Genital Mutilation: A Prospective Cohort Study*, 380 LANCET 134, 137 (2012), available at <http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2812%2960400-0/abstract> [<http://perma.cc/BX9L-3GVE>] (archived Feb. 4, 2015).

320. See *id.* at 140 (noting that the availability of reconstructive surgery is limited due to the small number of doctors trained to provide the surgery and the cost of the surgery).

321. See *Female Genital Mutilation*, NHS CHOICES (June 27, 2014), <http://www.nhs.uk/Conditions/female-genital-mutilation/Pages/Introduction.aspx>

Institute for Gender Equality also notes that there is a lack of psychological care for FGM survivors and particularly notes the lack of “professionals skilled in handling post-traumatic stress disorder, sexual trauma and sexual violence.”³²²

An additional consequence of the lack of psychological care and emphasis on gynecological and maternity care is that girls who are too young to have consulted a gynecologist and those who are not yet married are the least likely to access specialist health services for FGM survivors.³²³ The provision of specialist health services, and signposting about them, should be expanded, particularly with a focus on ensuring that girls and young, unmarried women can find appropriate services.

F. Coordination of International Efforts Against FGM

FGM is a global, transnational phenomenon. For that reason, European institutions have been working toward a coordinated, European-wide FGM campaign and EU Action Plan on FGM.³²⁴ In some areas of FGM work, notably child protection, international protection of refugees, and prosecution of perpetrators, EU countries should work together to ensure that people seeking asylum on the basis of FGM receive the same treatment in different countries. They should also work to ensure that those seeking to transport girls for FGM through Europe, or to carry out FGM in Europe, do not escape detection because laws or policies differ between countries, or because police or other statutory agencies do not communicate between countries.

In other areas of FGM work, such as the provision of specialist health services, the training of professionals, awareness-raising, and behavior change, stakeholders can enhance efforts across Europe by sharing strategies and best practices with one another. Another important area for European-wide collaboration is in establishing consistent methods of data collection so that FGM prevalence and other data are available and comparable across Europe.

Third Countries and FGM: Use of the Cotonou Agreement. The European Parliament Resolution of 2001 specifies that EU countries should use the Cotonou Agreement and its Country Strategy Papers

[<http://perma.cc/LXR5-B66E>] (archived Mar. 15, 2015) (noting that “[c]ase histories and personal accounts taken from women indicate that FGM is an extremely traumatic experience for girls and women,” but failing to include details of these problems or suggest treatment options).

322. See LEYE ET AL., *supra* note 95, at 60.

323. See Interview with Naana Otoo-Oyortey, *supra* note 292.

324. See, e.g., Christine Loudes, Speech at the European Commission Round Table on FGM (Mar. 6, 2013), available at *Why Does the EU Need an Action Plan on FGM?*, END FGM EUR. CAMPAIGN, <http://www.endfgm.eu/en/news-and-events/news/press-releases/why-does-the-eu-need-an-action-plan-on-fgm-0102/> [<http://perma.cc/PB2F-RLGQ>] (archived Feb. 4, 2015) (advocating for an EU-wide action plan against FGM).

reporting process to forge a link between the EU's foreign aid to FGM-affected countries and those countries' efforts to end FGM.³²⁵ The Cotonou Agreement "is the most comprehensive partnership agreement between developing countries and the EU. Since 2000, it has been the framework for [the] EU's relations with [seventy-nine]" African, Caribbean, and Pacific countries (ACP Countries).³²⁶ The Cotonou Agreement is founded on such universal principles as democracy and respect for human rights, and it contains provisions that support the eradication of FGM—in particular, Article 9 on respect for all human rights and fundamental freedoms and Articles 25 and 31 on social development and gender issues, respectively. Article 31 states that cooperation under the agreement shall help improve the access for women to all the resources required to fully exercise their fundamental rights, while Article 25 includes the prevention of female genital mutilation as one of the agreement's social sector development goals.

Currently, the agreement's country reporting process is underutilized with respect to anti-FGM strategies, and there is room for substantial improvement. Most countries' current reports include only a cursory mention of FGM and offer no details on specific eradication efforts that could be implemented. For example, the Country Strategy Report for Eritrea for the period 2009–2013 makes only one mention of "female circumcision."³²⁷ The report does not include any details on a strategy against FGM, even though it states that 89 percent of Eritrea's female population has been subjected to circumcision.³²⁸ While the report does indicate that a law against "female circumcision" was passed in 2007, it does not provide any details on this law, penalties under the law, or measures taken to ensure its enforcement.³²⁹

Similarly, the Country Strategy Paper for Somalia (the Somalia Paper) mentions that female genital mutilation is a problem, affecting as much as 98 percent of the population, but it provides no details on a strategy for fighting FGM.³³⁰ FGM was not banned in Somalia until

325. See 2001 EP Resolution, *supra* note 35, ¶ 18–21.

326. ACP – The Cotonou Agreement, EUR. COMM'N, https://ec.europa.eu/europeaid/regions/african-caribbean-and-pacific-acp-region/cotonou-agreement_en (last visited Mar. 16, 2015) [<https://perma.cc/5B4S-BGWY>] (archived Mar. 16, 2015).

327. See ERITREA – EUROPEAN COMMUNITY, COUNTRY STRATEGY PAPER AND NATIONAL INDICATIVE PROGRAMME FOR THE PERIOD 2009-2013 10 (2013), available at http://ec.europa.eu/europeaid/sites/devco/files/csp-nip-eritrea-2009-2013_en.pdf [<http://perma.cc/3GWF-699X>] (archived Feb. 5, 2015).

328. See *id.*

329. See *id.*

330. See SOMALIA JOINT STRATEGY PAPER FOR THE PERIOD 2008-2013 31 (2013) [hereinafter SOMALIA JOINT STRATEGY PAPER], available at http://ec.europa.eu/europeaid/sites/devco/files/csp-somalia-2008-2013_en.pdf [<http://perma.cc/N5C7-65SC>] (archived Feb. 5, 2015).

2012.³³¹ This lack of discussion of FGM is particularly striking given that the preparation of the Somalia Paper included a Country Gender Profile (CGP), a six-page executive summary of which is included as an annex to the Somalia Paper.

Since Somalia practices the most severe, debilitating form of FGM, and also has some of the worst maternal mortality and female literacy statistics in the world,³³² it would be appropriate for the Somalia Paper or the CGP summary to include a much more sophisticated discussion of the role that FGM plays in these poor maternal outcomes as well as in the disadvantaged position women face in society more generally. Given the extremely severe health consequences of infibulation, there is most likely a strong link between the practice and Somalia's other low development indicators with respect to women and children. The Country Strategy Paper could be an opportunity to examine these relationships and detail strategies for combating FGM.

In keeping with the spirit of the 2001 Resolution, the British government should insist that all FGM-affected ACP Countries receiving British aid include comprehensive strategies for combating FGM in their Country Strategy Reports. Britain should also encourage the EU to be similarly insistent on this matter. FGM should be an area that is scrutinized closely, and countries should be required to take robust steps toward the eradication of FGM if they are receiving British or EU aid.

V. DESIGNER VAGINAS

A. *Female Genital Cosmetic Surgery and the FGM Act*

According to the Royal College of Obstetricians and Gynaecologists (RCOG), female genital cosmetic surgery (FGCS) "refers to *non-medically indicated* cosmetic surgical procedures which change the structure and appearance of healthy external genitalia of women, or internally in the case of vaginal tightening."³³³ FGCS includes the most common procedure labiaplasty (surgical reduction of

331. See *Female Genital Mutilation Banned Under Somalia's New Constitution*, GUARDIAN (U.K.) (Aug. 17, 2012, 7:20 AM), <http://www.theguardian.com/global-development/2012/aug/17/female-genital-mutilation-banned-somalia> [<http://perma.cc/ZWA5-SNYX>] (archived Feb. 5, 2015).

332. See SOMALIA JOINT STRATEGY PAPER, *supra* note 330, Annex 9.

333. ROYAL COLL. OF OBSTETRICIANS AND GYNAECOLOGISTS, ETHICAL OPINION PAPER: ETHICAL CONSIDERATIONS IN RELATION TO FEMALE GENITAL COSMETIC SURGERY (FGCS) 1 (Oct. 2013) [hereinafter RCOG ETHICAL OPINION PAPER], available at <https://www.rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf> [<https://perma.cc/F88G-ALC4>] (archived Feb. 5, 2014).

the labia minora), as well as hymenoplasty (reconstruction of the hymen) and vaginoplasty (tightening of the vagina).³³⁴ FGCS is practiced with increasing frequency in Britain, where “the number of labial reduction procedures in the National Health Service . . . increased five-fold” between 2001 and 2010.³³⁵ Over two thousand such operations were performed in 2010.³³⁶

Because the RCOG has defined FGCS as a procedure which is, by definition, nonmedically indicated (i.e., not necessary for physical or mental health), it is prohibited under the FGM Act anytime it involves the excision, infibulation, or other mutilation of the labia majora, labia minora, or clitoris.³³⁷ Accordingly, labiaplasty done for cosmetic reasons is in fact prohibited under the FGM Act because it involves the excision, or “cutting away,” of the labia minora. Similarly, the legal status of hymenoplasty and vaginoplasty would depend on whether the particular procedure performed involved excision, infibulation, or “other mutilation.” Essentially this means that all such procedures currently being carried out in the UK, which involve excision or “other mutilation,”³³⁸ are in fact unlawful under the FGM Act.

There are two likely explanations for why so many FGCS procedures are occurring in the UK without being subjected to prosecution under the FGM Act. First, enforcement efforts are focused on targeting cultural groups known to practice FGM, so the widespread practice of FGCS is flying under the radar. Second, NHS collects data on genital surgery using Hospital Episode Statistics codes that do not distinguish between labiaplasty procedures performed for medical versus nonmedical reasons.³³⁹ The relevant codes are “P05.5: Excision of excess labial tissue” and “P05.6: Reduction of labia minora.”³⁴⁰

Since these codes do not distinguish between procedures that are medically necessary and those that are purely cosmetic, they obscure the number of cosmetic procedures being performed in contravention of the FGM Act.³⁴¹ The British Society for Pediatric & Adolescent Gynecology (BritSPAG) indicates that the majority of FGCS procedures are carried out “in the private sector where there is no

334. *See id.*

335. *See* NS Crouch et al., *supra* note 70, at 1507.

336. *See* RCOG ETHICAL OPINION PAPER, *supra* note 333, at 3 (citing NATIONAL HEALTH SERVICE HOSPITAL STATISTICS (2010)).

337. *See* Female Genital Mutilation Act, 2003, c. 31, § 1(1)–(2).

338. This Article assumes that no medical practitioner would perform a procedure involving infibulation.

339. *See* RCOG ETHICAL OPINION PAPER, *supra* note 333, at 3.

340. *Id.*

341. *See id.*

requirement to provide activity and outcome data.”³⁴² Consequently, NHS figures probably represent just “the tip of the iceberg.”³⁴³

B. Harmful Effects of FGCS and Lack of Robust Data

Although the FGM Act permits any genital surgery that is necessary to a woman’s physical or mental health,³⁴⁴ there is virtually no medical evidence demonstrating that FGCS has health benefits. The RCOG has stated that “given the dearth of evidence of efficacy or safety for cosmetic vulvovaginal surgery, it is difficult to understand how cosmetic genital surgery can currently be presented as ‘in the best interests’ of a woman.”³⁴⁵

FGCS may even be harmful, resulting in effects similar to those associated with FGM. “The labia minora [likely] have an important role in sexual function.”³⁴⁶ There is evidence that such tissue is densely enervated and that “[l]ong-term damage to sensitivity and sexual function may occur after labiaplasty, as surgery will disrupt nerve supply with consequences for sensitivity.”³⁴⁷ BritSPAG points out that there is currently no data on whether FGCS could result in trauma to the genital area during delivery, but that “obstetric difficulties have been reported for women who have had the labia removed as a result of [Type 2 FGM].”³⁴⁸ Since labiaplasty is very similar to Type 2 FGM, it could result in similar complications. Studies suggest that women who undergo FGCS may experience a loss of sensation in the genital region affecting their sexual responsiveness, and they may experience a loss of elasticity in the labia and the development of scar tissue—conditions that can cause complications during labor and delivery.³⁴⁹

There have been no controlled studies evaluating the short- and long-term clinical effectiveness of FGCS. The majority of “studies” claiming that FGCS is safe and that women who undergo it are satisfied have been carried out unsystematically by those who perform

342. BRITISH SOC’Y FOR PAEDIATRIC & ADOLESCENT GYNAECOLOGY, POSITION STATEMENT: LABIAL REDUCTION SURGERY (LABIAPLASTY) ON ADOLESCENTS 4 (2013) [hereinafter BSPA GYNAECOLOGY], available at <http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf> [<http://perma.cc/3HKD-7AWJ>] (archived Feb. 5, 2015).

343. *Id.*

344. See Female Genital Mutilation Act, 2003, c. 31, § 1(2) (Eng., Wales, N. Ir.).

345. ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS, RCOG STATEMENT NO. 6: HYMENOPLASTY AND LABIA SURGERY 2 (2009), available at <http://www.rcog.org.uk/files/rcog-corp/Statement6Hymenoplasty.pdf>.

346. RCOG ETHICAL OPINION PAPER, *supra* note 333, at 4.

347. *Id.*

348. BSPA GYNAECOLOGY, *supra* note 342, at 6.

349. See RCOG ETHICAL OPINION PAPER, *supra* note 333, at 4; see also BSPA GYNAECOLOGY, *supra* note 342, at 7 (suggesting that surgery brings with it greater risks of scarring and numbing); NS Crouch et al., *supra* note 70, at 1510 (concluding that while information on the long-term effects of FGCS is not fully formed, studies suggest that it is associated with reduced sensitivity).

the surgery and thus have a vested interest in the results.³⁵⁰ BritSPAG also notes that there are significant barriers to eliciting quality data on the effectiveness of FGCS:

Recipients are likely to be secretive about the operation and unlikely to attend long term follow up to participate in research. Dissatisfied recipients are likely to present to a different provider for improvement to the unsatisfactory result. The absence of negative feedback to service providers' [sic] may give rise to overestimation of effectiveness and satisfaction.³⁵¹

Accordingly, the possibility that FGCS has negative consequences in the long term has not been ruled out.

C. *Could FGCS Ever Be Necessary for Mental Health?*

The FGM Act allows exceptions for procedures necessary for mental health, and the RCOG interprets this exception to permit "cosmetic surgery resulting from the distress caused by a perception of abnormality."³⁵² It should be evident from the foregoing discussion that there is virtually no support for the proposition that FGCS can enhance a woman's mental health. No studies have been done on this issue. Further, it would be virtually impossible to conduct such a study without reliable data on the long-term physical health consequences of FGCS, given that a woman's mental health would likely be impacted by such long-term consequences. Given that the harmful effects of FGCS have not been fully explored, it is impossible to conclude with any certainty that FGCS could ever be necessary for a woman's mental health. Or, as one team of physicians concluded, "[i]t is difficult to see how operations on normal sex organs in the absence of quality data could be therapeutic. It is equally difficult to see how FGCS could be anything other than cultural."³⁵³

D. *Remedying Distress Caused by "a Perception of Abnormality": Cosmetic Surgery or Education?*

Importantly, the RCOG has noted that many women suffering from distress caused by a perception that their genitals are abnormal are best served by being provided with accurate information about the normal range of female genital appearance.³⁵⁴ They note that genital dissatisfaction appears to be increasing among women because

350. See BSPA GYNAECOLOGY, *supra* note 342, at 4–6 (suggesting that there are "[s]ignificant barriers to quality research outcomes"); see also RCOG ETHICAL OPINION PAPER, *supra* note 333, at 3.

351. BSPA GYNAECOLOGY, *supra* note 342, at 6.

352. RCOG ETHICAL OPINION PAPER, *supra* note 333, at 2.

353. NS Crouch et al., *supra* note 70, at 1510.

354. See BSPA GYNAECOLOGY, *supra* note 342, at 7; RCOG ETHICAL OPINION PAPER, *supra* note 333, at 2–3.

unrealistic, idealized images of female genital appearance are widely available in popular culture, but information about the true normal range of female genital appearance is comparatively inaccessible:

Because there is limited authoritative information on normal female genital anatomy, women and girls who are self-conscious about their genital appearance have to refer to cultural representations of female genitalia for self-evaluation. These sources are currently found mainly in photographic pictures on the web, in the media and in advertising for FGCS services and give rise to the erroneous perception that the labia minora are normally invisible, hidden by the labia majora. Women who are worried about the appearance of their labia or requesting labial surgery often report being influenced by marketing or these media images³⁵⁵

In a number of cases, for instance, women have developed a negative perception of their genitals after comparing themselves to photographs in popular culture sources, such as pornographic magazines.³⁵⁶ A study carried out by gynecologist Sarah Creighton and her colleagues supports the notion that a woman's satisfaction with her genital appearance has more to do with her subjective beliefs than with any physical abnormality.³⁵⁷ The study measured the labia minora of two healthy groups of women—those requesting FGCS and those not desiring such surgery. They found wide variation in the size of the labia minora within each group, but no significant difference in size or appearance of the labia minora *between* the two groups.³⁵⁸ Accordingly, if mental health is cited as a reason for FGCS, it is typically not tied to any actual medical necessity but is likely a subjective response to genitalia *perceived* as abnormal.³⁵⁹ Therefore, much distress over genital appearance could more easily be alleviated with education about the range of normal genital appearance than the expense and pain of surgery.³⁶⁰

355. RCOG ETHICAL OPINION PAPER, *supra* note 333, at 3 (footnotes omitted).

356. *See id.*; *see also* BSPA GYNAECOLOGY, *supra* note 342, at 5; NS Crouch et al., *supra* note 70, at 1508 & tbl.1 (listing the reasons participants sought labial reduction surgery).

357. *See* NS Crouch et al., *supra* note 70, at 1509–10 (finding that all but three participants felt that surgery was appropriate despite their doctor finding that their “labial dimensions were within the normal range”).

358. *See id.* at 1508–10.

359. *See id.* at 1509–10; *see also* BSPA GYNAECOLOGY, *supra* note 342, at 5; RCOG ETHICAL OPINION PAPER, *supra* note 333, at 2, 7.

360. In recent years websites have sprung up to address this issue. *See, e.g., Love your Labia*, TUMBLR, <http://lovelargelabia.tumblr.com/> (last visited Mar. 16, 2015) [<http://perma.cc/4G4V-L9NW>] (archived Feb. 5, 2015). This website allows women to submit actual photographs of their genitals. The photographs depict a wide range of variation. Comments such as the following are typical: “I am 25 years old. I felt like there was something wrong with me and only in the past few years have I begun to research large labia thinking that I was the only one with big lips. I have grown to accept my labia as beautiful and I am happy to see that there are other women out there like me Thank you for sites like this one, allowing woman [sic] to embrace themselves as who [sic] they are. Beautiful.”

E. A Double Standard for FGM and FGCS?

It is difficult to argue that a mental health exception allowing FGCS is a rational policy when the FGM Act states that, in “determining whether an operation is necessary for [someone’s] mental health,” whether FGM is “required as a matter of custom or ritual” shall not be taken into account.³⁶¹ The intent of this provision is to preserve women’s bodily integrity and eliminate social control of women’s bodies; if FGCS is allowed in contravention of the FGM Act simply because a woman (or her partner) does not like the way she looks, there is an easy way around the “custom or ritual” prohibition on FGM. Members of FGM-affected communities could easily use this mental health exception to argue that FGM is necessary in order to allow a particular individual to fit in and be normal. It makes little sense to prohibit FGM while allowing other women to freely access cosmetic surgery that achieves similar results.

Some people in FGM-affected communities perceive a double standard whereby FGM is prohibited but FGCS occurs with frequency and no legal sanction.³⁶² Some may take the view that the double standard essentially allows the state to regulate what women of color do with their genitals, while allowing white women to undergo similar procedures legally and with the support—until recently—of the National Health Service. This perception may complicate efforts to eliminate FGM in the UK and may fuel arguments that campaigns against FGM are disguised efforts to attack the culture of FGM-affected communities.

To address this problem, two strategies are necessary. First, there are, in fact, differences between the two procedures that may legitimize treating them somewhat differently, and these differences must be clarified. But, in addition, the current approach to FGCS—essentially allowing it to happen with no oversight—must be revisited for two reasons. First, there are likely harmful consequences to FGCS that have not been adequately explored and addressed. Second, the legal obligation under the British Human Rights Act to non-discrimination³⁶³ requires that the government take measures to ensure that individuals and cultural groups are being treated fairly and in accordance with the same standards. Fortunately, as discussed below, the RCOG and BritSPAG have recently made recommendations to more strictly regulate FGCS.

361. See Female Genital Mutilation Act, 2003, c. 31, § 1(5) (Eng., Wales, N. Ir.).

362. See Interview with Naana Otoo-Oyortey, *supra* note 292; see also HEMMINGS, *supra* note 259, at 13.

363. See HRA, *supra* note 18, sch. 1, art. 14.

F. Differences Between FGCS and FGM

While FGCS and FGM are physically similar procedures, they have very different cultural meanings. FGM is usually imposed on children at an age when they are unable to consent, and, typically, it is a requirement for marriage and for broader acceptance as an adult member of the community. The importance of FGM means that a woman's status as "circumcised" is of interest to other people in the community and affects how they treat her. In such communities, women are forced to accept FGM because they are unable to survive, either socially or economically, without it.

In contrast, FGCS in the western world involves an element of choice that is not present in communities affected by FGM. FGCS is not required for social acceptance—indeed, most women do *not* undergo it—and most people are unaware of *who* has undergone it. Thus, the practice is a much more private matter than FGM, having little social relevance beyond the woman and her intimate partners. FGCS is therefore less coercive and in that sense does not violate women's human rights in the way that FGM does.

An additional factor that appears to distinguish FGM from FGCS is that only FGM is advocated as a means of controlling women's sexuality. Accordingly, FGM often involves the removal of a woman's most sexually sensitive organ—the clitoris—while FGCS generally does not. However, BritSPAG notes that "[w]omen have self-rated the labia minora as being second only to the clitoris in terms of sensation and sensitivity."³⁶⁴ It follows, then, that labiaplasty could result in a loss of sexual sensitivity, further reinforcing the similarity between FGM and FGCS.

The fact that requests for FGCS have risen five-fold in the NHS in recent years is disturbing evidence that western women are increasingly concluding that their genitals are not acceptable in their natural state. Since many women reach this conclusion based on comments from partners or after viewing images in pornographic magazines, there is undoubtedly a social dimension to their dissatisfaction that is not unlike the pressure facing women in FGM-affected communities. In addition, the fact that FGCS may result in complications similar to those resulting from FGM, including a loss of sexual sensitivity, is a significant parallel between the two procedures, reinforcing the importance of treating the procedures similarly under the law.³⁶⁵

364. BSFA GYNAECOLOGY, *supra* note 342, at 3.

365. However, advocates of FGCS may be able to argue that even if FGCS results in complications, those complications are likely to be much less severe than the complications associated with infibulation, given that infibulation obstructs the flow of urine and menstrual blood, whereas no form of FGCS does so.

In short, although there are important differences between FGM and FGCS, there are also disturbing similarities between the two procedures, and it is not inconceivable that widespread acceptance of FGCS could intensify the pressure that some women feel to surgically alter their genitals.

In keeping with the principle of nondiscrimination, FGCS and FGM should be treated similarly under the law. This means that any nonmedically necessary procedure carried out in contravention of the FGM Act should be prosecuted, regardless of whether the procedure is considered FGM or FGCS by those involved.

G. RCOG and BritSPAG Guidance on FGCS: A Changing Landscape

The RCOG issued an Ethical Opinion Paper in November 2013 that sets out new guidelines for FGCS. The document notes that labiaplasty as currently practiced raises a number of ethical concerns: (a) there are no controlled studies on its clinical effectiveness, risks, or long-term outcomes; (b) the number of labiaplasties has increased considerably both in Britain and across the western world; (c) labiaplasty has been performed on a significant number of girls below the age of eighteen years; and (d) despite the absence of substantial evidence showing any benefit, labiaplasty is increasingly being advertised as beneficial by private clinics.³⁶⁶

If these trends continue without intervention, the result could be the embrace of FGM-like norms, with women across the western world potentially feeling compelled to alter their bodies in order to meet these norms. Although this outcome may seem farfetched, the fact that sharply increasing numbers of western women have been embracing FGCS, including girls under the age of eighteen, coupled with the promotion of labiaplasty as supposedly beneficial, bears disturbing similarities to the norms prevalent in FGM-affected communities.

The RCOG has responded to these ethical concerns with a number of recommendations meant to decrease the incidence of FGCS and dampen demand for the procedures. First, healthcare professionals should have access to accurate and sensitive teaching materials on the normal variations in female genitalia, and they should provide women requesting labiaplasty with this accurate information. They should also offer counseling and other psychological resources to such women.³⁶⁷ The effect of this recommendation is to discourage immediate recourse to surgery as a reaction to dissatisfaction with genital appearance.

366. See RCOG ETHICAL OPINION PAPER, *supra* note 333, at 5–6 (identifying the ethical concerns that arise out of current labial reduction practices).

367. See *id.* at 7 (recommending that women requesting labiaplasty be provided with information on normal variation in genitalia, counseling, and treatment for body image issues as necessary).

RCOG's second recommendation is that FGCS should not ordinarily be carried out on those under the age of eighteen because full genital development is not normally achieved before that age.³⁶⁸ This recommendation helps to ensure that those undergoing FGCS have the capacity to give fully informed consent. BritSPAG also points out that if labiaplasty is done before the age of eighteen, it can "lead to . . . poor long-term [results] . . . as the labia continue to develop."³⁶⁹ This can lead to further requests for surgery, which carries additional risks of scarring and numbing.³⁷⁰

Third, NHS should no longer provide labiaplasty for cosmetic reasons alone because doing so is not a good use of public resources.³⁷¹ Excision of the labia for cosmetic reasons alone is also unlawful, as this Article has demonstrated. RCOG's final recommendation is that in order to demonstrate compliance with the FGM Act, "it is essential that all surgeons who undertake FGCS keep written records of the physical and mental health reasons which, in their view, necessitate the FGCS procedures they carry out."³⁷²

BritSPAG has issued a position statement concerning labiaplasty among adolescents.³⁷³ This statement addresses many of the same concerns and makes similar recommendations to those contained in the RCOG Ethical Opinion Paper. In addition, BritSPAG recommends that adolescents seeking labiaplasty should be provided with information on labial anatomy and its development, diversity in vulval appearance, the unknowns about labiaplasty, measures for managing labial discomfort, and, where distress is significant, the importance of psychological assessment.³⁷⁴

These recommendations, if fully implemented, will go a long way towards ensuring that the respective approaches to FGCS and FGM are more consistent and in keeping with the FGM Act. In particular, it is important that FGCS not be carried out on children and that healthcare professionals are held accountable for ensuring that they do not carry out FGCS in contravention of the FGM Act. Note, however, that the final RCOG recommendation embodies an inconsistency—since the RCOG defines FGCS as nonmedically indicated, it is internally inconsistent to imply that physicians can document physical and mental health reasons for carrying FGCS out.

368. See *id.* at 8.

369. BSPA GYNAECOLOGY, *supra* note 342, at 7.

370. See *id.*

371. See RCOG ETHICAL OPINION PAPER, *supra* note 333, at 8.

372. *Id.*

373. See generally BSPA GYNAECOLOGY, *supra* note 342.

374. See *id.* at 7–8.

VI. CONCLUSIONS AND RECOMMENDATIONS

Since the UK passed its first law against female genital mutilation in 1985, momentum has been building across the UK, Europe, and internationally to intensify efforts to eliminate this violation of girls' and women's health and human rights. It has become clear that anti-FGM legislation alone will not eliminate FGM. FGM is a problem that must be addressed in multi-faceted ways, and interventions must be matched with funding commitments that enable successful completion of the work on every front. This Article has argued that FGM must be addressed in a comprehensive manner. It has also offered recommendations for strengthening legal measures against FGM, working with communities to help them abandon the practice, educating professionals, advancing international efforts against FGM, and coordinating the approaches to FGM and FGCS.

A. Recommendations for Strengthening the Legal Framework Against FGM

The current UK law on FGM has some effective aspects, but the legal framework can be strengthened considerably. The Model Act proposed by this Article and included in the Appendix provides a framework for strengthening the law by closing gaps in the current law and expanding the range of prosecutable offenses. The Model Act also includes reporting obligations for persons with knowledge of suspected cases of FGM, provides compensation and civil remedies for victims, empowers courts to issue orders of protection in cases of FGM, and incorporates an obligation to provide education on FGM to relevant professionals, affected communities, and immigrants from FGM-affected regions of the world. Many of the new provisions in the Model Act are consistent with the UK's obligations under the Istanbul Convention, the UN FGM Resolution, and the various resolutions passed by the European Parliament and the Council of Europe. The British government should seriously consider its adoption.

There are additional legal measures that the government can take. It can use existing domestic legislation more effectively, and it can adopt a national action plan on FGM. The Domestic Violence, Crime and Victims Act, for example, provides a way to bring charges against parents who fail to protect their daughters from FGM. In addition, the Children Act provides protective measures that can be invoked to protect girls at risk of FGM. Moreover, prosecutors and law enforcement should be trained in the application of these laws to FGM. Finally, a national action plan would coordinate all anti-FGM efforts across sectors and ensure that all stakeholders are included in planning. It would also provide a system for disseminating best practices across sectors and organizations, while allowing stakeholders to avoid duplication of effort.

B. Recommendations for Working with Communities

It is important to continue to fund and expand the work of the Female Genital Mutilation Initiative. This initiative funds a wide range of interventions across FGM-affected communities. Its research has identified obstacles to ending FGM in the UK and addresses those obstacles through well-crafted intervention. It is crucial that this work receive ongoing financial support.

The FGM Telephone Helpline should also continue to receive funding support and should be expanded. Established in June 2013, the helpline fulfills the Istanbul Convention's call to establish twenty-four-hour telephone helplines for those affected by gender-based violence.

The Health Passport should be improved. The Health Passport's use of the term "female genital mutilation" could alienate the target audience. It should use a more neutral term, include information on the health consequences of FGM, and incorporate diagrams for those who cannot read.

A National Advisory Board on FGM should be established and be comprised of individuals from affected communities. Members of FGM-affected communities can offer essential leadership, cooperation, and facilitation of efforts against FGM. Such a board could enhance cooperation and communication between affected communities and statutory groups. FGM specialist health services must also be expanded. In particular, signposting and referral networks for currently available aftercare must be improved, and psychological support services still need to be developed.

C. Recommendations for Working with Professionals

Building competency among professionals who come into contact with those affected by FGM is of critical importance. Lack of FGM awareness among such professionals is a significant problem and a key barrier to change. Professionals from any sector who may encounter cases of FGM need education and awareness-raising.

In particular, comprehensive FGM training for teachers should receive great priority. Because of their regular and consistent interaction with young people, teachers are in the best position to notice the warning signs that FGM may take place during an upcoming holiday. All teachers must be equipped to fulfill this role.

Health professionals also need training to recognize and respond to FGM. Since some health professionals, such as midwives, are more knowledgeable about FGM than others, efforts should especially target groups, such as general practitioners, where levels of awareness and referral are low.

Training should be culturally sensitive and respect human rights. All types of professionals who receive training on FGM will need

guidance on navigating the tension between respect for other cultures, on the one hand, and upholding the human rights of individuals, on the other.

D. International Efforts Against FGM

Collaboration across Europe on FGM is a priority. The UK should work with other European countries to establish consistent methods of data collection and share strategies and best practices with respect to all of the recommendations made here. The UK should also work with other European countries to ensure that individuals seeking asylum on account of FGM receive the same high standard of care and treatment across all countries. Additionally, the British government should insist that all FGM-affected ACP countries receiving British aid include comprehensive strategies for combating FGM in their reports under the Cotonou Agreement.

E. Female Genital Cosmetic Surgery and FGM

FGCS should be prohibited by law for those under the age of eighteen, and the law against FGM should be applied consistently. This means that unless the FGM Act is modified to permit medically unnecessary FGCS, a ban on all medically unnecessary FGCS procedures should be enforced. Legislation should be passed to require that those interested in undergoing FGCS be informed of possible long-term side effects and of the limited amount of research available on such long-term effects.

VII. APPENDIX: MODEL FGM ACT

Part I: Preliminary**(1) Definitions**

(a) Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs, *for nonmedical reasons*. Infibulation and reinfibulation are included in the definition of female genital mutilation.

(b) “Infibulation” means the stitching together of the two sides of the vulva, labia minora, or labia majora in order to create a barrier over the vagina.

(c) “Reinfibulation” means the restitching together of the two sides of the vulva, labia minora, or labia majora on a person who was previously infibulated and subsequently deinfibulated, such as after the birth of a child.

Explanatory note: There is no need to have a carve-out for medically necessary procedures when the definition clearly states that FGM only includes procedures performed for nonmedical reasons. Medically necessary procedures would not be prohibited by this statute.

(d) “Child” means anyone who has not yet reached her eighteenth birthday.

(2) FGM as Child Abuse

FGM constitutes child abuse.

Part II: Offenses Involving Female Genital Mutilation**(3) Offense of Female Genital Mutilation**

(a) A person is guilty of an offense if he performs FGM on any person or attempts to perform FGM on any person.

(b) A person is guilty of an offense if he aids, abets, counsels, or procures a person to perform FGM on any person, regardless of whether the act of FGM occurs within the United Kingdom or abroad.

Explanatory note: This aiding/abetting liability is broader here than in Section 2 of the 2003 FGM Act. It covers aiding and abetting FGM in

relation to any person, not solely with respect to one particular individual. The 2003 FGM Act could be read as implying that in order to convict someone of an aiding and abetting offense, he would have to be aiding a girl who was carrying out FGM on herself.

(4) Aggravated Female Genital Mutilation

A person is guilty of the offense of aggravated female genital mutilation where—

- (a) death occurs as a result of female genital mutilation;
- (b) the offender is a parent of, guardian of, husband of, or person having authority or control over the victim;
- (c) the victim suffers disability;
- (d) the victim is infected with HIV as a result of the act of female genital mutilation; or
- (e) the female genital mutilation is done by a person licensed to practice any health profession.

(5) Use of Premises to Perform Female Genital Mutilation

A person is guilty of an offense if he knowingly allows any premises that is under his ownership or control, or that he is responsible for, to be used for the purpose of performing female genital mutilation.

(6) Possession of Tools Used to Perform Female Genital Mutilation

A person is guilty of an offense if he is found possessing any tool or equipment for a purpose connected with the performance of female genital mutilation.

(7) Discrimination Against Any Person Who Opposes FGM

- (a) A person is guilty of an offense if he discriminates against, threatens, harasses, or stigmatizes any female who resists or refuses to undergo FGM.
- (b) A person is guilty of an offense if he prevents any female who resists FGM or refuses to undergo FGM from engaging in or participating in any economic, social, educational, political, or other activity in the community.

(c) A person is guilty of an offense if he takes any of the actions enumerated in (a) and (b) above against any relative of a female who resists or refuses to undergo FGM.

(d) A person is guilty of an offense if he discriminates against, threatens, harasses, or stigmatizes any person who speaks out against FGM.

(8) Arranging for a Person to Enter the United Kingdom for the Purpose of FGM

(a) A person is guilty of an offense if he arranges for another person to enter the United Kingdom from another country with the intention of having that other person perform female genital mutilation or aid others to perform female genital mutilation.

(b) A person is guilty of an offense if he arranges for another person to enter the United Kingdom from another country with the intention of having FGM performed on that other person.

(9) Removal from State for Purposes of Female Genital Mutilation

(a) A person is guilty of an offense if the person removes or attempts to remove a girl or woman from the United Kingdom where one of the purposes of the removal is to have an act of female genital mutilation done to her.

(b) In proceedings for an offense under subsection (a), it shall be presumed, until the contrary is shown, that one of the purposes of the removal from the United Kingdom by the accused person was to have FGM performed on the girl or woman concerned if:

(i) The accused person removed or attempted to remove the girl or woman from the United Kingdom in circumstances giving rise to the reasonable inference that one of the purposes of such removal was to have an act of FGM done to her, or

(ii) an act of FGM was done to her after she was removed from the United Kingdom and, where she subsequently returned to the United Kingdom, before that return.

(c) For the purposes of this section, to “remove to attempt to remove a girl or woman from the United Kingdom” includes, but is not limited to,

(i) arranging any part of her travel out of the United Kingdom;

(ii) accompanying her for any portion of that travel,

(iii) arranging that she be met when her travel out of the United Kingdom has terminated, or

(iv) doing any other act that could facilitate her travel out of the United Kingdom.

(10) Extension of Paragraphs 3 to 9 to Extraterritorial Acts

(a) Paragraphs 3 to 9 extend to any act done outside the United Kingdom by any person who (1) is a United Kingdom national or permanent resident or (2) habitually resides in the United Kingdom, regardless of the nationality of the victim.

(b) “Habitually Resident” in the United Kingdom.

For the purposes of this Act, whether any person is “habitually resident” in the United Kingdom shall be determined by a court of competent jurisdiction through (1) educational records from any school, preschool, or daycare center attended by the person; (2) medical records; (3) records from any border control, law enforcement, or social service agency; (4) testimony of relatives, friends, neighbors, or other persons with knowledge of the relevant person’s life; or (5) any other evidence deemed sufficient by the court.

(c) If an offense under this Act is committed outside the United Kingdom—

(i) proceedings may be taken, and

(ii) the offense may for incidental purposes be treated as having been committed in any place in England and Wales or Northern Ireland.

Part III: Prohibited Defenses; Penalties for Offenses

(11) Consent of the Victim to Female Genital Mutilation

Consent of the victim to female genital mutilation shall not be a defense under this Act.

(12) Culture and Religion not a Defense to Female Genital Mutilation

Any culture, custom, ritual, tradition, religion, or any other nontherapeutic reason shall not be a defense under this Act.

(13) Penalties for Offenses

(a) A person guilty of an offense under Paragraph (3) or (9) of this Act is liable—

(1) on conviction on indictment, to imprisonment for a term not exceeding fourteen years or a fine (or both),

(2) on summary conviction, to imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum (or both).

(b) A person guilty of an offense under Paragraph (4) of this Act is liable on conviction on indictment to life imprisonment or a fine (or both).

(c) A person guilty of an offense under Paragraph (5), (6), (7), or (8) of this Act is liable—

(1) on conviction on indictment, to imprisonment for a term not exceeding five years or a fine (or both),

(2) on summary conviction, to imprisonment for a term not exceeding six months or a fine not exceeding the statutory maximum (or both).

Part IV: Duty to Report; Penalties for Failure to Report**(14) Duty to Report Female Genital Mutilation**

(a) Any adult person who knows that another person has committed or intends to commit an offense under this Act shall report the matter to the police or other authority for appropriate action.

(b) Any adult person who, knowing that another person has committed or intends to commit on offense under this Act, does not report the matter to the police or other authority within twenty-four hours of having such knowledge, commits an offense and is liable upon conviction to a fine or to imprisonment not exceeding six months, or both.

(c) Any person who in any way threatens, harms, or inhibits a person who is reporting or about to report an offense under this Act commits an offense. Such person is liable upon conviction to a fine or to imprisonment not exceeding six months, or both.

(15) Safeguarding Obligations of Those Who Work with Children

(a) Any law enforcement officer or social service, education, or health care professional who becomes aware of a case, or a suspected case, of FGM affecting a child must follow the child protection procedures mandated in cases of child abuse.

(b) Requirement of aftercare. In the case of a child who has been subjected to FGM, any law enforcement officer or social service, education, health care, or other professional who becomes aware of this fact must report it immediately to the relevant health care authorities. The relevant health care authorities shall make arrangements to ensure that such child has access to, and is offered, appropriate aftercare, including deinfibulation, as well as other appropriate physical and mental health care, as expeditiously as possible. This obligation is in addition to the child protection obligations in paragraph (14)(a).

Part V: Court Orders and Jurisdiction

(16) Compensation

Where a person is convicted of any offense under this Act, the court may, in addition to the punishment provided herein, order such person to pay by way of compensation to the victim, such sum as in the opinion of the court is just, having regard to (a) the injuries suffered by the victim and (b) the victim's medical and other expenses.

(17) Civil Remedy

(a) An individual who is a victim of a violation of this Act may bring a civil action against the perpetrator or perpetrators in an appropriate court of the United Kingdom and may recover damages and reasonable attorneys' fees.

(b) No action may be maintained under this section unless it is commenced not later than twenty years after the cause of action arose or twenty years after the victim reaches majority age, whichever is later.

(18) Order of Protection

A court may, if satisfied that a person is at risk of being compelled to undergo FGM, upon application of any person, issue an order of protection.

**Part VI: Further Obligations of the Government Towards
Eliminating FGM**

(19) Education and Aftercare

The government shall take all necessary measures within its available resources to—

(a) undertake public education and sensitize the people of the United Kingdom on the dangers and adverse affects of FGM;

(b) ensure that professionals working with FGM-affected communities (1) receive adequate education about the dangers and adverse affects of FGM and (2) are competent to carry out the following duties: (A) safeguard children affected by FGM and report such cases to the relevant authorities and (B) provide appropriate care and services to those affected by FGM while also respecting the dignity of those so affected; and

(c) provide all necessary support services, including specialist health services, to those affected by FGM.

(20) Provision of Information Regarding Female Genital Mutilation

(a) The United Kingdom Border Control Agency shall make available to all non-UK persons who are issued immigrant or nonimmigrant visas, prior to or at the time of entry into the United Kingdom, the following information:

(1) Information on the severe harm to physical and psychological health caused by female genital mutilation which is compiled and presented in a manner which is limited to the practice itself and respectful of the cultural values of the societies in which such practice takes place; and

(2) Information concerning potential legal consequences in the United Kingdom for (A) performing female genital mutilation or (B) allowing a child under the person's care to be subjected to female genital mutilation under criminal or child protection statutes or as a form of child abuse.

(b) Limitation. The UK Border Agency shall identify those countries in which female genital mutilation is commonly practiced and, to the extent practicable, limit the provision of information under subsection (a) of this section to persons from such countries.

Part VII: Miscellaneous

(21) Consequential Provision

(a) The Female Genital Mutilation Act 2003 ceases to have effect.

(b) In paragraph 1(b) of the Schedule to the Visiting Forces Act 1952 (c. 67) (“offences against the person in respect of which a member of a visiting force may in certain circumstances not be tried by a United Kingdom court”), for paragraph (xi) there is substituted—

“(xi) the Female Genital Mutilation Act [insert year];”.

(22) Short title, commencement, extent and general saving

(a) This Act may be cited as the Female Genital Mutilation Act [insert year].

(b) This Act comes into force on such day as the Secretary of State may by statutory instrument appoint.

(c) This Act does not extend to Scotland.

(d) Nothing in this Act affects any criminal liability arising apart from this Act.