House of Commons

Women and Equalities Committee

Female genital mutilation

Seventh Report of Session 2024–25 HC 714

Women and Equalities Committee

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Summary

Female Genital Mutilation (FGM) is an internationally recognised human rights violation. It is a form of gender-based violence and, in most circumstances, violent child abuse that has serious and lifelong impacts on the health and wellbeing of women and girls. According to the latest estimate, there are 137,000 women and girls living with FGM in England and Wales. Despite this, access to services for FGM survivors in the UK is a postcode lottery and FGM services often do not provide appropriate counselling services. The Government must ensure that all FGM survivors can access the essential support and care they need through funded multidisciplinary services and clear referral pathways, including specialist counselling support.

In healthcare settings, some FGM survivors have reported being shamed or humiliated by healthcare professionals who lack awareness of cultural sensitivities. This is worsened by a lack of mandatory training and training that does not give practical advice to healthcare professionals on speaking about FGM. We recommend that FGM training should be made mandatory for midwives and other healthcare professionals working in services where they are likely to encounter FGM survivors.

Many FGM survivors seek reconstructive surgery as a means of reducing pain, sexual dysfunction, and body dysmorphia. However, the Government cites a lack of evidence as a barrier to providing reconstructive surgery while simultaneously failing to invest in the research necessary to generate such evidence. The Government should facilitate and fund research into reconstructive surgery for FGM survivors as a matter of priority.

FGM services need to be provided according to local need but the most recent prevalence study took place in 2015 and is outdated. The Home Office should carry out an updated prevalence study to ensure services can be aligned with local needs.

We are seriously concerned by evidence and data that suggests FGM is taking place in the UK and that UK citizens or residents are being taken abroad to undergo FGM. The Government needs to provide consistent and long-term funding to tackle this gender-based violence. This includes through education and awareness raising campaigns which inform affected communities of the serious health impacts of FGM, and which engage with key figures in affected communities.

Small survivor-led organisations drive vital work within these communities but have access to limited funding, must compete against each other for the funding that is available, and can lack the capacity or expertise necessary to access complex application processes. The Government should ensure that applications for

funding are accessible and inclusive for organisations that lack the resources to navigate complex tendering processes.

Border monitoring is an effective mechanism for preventing FGM being carried out on UK citizens and residents taken abroad. However, improved training of border officials, better follow-up of suspected cases, and enhanced communication between different agencies could improve its effectiveness.

There have only been three convictions for FGM offences in England and Wales to date. There are several reasons for the low convictions rates, including a lack of referrals, insufficient evidence collection and a reluctance of survivors to testify against family members. However, many survivors may have pursued prosecutions against their family members had they felt sufficiently supported. FGM is a serious crime, and survivors deserve recourse to justice. An effective criminal justice deterrent is a vital part of the process in tackling FGM, and it is currently missing. Criminal justice agencies should review police intervention and CPS prosecution strategies with a view to increasing the prosecution rate for FGM. This could include increasing safeguarding referrals by improving training so that professionals feel confident to ask questions around FGM.

The continued prevalence of FGM globally increases the risk of FGM to current and future UK citizens and residents. Supporting international efforts to end FGM through aid programmes and diplomacy is necessary to reduce the risk of FGM occurring. The planned

reduction in Official Development Assistance (ODA) from 0.5% to 0.3% of GNI in 2027 after the prior reduction from 0.7% risks the effectiveness of these programmes and present a direct risk to the safety of girls in the UK and those overseas. We call on the Government to protect FGM programmes from further reductions in funding.

1 Introduction

1. Female Genital Mutilation (FGM), also known as Female Genital Cutting (FGC), includes "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."[1] There are four types of FGM and the methods for carrying out FGM can vary, with FGM often being carried out using knives, scissors, scalpels, pieces of glass or razor blades without the use of anaesthetics and antiseptics. FGM frequently happens without consent and women and girls may be forcibly restrained.[2] FGM is recognised internationally as a human rights violation.[3] The United Nations Sustainable Development Goals lists elimination of FGM as part of Goal 5: to achieve gender equality and empower all women and girls by 2030.[4]

Box 1: Types of FGM

- Type 1–Clitoridectomy

Removal of part or all of the clitoris.

- Type 2–Excision

1 World Health Organization, Female genital mutilation, 31 January 2025

2 NHS, Female genital mutilation (FGM), accessed 17 June 2025

3 UNFPA, Female genital mutilation, accessed 1 July 2025

4 United Nations, Sustainable Development Goals: Goal 5 | Department of Economic and Social Affairs, accessed 1 July 2025

Removal of part or all of the clitoris and the inner labia, with or without removal of the labia majora.

- Type 3–Infibulation

The narrowing of the vaginal opening by creating a seal, formed by cutting and repositioning the labia.

- Type 4–Other

Other harmful procedures to the female genitals, including pricking, piercing, cutting, scraping or burning the area.

Source: NHS, Female genital mutilation (FGM), accessed 22 July 2025

2. Each year, four million girls are estimated to be at risk of FGM globally.[5] Drivers of FGM differ across communities and include beliefs related to sexual purity, marriage eligibility and misconceptions about hygiene and religious teachings.[6]

3. Over 230 million women and girls have undergone FGM worldwide. According to UNICEF, an estimated 144 million women and girls who have undergone FGM live in Africa, 80 million in Asia and 6 million in the Middle East. Another one to two million women and girls are subject to FGM in small practising

5 World Health Organization, Female genital mutilation, 31 January 2025

6 Q4 [Valerie Lolomari and Aissa Edon]

communities and destination countries for migration in the rest of the world.[7] These figures are considered an underestimation.

4. In 2015, it was estimated that 137,000 women and girls live with FGM in England and Wales amongst migrant communities.[8] To look at the UK Government's work combatting FGM and supporting survivors in the UK, we held an oral evidence session with two FGM survivors and campaigners, as well as other health professionals, a practice manager at an FGM helpline, and one current and one former police officer. We received written evidence from other FGM survivors, organisations working to support FGM survivors and to prevent FGM, and FGM specialist midwives. We also wrote to the Home Office, Department of Health and Social Care, Department for Education, and Foreign, Commonwealth and Development Office regarding their work to prevent FGM and to support FGM survivors. We are grateful to everyone who contributed to our work, but particularly to all the survivors who relayed their personal experiences to us.

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7 UNICEF DATA, Female Genital Mutilation (FGM) Statistics, 1 June 2025; UNICEF notes that self-reported data on FGM need to be treated with caution for several reasons. First, women may be unwilling to disclose having undergone the procedure because of the sensitivity of the topic or the illegal status of the practice in their country. In addition, women may be unaware that they have been cut or of the extent of the cutting, particularly if FGM was performed at an early age.

8 Equality Now, Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, July 2015

2 Healthcare support for survivors of FGM

Impact of FGM

5. FGM survivors "experience a complex range of physical, psychological, and social health issues", and these issues are often lifelong.[9] Short-term complications of FGM include severe pain, genital tissue swelling, haemorrhage, infections, fever, urinary problems, shock and even death.[10] One study found that 44,000 women die globally because of FGM every year.[11] Long-term FGM complications include pelvic pain, painful menstruation, and urinary tract infections. Scar tissue from FGM can lead to urinary difficulties, cysts, and abscesses, requiring medical intervention. FGM survivors can also face obstetric complications, with FGM increasing the risk of prolonged labour, perineal tearing, postpartum

9 Manor Gardens Welfare Trust (FGM0001)

10 World Health Organization, Female genital mutilation, 31 January 2025

11 Q17 [Professor Shehata] and Arpita Ghosh, Heather Flowe, James Rockey, "Estimating excess mortality due to female genital mutilation", Scientific Reports, Vol 13 No 1, 16 August 2023

haemorrhage, and obstetric fistula.[12] Despite this, the Manor Gardens Welfare Trust (MGWT), a health and wellbeing charity, said:

> Many women do not realize that their ongoing health complications are related to FGM until much later in life, often after pregnancy or repeated medical visits.[13]

6. The mental and emotional impact of FGM includes post-traumatic stress disorder, depression and anxiety, often accompanied by feelings of isolation, guilt, shame, and profound hopelessness.[14] It can involve experiences such as flashbacks of the abuse, panic attacks, "persistent fear and distress" and suicidal ideation. In addition, FGM survivors suffer sexual complications, including decreased desire and pleasure, painful sexual intercourse, fear of having sex, and difficulties in maintaining intimate relationships.[15] FGM survivors may also avoid vital future medical care due to trauma, including smear tests, maternity care and gynaecological care.[16]

7. The call for evidence for the Women's Health Strategy for England found that awareness was very low of NHS services for victims of violence or abuse, such

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12 Manor Gardens Welfare Trust (FGM0001). Obstetric fistula is an abnormal opening between a woman's genital tract and her urinary tract or rectum. (World Health Organization, Obstetric fistula, 19 February 2018)

13 Manor Gardens Welfare Trust (FGM0001)

14 Manor Gardens Welfare Trust (FGM0001)

15 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002) and Q17 [Professor Shehata]

16 Manor Gardens Welfare Trust (FGM0001)

as sexual assault referral centres and FGM clinics. The Strategy includes a ten-year ambition to raise awareness of specialist treatment and support services. The Strategy further stated that the NHS would raise awareness of FGM among healthcare professionals who are involved in women's health screening services, "so they know how to identify FGM, how to provide a sensitive service and where to refer women for expert services".[17]

8. All FGM survivors have different stories.[18] We heard from four FGM survivors, two in public, one in private and one through written evidence,[19] and all detailed the significant impact it had on their lives. Valerie Lolomari, FGM survivor and founder of Women of Grace UK, an organisation providing support to FGM survivors, told us:

> FGM is a life sentence. It has been over 40 years since I was mutilated, but I still suffer. It leaves a long-lasting impact on you mentally. I still do not feel as if I am a real woman. I still struggle with infections. I still have pains. FGM is a terrible thing: it just does not go away. It takes away your confidence. It takes away your liberty. Every single day, I feel as if I did something wrong to deserve that. It has left me with physical pain, psychological pain and emotional trauma, and it is going to be with me for the rest of my life.[20]

17 Department of Health and Social Care, Women's Health Strategy for England, gov.uk, 30 August 2022

18 Q12 [Aissa Edon]

19 Shamsa Sharawe (FGM0008)

20 Q12

Aissa Edon, FGM survivor, midwife and founder of the FGM Hope Clinic, described her experience:

> I had type 1 female genital mutilation at six years old. I am 43 years old […] and a few years ago I was still wetting myself. I was incontinent because of FGM. […] Having sex: when you started to be a young girl, you wanted to have a partner, which was impossible because pain and fear of sex were something completely covering me forever.
>
> I have now fought against all these consequences. I had reconstruction of the clitoris 20 years ago. I feel complete. I feel a female. I feel that I have back the power that they took from me, but I still suffer from a psychological fear of sex. I am still sometimes suffering with nightmares—not as much, obviously, but it is still there and will always be there. Even though I have a beautiful clitoris back, I will still feel like someone who had female genital mutilation.[21]

Availability of healthcare services

9. FGM survivors require a range of healthcare support. In England and Wales, survivors of FGM are treated primarily through specialist clinics or through Women's Health Hubs, which are managed by

21 Q12

Integrated Care Boards (ICBs).[22] In addition, there are 28 FGM Support Clinics across the UK, including one in Wales and one in Scotland.[23]

Variation in service

10. Despite the introduction of Women's Health Hubs and additional FGM clinics, witnesses said that the availability and quality of existing services for FGM survivors is uneven, varying significantly across the UK.[24] The location of clinics means that some women must travel long distances for treatment, for example, while there are around 15 in London, there are none in Northern Ireland.[25] In some cases, women who are not pregnant have to attend maternity settings for FGM services, which due to cultural sensitivities can pose a problem if they are unmarried.[26]

11. Certain treatments for FGM are not available in some locations. Deinfibulation for example, a surgical procedure to open up the vagina after Type 3 FGM, is not offered in some clinics under local anaesthetic meaning some women have no choice but to go on

22 Q20 [Janet Fyle]; following a commitment in 2023 for all ICBs to have a Women's Health Hub by 2025, currently 41 of 42 ICBs have one. (HC Deb, 18 June 2025, col 360)

23 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

24 Q28 [Juliet Albert] and Q30 [Professor Shehata and Janet Fyle]

25 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002) and NHS, National FGM Support Clinics, accessed 23 June 2025

26 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

long gynaecological waiting lists to undergo the procedure under a general anaesthetic. Alarmingly, we also heard that in some areas, pregnant women are being told to wait until labour to undergo the procedure,[27] something which is against NHS advice.[28] Professor Hassan Shehata, Senior and Global Health Vice President at the Royal College of Obstetricians and Gynaecologists, emphasised the need for early intervention:

> … if things are followed properly, we do the deinfibulation earlier on, and with that we try to avoid complications that may arise if somebody just arrives at the birthing stage. Because of the scar tissue, there can be complications immediately—mainly bleeding at the time of giving birth—as well as complications of nerve damage, and complications of infections, especially after delivery. There are lots of complications.[29]

Despite FGM survivors being more likely to have pregnancy complications and to suffer from trauma during pregnancy, most maternity hospitals do not have an FGM specialist. When hospitals do have specialist FGM services, they are often operated by a lone midwife.[30]

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27 Q28 [Juliet Albert] and Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

28 NHS, Female genital mutilation: overview, accessed 29 July 2025

29 Q28

30 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

12. Professor Shehata emphasised the challenges to diagnosing and treating young women and girls under the age of 18 with FGM, such as with determining who assesses them and how.[31] While University College London Hospitals NHS Foundation Trust has a paediatric clinic and there are some other clinics that now link up with satellite centres,[32] paediatric coverage remains "patchy".[33]

13. Contributors to our inquiry emphasised the importance of improving services for FGM survivors.[34] We were told that FGM services needed to be consistent and that teams be multidisciplinary to help manage the complex health issues that arise from FGM. Such multidisciplinary teams should include a service lead, trauma counsellor, and health advocates.[35] Juliet Albert, Specialist FGM Midwife at Imperial College Healthcare NHS Trust, explained that self-referral, no geographical boundaries and fast-track walk-in services are really important for FGM survivors, because of the barriers (discussed below) to them in accessing the specialist care they need.[36]

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31 Q29 [Professor Shehata]

32 Q29 [Juliet Albert] and NHS, National FGM Support Clinics, accessed 23 June 2025

33 Q29 [Juliet Albert]

34 Q16 [Valerie Lolomari], Q19 [Janet Fyle and Juliet Albert], Huda Mohamed MBE (FGM0003), The Vavengers (FGM0005), Shamsa Sharawe (FGM0008), and Educate not Mutilate (FGM0010)

35 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002) and The Royal College of Midwives (FGM0004)

36 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002) and Q19

MGWT reported that some women may travel back to countries without legislative protections against FGM for healthcare rather than attend UK medical settings. This is particularly concerning as there may be a risk of re-infibulation after treatment.[37]

14. The prevalence of FGM in England and Wales varies considerably by region.[38] Juliet Albert told us that it is necessary to be realistic about the provision of services in low-prevalence areas.[39] While specialist centres are required in high prevalence areas like London, Professor Shehata explained that in low-prevalence areas, "it would be reasonable to have something in the Women's Health Hubs, but with expertise".[40] Janet Fyle MBE, Professional Policy Adviser at the Royal College of Midwives, noted the importance of a referral pathway if certain services are not available at the Women's Health Hub.[41] Huda Mohammed, a FGM Specialist Midwife, observed that such pathways have not been setup systematically.[42]

Funding and prioritisation

15. Witnesses also described ongoing concerns around funding for FGM services. It is difficult to assess the trend of funding on FGM health services. In response to a parliamentary question tabled by the Chair of this

37 Manor Gardens Welfare Trust (FGM0001)
38 Equality Now, Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, July 2015
39 Q21
40 Q21
41 Q21
42 Huda Mohamed MBE (FGM0003)

Committee, the Department of Health and Social Care said that spending on FGM services varies locally and it does not collect data on it.[43] However, Educate Not Mutilate (ENM), a survivor-led organisation fighting against FGM, indicated that a reduction in funding has previously led to the closure or reduction of services. The Lotus Clinic at Whipps Cross Hospital, which ENM said set the blueprint for eight more clinics, has now also shut down.[44] Janet Fyle reported signs that "some clinics are facing gradual cut-backs which will impact the holistic nature of the service, removing counselling and/or advocacy support which were addressing barriers to access."[45] There are concerns that without a commitment to long-term investment, current specialist clinics could end up closed.[46]

16. Similar concerns were expressed to us about Women's Health Hubs. The introduction of Women's Health Hubs with appropriately trained accredited personnel could provide good accessibility to services for survivors of FGM yet they face challenges in funding and resources.[47] Professor Shehata explained:

> The concern I have with Women's Health Hubs is that it seems they are going to be the solution for a lot of things, and at the moment there does not seem to be any secure central funding. For example, I come from South West London ICB,

43 PQ63321 [on Female Genital Mutilation: Health Services], 18 July 2025
44 Educate not Mutilate (FGM0010)
45 The Royal College of Midwives (FGM0004)
46 Educate not Mutilate (FGM0010)
47 Q20 [Professor Shehata]

> and it has been asked to reduce its budget by 30%, so I am not really sure how we are going to fit in all these things.[48]

17. We also heard concerns that integrating FGM into women's health services more broadly had a negative impact. Janet Fyle told us that some ICBs have streamlined funding for pelvic health services and that FGM sits within this service. Survivors of FGM and women with physical birth trauma are therefore "vying for access and FGM survivors [are] not always getting the appropriate support and care".[49] Janet Fyle added:

> By apparently moving FGM into the wider women's health agenda, NHS England and DHSC specialist teams have reduced their input and disengaged with the FGM stakeholder community, however there has not been any apparent pick-up of the matter within the women's health policy area.[50]

18. **CONCLUSION**
Survivors of female genital mutilation (FGM) experience profound physical, emotional and psychosexual consequences and require specialised care and support to manage these impacts. Despite this, survivors may not be aware that the health complications they experience are a consequence of FGM, meaning awareness among survivors of the long-term health implications of FGM is vital.

48 Q20
49 The Royal College of Midwives (FGM0004)
50 The Royal College of Midwives (FGM0004)

19. CONCLUSION

Services for FGM survivors and access to them remains inconsistent across the UK. While some variation in access to services may be expected in line with local prevalence, there is a lack of effective referral pathways. This has created a postcode lottery that risks leaving women and girls without the essential support and care they need.

20. RECOMMENDATION

The NHS should use Women's Health Hubs, as well as other relevant points of contact such as sexual health services and sexual assault referral centres, to raise awareness among survivors of the potential consequences of FGM and the benefits of seeking medical advice.

21. RECOMMENDATION

The Government should ensure that all FGM survivors can access the essential support and care they need in a timely manner. While some variation in service provision may be necessary to reflect local prevalence rates, higher-prevalence areas should offer funded multidisciplinary services that allow quick access to specialist care. In lower-prevalence areas, there must be clear referral pathways in all relevant healthcare settings including General Practice, Women's Health Hubs and sexual health services to ensure women can access care without delay. The NHS must take steps to ensure that advice on when certain procedures, such as deinfibulation, can be accessed reflects the latest NHS guidance.

22. CONCLUSION

There is a notable lack of data on spending on FGM services but evidence to this Committee indicates that funding for FGM services may have reduced and remains precarious. There are also concerns that the integration of FGM services within the wider women's health agenda has led to a reduced focus.

23. RECOMMENDATION

Integrated Care Boards (ICBs) should ensure sufficient funding is available to meet local demand for services tailored to the needs of FGM survivors. Spending on FGM services should be published and data collected at a local and national level to help build up a comprehensive picture of demand for and funding of FGM services.

Access to counselling

24. Counselling is crucial for women who have undergone FGM, particularly psychosexual and trauma counselling.[51] An NHS England evaluation of FGM clinics for non-pregnant women in 2022 revealed that access to counsellors and psychotherapists was one of the most valuable forms of support for the service

51 Manor Gardens Welfare Trust (FGM0001), Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002), The Royal College of Midwives (FGM0004), The Vavengers (FGM0005) and Shamsa Sharawe (FGM0008)

user.[52] However, counselling services are not routinely available, and do not appear to be adequately funded or appropriate to support the needs of FGM survivors.

25. The Vavengers, a UK-based charity committed to ending FGM, told us that FGM clinics do not offer specialist mental health care to FGM survivors,[53] while other written evidence indicated that 10 of the 28 specialist FGM clinics (35%) offered no counselling support to FGM survivors.[54] The Manor Gardens Welfare Trust (MGWT) described how it had been contracted to provide specialist therapy in FGM clinics in London under the Dahlia Project but that funding for this work was withdrawn over time and replaced with "generic mental health support that fails to meet the needs of FGM survivors."[55] MGWT told us:

> The UK's healthcare system does not provide adequate, trauma-informed care for FGM survivors. The few specialist services that existed have been steadily dismantled, leaving survivors with nowhere to turn for psychotherapeutic support.[56]

And:

> In the last clinic where Dahlia continued to operate, the project withdrew because the dedicated therapy space was removed. The

52 The Royal College of Midwives (FGM0004)
53 The Vavengers (FGM0005)
54 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)
55 Manor Gardens Welfare Trust (FGM0001)
56 Manor Gardens Welfare Trust (FGM0001)

> therapist was asked to hold sessions in a medical examination room with stirrups—a setting that completely disregarded the trauma needs of survivors. This was not an environment where women could safely process their experiences.[57]

26. Submitters to the inquiry called for trauma-informed psychosexual therapy in FGM clinics, with some calling for it to be free and for at least one year per survivor.[58] Janet Fyle told us that FGM survivors should receive counselling from someone who is an expert in counselling women who have had FGM,[59] a point echoed by Juliet Albert:

> It is not good enough just having a counsellor: they have to have FGM training. You hear stories of women going to see a counsellor, and the counsellor ends up crying because they know nothing about FGM. We need to make sure these are expert counsellors who have had FGM training and that there are health advocates the women can identify with, who can translate as well.[60]

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57 Manor Gardens Welfare Trust (FGM0001)

58 Huda Mohamed MBE (FGM0003), The Vavengers (FGM0005) and Shamsa Sharawe (FGM0008)

59 Q19

60 Q20

27. **CONCLUSION**

FGM survivors often suffer psychosexual, emotional and mental health complications from undergoing FGM. However, many FGM survivors do not have access to appropriate counselling services, with many FGM services not offering any counselling to FGM survivors and others offering counselling which is not appropriate or tailored for their needs.

28. **RECOMMENDATION**

The Government should ensure that all FGM Support Clinics offer specialist counselling support to FGM survivors in appropriate settings, provided by counsellors who are trained in the specific challenges of FGM. There should be clear referral pathways to this counselling for women who access FGM services through Women's Health Hubs.

Training for healthcare professionals

29. FGM survivors can experience a lack of trust in healthcare professionals, fear of judgment, and structural discrimination.[61] MGWT told us that progress in professional awareness of the trauma and care needs of FGM survivors had regressed after covid-19 and survivors were reporting "retraumatising experiences when accessing NHS services", where medical professionals had reacted with horror or disgust to FGM. MGWT described how this has caused

61 Manor Gardens Welfare Trust (FGM0001)

some survivors to withdraw from healthcare services due to shame and humiliation, meaning they do not seek important reproductive, gynaecological, and maternity care.[62]

30. During our evidence session, we heard that training on FGM for midwives is not mandatory.[63] Witnesses also stated that the training package for FGM is over 10 years old,[64] but that it was "up for a review and an update" which was expected to happen.[65] Janet Fyle explained that the push for training over the last 10 years has "focused on awareness and legal consequences" which is:

> […] understandable but health care professionals need skills-based training to know how to deliver the right care for women with FGM, starting with how to best talk to their patients about FGM. There has been no effort nationally or regionally to support this need for at least five years.[66]

31. Janet Fyle explained that training needed to include bias training and cultural competence training,[67] with basic training made available to all hospital and healthcare staff to prevent situations such as staff shouting out "FGM clinic" in waiting areas.[68]

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62 Manor Gardens Welfare Trust (FGM0001)
63 Q23 [Juliet Albert and Janet Fyle]
64 Qq21–22 [Professor Shehata]
65 Q22 [Janet Fyle]
66 The Royal College of Midwives (FGM0004)
67 The Royal College of Midwives (FGM0004)
68 The Royal College of Midwives (FGM0004)

We heard that training needed to cover how healthcare professionals ask questions around FGM.[69] Terminology can be a key issue for treating FGM as different communities may have different ways to refer to FGM.[70] Some women also experience FGM very young, such as at 40 days of life, meaning that they will not remember undergoing FGM and therefore not even know they are FGM survivors.[71] Aissa Edon told us:

> As a midwife, it is very rare that I say female genital mutilation when I am talking to the women because they do not understand. They will understand cutting. Some are going to understand sunna or pharaonic cutting. I am always adapting my language to the person I have facing me. Sometimes I do not even use language; I use pictures for them to understand, because that is really important.[72]

32. FGM survivors often face other challenges, with some survivors being asylum seekers and needing further support such as with English classes and housing.[73] Many FGM survivors have often suffered other forms of abuse and violence and may be "fleeing from war, rape, domestic violence, early forced marriage, or juju witchcraft."[74]

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69 Q30 [Janet Fyle]
70 Q8 [Aissa Edon] and Q20 [Professor Shehata]
71 Q8 [Aissa Edon]
72 Q8
73 Q29 [Juliet Albert]
74 Q29 [Juliet Albert]

33. **CONCLUSION**

Evidence suggests some FGM survivors are experiencing shame or humiliation in healthcare settings, reducing the likelihood of them engaging further with healthcare services essential to their physical and mental wellbeing. Training for midwives and healthcare professionals is not mandatory and often does not include practical advice on how to ask questions and discuss FGM in a culturally sensitive manner, which makes it difficult for healthcare professionals to deliver services effectively.

34. **RECOMMENDATION**

FGM training should be made mandatory for midwives and other healthcare professionals working in services where they are likely to encounter FGM survivors. That training should include how to treat survivors with appropriate sensitivity. Staff working in FGM Specialist Clinics and Women's Health Hubs should be able to signpost survivors to non-health related local services where necessary such as those that can offer support relating to gender-based violence, insecure housing, and language barriers.

Language barriers

35. Language barriers can be a significant challenge for FGM survivors seeking care, which is a particular concern for migrant women and asylum seekers.[75] More than half of women attending specialist services

75 Manor Gardens Welfare Trust (FGM0001)

have English as a second language and one in eight have no or minimal English.[76] MGWT told us that women are not always aware that they can have an interpreter when attending healthcare services and do not know how to request one. MGWT stated that interpreters are not always available, or they speak the wrong dialect leading to miscommunication.[77] Professor Shehata reported a lack of standards for interpretation services, noting that NVQ level 3,[78] which is equivalent to an A-Level qualification, is deemed sufficient.[79] Some women have to rely on family members to translate, including children, which prevents open communication.[80]

36. CONCLUSION

FGM survivors are not consistently being made aware that they are entitled to interpretation services. However, interpretation services that are available can be unsuitable and interpreters can lack the necessary proficiency to advocate on behalf of survivors. This can lead to survivors relying on family members which can prevent open communication.

76 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

77 Manor Gardens Welfare Trust (FGM0001)

78 Q20

79 UK Government, What qualification levels mean: England, Wales and Northern Ireland, gov.uk, accessed 24 July 2025

80 Manor Gardens Welfare Trust (FGM0001)

37. **RECOMMENDATION**

FGM Specialist Clinics and Women's Health Hubs should ensure that women are informed of their right to have an interpreter. Those interpreters must be appropriately trained and sensitive to the cultural sensitivities around FGM.

3 Reconstructive surgery

38. Reconstructive surgery for FGM aims to reverse the procedure as far as possible, such as through reconstruction of the labia or clitoris. Juliet Albert, Specialist FGM Midwife at Imperial College Healthcare NHS Trust, reported that more than 90 women across the UK requested reconstruction surgery for FGM in 2023.[81] She explained:

> Women are seeking reconstruction surgery for three main reasons. The first is long-term genital pain. Secondly, there is sexual dysfunction or lack of sexual pleasure. Thirdly, there is what we call body dysmorphia, so not feeling whole or complete. The evidence shows that for a lot of women it is extremely beneficial.[82]

Aissa Edon, FGM survivor, midwife and founder of the FGM Hope Clinic, told us that women want the next steps following FGM and are "desperate" for reconstruction of the clitoris.[83]

81 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

82 Q25

83 Q16

39. However, reconstructive surgery for FGM is not available in the UK,[84] despite being available in countries in Europe, Africa, and in parts of the USA.[85] This means that survivors of FGM living in the UK must travel abroad to access this surgery.[86] Surgical tourism is expensive and can be costly for the NHS should people undergoing it come back with complications.[87]

40. FGM midwives and survivors are calling for reconstructive surgery following FGM to be available in the UK. We heard that although not all women with FGM will want or benefit from reconstruction surgery, women should be able to make an informed choice to access this if they wish.[88] Shamsa Sharawe, an FGM survivor, explained her experience, telling us:

> I was forced to fundraise £30,000 to access reconstructive surgery in Germany because the NHS failed to provide me with the healthcare I needed. When I sought help, I was told, "no doctor in this country will touch you," as if I was beyond repair. Meanwhile, labiaplasty—despite falling under the legal definition of FGM—is widely practiced in the UK.
>
> The financial and emotional burden of seeking treatment abroad was overwhelming.

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84 The Vavengers (FGM0005) and Qq25–27

85 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

86 Q13 [Aissa Edon] and Q25 [Juliet Albert]

87 Q25 [Juliet Albert]

88 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

> At the time of my surgery, I had only raised £26,000, just enough to cover the procedure, leaving me in debt. My daughter had to take weeks off school, disrupting her education. If I had suffered complications, I would have had to fly back to Germany, because the UK healthcare system refuses to acknowledge our needs. No survivor should have to go through this. Reconstructive surgery should be available on the NHS.[89]

Huda Mohamed MBE, an FGM Specialist Midwife, told us:

> The NHS's refusal to offer this procedure forces survivors to either endure a lifetime of suffering or raise tens of thousands of pounds to seek treatment abroad. No survivor should have to crowdfund their right to a pain-free life.[90]

41. The UK has the expertise to undertake reconstructive surgery, for example, the UK offers vulval reconstruction surgery for cancer patients and gender reassignment surgery.[91] Juliet Albert and her colleagues published a scoping review in 2024 on the benefits of reconstructive surgery and found that in 94% of cases there was some improvement, and the complication rate was just 3%. She observed that it "is not life-threatening surgery and this is not expensive surgery. It can be done as day-case surgery."[92]

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89 Shamsa Sharawe (FGM0008)
90 Huda Mohamed MBE (FGM0003)
91 Q25 [Juliet Albert]
92 Q25

42. The Government and Royal College of Obstetricians and Gynaecologists do not currently support NHS centres for reconstructive surgery due to a lack of evidence of its benefits but would welcome research.[93] Juliet Albert informed us that she led on a joint application to the National Institute for Health and Care Research (NIHR) for funding for a clinical trial on reconstructive surgery to build up the evidence base.[94] The NIHR rejected this application but has advised on adjusting the application to receive a positive outcome in the future.

43. **CONCLUSION**

Many women who have undergone FGM seek reconstructive surgery to reverse FGM as far as possible. It is clear that the NHS is equipped to perform this surgery as it delivers it for other medical conditions. We acknowledge that the current medical evidence supporting reconstructive surgery for FGM survivors may be limited. However, it is unreasonable for the Government to cite a lack of evidence as a barrier to reconstructive surgery while simultaneously failing to invest in the research necessary to generate such evidence.

93 Qq25–26 and Correspondence from Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care, re Female genital mutilation, dated 20 March 2025

94 Q25

44. RECOMMENDATION

The Government should facilitate and fund research into the effectiveness of reconstructive surgery for FGM survivors as a matter of priority. If evidence indicates that the surgery is effective, then the NHS should provide it.

4 Estimating the prevalence of FGM

45. There is a lack of data on the prevalence of FGM within the UK. Equality Now, a women's rights organisation, conducted the most recent study on the prevalence of FGM in England and Wales in 2015. It used studies measuring FGM prevalence in countries of origin and applied these rates to the number of people from the diaspora communities according to the 2011 census.[95] The study suggested there were 137,000 women and girls living with FGM in England and Wales. It also found that prevalence varied considerably by region, with London having the highest prevalence rate at 21 per 1,000 population, with prevalence even higher in some London boroughs. The next highest prevalence rates were in Manchester, Slough, Bristol, Leicester and Birmingham, with people born in countries where FGM is practised tending to live in urban areas in England and Wales. However, it found that there are likely to be FGM survivors in every local authority area.[96]

95 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025

96 Equality Now, Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, July 2015

46. The Home Office told us that the study "provided some useful information" but that there were "limitations", and the statistics are now out of date.[97] The Home Office said:

> To ensure we have a more up-to-date prevalence estimate of FGM in England and Wales, the Home Office commissioned a feasibility study in 2023 (which concluded in 2024) to examine whether it is possible to produce robust prevalence estimates for FGM, as well as forced marriage. The study proposed an approach, and we are considering next steps.[98]

47. Other organisations and experts also emphasised that the 2015 study was outdated and more up-to-date data is required.[99] The Five Foundation, a charity focused on ending FGM, criticised the approach of the Home Office, telling us:

> The Five Foundation has reached out to the Home Office on many occasions to discuss cooperation in relation to doing this. Instead, the department has funded a completely unnecessary study on how to carry out the study itself.[100]

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97 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025

98 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025

99 Huda Mohamed MBE (FGM0003), The Royal College of Midwives (FGM0004), and The Five Foundation (FGM0009)

100 The Five Foundation (FGM0009)

It is not clear why, if the feasibility study was completed in 2024, that the Home Office has not yet acted to carry out the prevalence study.

48. NHS Digital collects data on FGM. From April 2015 to March 2024, 37,615 individual women and girls had attendances where FGM was identified.[101] However, we are aware that this may be an incomplete picture of FGM prevalence. Huda Mohamed, an FGM Specialist Midwife, explained that there is a "scarcity" of data due to poor pathways and systems that do not ask everyone about FGM, meaning "many women fall through the gaps and are not recorded".[102] It also relies on affected women attending certain women's health services, which they may also avoid.[103]

49. **CONCLUSION**

To tackle FGM and be able to provide services based on need, the Government, local authorities and healthcare providers need to understand the prevalence of FGM within the UK. The most recent study on FGM prevalence in England and Wales was published in 2015 and was based on 2011 census data. It is a significant oversight that the Government lacks up-to-date information on the current prevalence of FGM nationwide and per locality. This gap undermines the Government's, local authorities and healthcare providers' ability to provide services to women in need.

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101 NHS England Digital, Female Genital Mutilation, Annual Report - April 2023 to March 2024, 19 September 2024

102 Huda Mohamed MBE (FGM0003)

103 Manor Gardens Welfare Trust (FGM0001)

50. RECOMMENDATION

The Government should immediately commission research into the number of women with FGM in the UK, including on prevalence within local areas. It must make this data accessible so that local authorities and health providers can provide their services accordingly. The NHS should ensure that data on the country of birth and the country where FGM was undertaken for individuals is consistently recorded and published. This will help build a picture of how many women and girls born in the UK have undergone FGM and how many have undergone FGM in the UK.

5 Preventing FGM

Female genital mutilation happening in the UK

51. FGM is illegal in the UK, and evidence suggests that most FGM cases in the UK concern survivors who migrated to the UK after undergoing FGM in their country of origin or elsewhere abroad.[104] However, despite there having been only three convictions for FGM offences to date in England and Wales, police recorded 111 FGM offences in England and Wales in the latest year (ending March 2024) and witnesses told us that they believed some women and girls living in the UK are being taken out of the UK to undergo FGM or are having it done within the UK.[105] Aissa Edon, FGM survivor, midwife and founder of the FGM Hope Clinic, told us:

> It is absolutely happening every day. Again, it is about evidence. Unfortunately, we do not have evidence—real evidence—but we know because we have our networking. […] Either we are bringing FGM practitioners to the UK to have it done in the UK, or the little girls are brought out

104 NHS England, Female Genital Mutilation (FGM) - Report - April 2023 to March 2024, 19 September 2024

105 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025

> of the UK. They are UK citizens or UK-born, and they are taken to their country of origin where it is practised, and that is where they have the FGM done. But we absolutely have FGM practice in the UK.[106]

This belief was reiterated by Shamsa Sharawe, an FGM survivor, to the Committee.[107] Gillian Squires, a retired Detective Constable in the West Midlands and now Director of Honour Me Ltd, also affirmed this view, stating:

> We have intelligence to suggest that FGM is happening here in specific cities in the UK, although unfortunately we do not have names.[108]

Educate Not Mutilate, an organisation working to combat FGM, reported that 60,000 girls are thought to be at risk of FGM in the UK.[109]

52. NHS data collected from April 2023 to March 2024 indicates that of the 6,655 individual women and girls in England who were recorded to have undergone FGM, around 225 were born in the UK and 135 underwent FGM in the UK.[110] These figures may be an

106 Q2
107 Shamsa Sharawe (FGM0008)
108 Q35
109 Educate not Mutilate (FGM0010) and Office for Health Improvement and Disparities, Female genital mutilation (FGM): migrant health guide, gov.uk, 31 August 2014, updated 13 September 2021
110 NHS England, Female Genital Mutilation (FGM) - Report - April 2023 to March 2024, 19 September 2024; Figures calculated using Table 2.3.2 and Table 2.4.2. Figures are an approximate estimate as yearly figures are rounded to the nearest 5, with numbers between 1 and 7 rounded to 5.

underrepresentation because the country where FGM took place and the country of birth of the individual is not recorded, stated or known for around 50% and 35% of cases recorded in 2023/24 respectively.

UK Government and local government work

53. The Home Office leads on preventing and tackling FGM in England and Wales. Annual spending allocated by the Home Office is set out in table 1 below.[111] The funding has been used to support a range of activity, including victim support helplines, training courses on FGM for frontline personnel, academic research and communication campaigns.[112]

Table 1: Home Office spending allocated to preventing and tackling FGM

Financial Year	Home Office spending allocated to preventing and tackling FGM
2015/2016	£2,718,000
2016/2017	£1,664,000
2017/2018	£2,358,768
2018/2019	£2,403,768
2019/2020	£1,023,768
2020/2021	£334,234
2021/2022	£211,020
2022/2023	£259,568
2023/2024	£1,170,209
2024/2025	£1,108,599

Source: PQ63320 [on Female Genital Mutilation], 7 July 2025

111 PQ63320 [on Female Genital Mutilation], 7 July 2025

112 PQ63320 [on Female Genital Mutilation], 7 July 2025

54. We heard some evidence on the impact of the reduction in funding on preventing and tackling FGM. For example, Gillian Squires told us that the UK had pushed hard on ending FGM in the 2010s but that intensity on the campaign had since dwindled. She stated:

> Obviously, the Government cannot keep up that level of intensity on one subject, but it has diminished significantly to the point where it is now almost forgotten about.
>
> I was upset to find that the campaign I was involved with when I was on secondment to the FGM unit in 2018 and 2019, which involved survivors appearing on posters and campaigning for change, had been decommissioned by the Home Secretary, leaving us with no national campaign that professionals could use to advertise services.[113]

This echoes other evidence, which suggested that survivors are often not aware of available specialist services.[114] Similarly, the Government signposts people to an NSPCC FGM helpline online and we heard that when the helpline was established in 2013, the Government initially provided some funding. However, this was short lived, and the signposted helpline is now funded out of the main NSPCC Helpline fund.[115]

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113 Q36

114 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002) and The Royal College of Midwives (FGM0004)

115 Q43 [Grainne Boyle]

55. Gillian Squires told us that there should be local funding and local delivery plans to combat FGM.[116] Although arrangements of local authorities vary, county councils in England and Wales usually provide social care, which includes safeguarding and FGM prevention.[117] Different councils have run various initiatives to combat FGM. For example, Coventry City Council was the first to support a full council motion to condemn FGM and a two-year programme was commissioned in 2016 to embed the REPLACE approach,[118] which focuses on "community-led approaches to foster sustainable behavioural change".[119] Equally, in 2017, Leeds City Council set up a new FGM strategic multi-agency group partnership to develop a co-ordinated approach to tackling FGM across Leeds.[120]

56. The Government has produced an FGM resource pack "in response to requests for clearer direction from central government about the safeguarding responsibilities of local authorities." This includes guidance to local authorities on working with voluntary and community sector organisations, FGM statutory multiagency guidance, safeguarding and the work of local authorities.[121] However, while local

116 Q39
117 The Vavengers (FGM0005)
118 Home Office, Female genital mutilation: resource pack, gov.uk, updated 6 February 2023 and The Vavengers (FGM0005)
119 ReplaceFGM2, accessed 23 July 2025
120 Home Office, Female genital mutilation: resource pack, gov.uk, updated 6 February 2023 and The Vavengers (FGM0005)
121 Home Office, Female genital mutilation: resource pack, gov.uk, updated 6 February 2023

delivery plans and funding are important to combat FGM, prevalence of FGM can vary significantly by local authority.[122] This means some local authorities may need to allocate more resources to preventing and tackling FGM.

Further support for FGM survivors

57. Other organisations providing essential support to FGM survivors and working to prevent FGM in the UK are often small grassroots organisations that are survivor led.[123] These organisations can offer support with health and wellbeing, including psychotherapeutic support, give survivors a voice, and educate about and raise awareness of FGM.[124] Valerie Lolomari, FGM survivor and founder of Women of Grace UK, emphasised the need for more funding for these 'by and for' organisations, which are often in competition for limited financial support.[125] The Vavengers, an FGM survivor-led organisation, pointed out that the Dahlia Project, a psychotherapeutic service for FGM survivors, is underfunded and does not have the capacity to respond to all survivors. In their view such support should be funded under the NHS.[126]

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122 Equality Now, Prevalence of Female Genital Mutilation in England and Wales: National and local estimates, July 2015

123 Q39 [Gillian Squires] and Q29 [Juliet Albert]

124 Q13 [Valerie Lolomari], The Royal College of Midwives (FGM0004), and The Vavengers (FGM0005)

125 Q16 and The Royal College of Midwives (FGM0004)

126 The Vavengers (FGM0005)

In addition, small grassroots organisations may not have charity status and/or people with the expertise to write a successful funding application, meaning they do not get funding.[127]

58. CONCLUSION

It is a matter of serious concern that evidence given to us and available data indicate both that FGM is taking place in the UK and that UK citizens or residents are being taken abroad to undergo FGM. The Government must allocate sufficient resources to tackle this form of gender-based violence and, in most circumstances, violent child abuse. While the UK Government has taken steps to prevent and address FGM, variations in funding on tackling FGM over recent years risk the consistency and long-term impact of this work.

59. CONCLUSION

Grassroots organisations, often run by FGM survivors from the affected communities, perform vital work in supporting FGM survivors and combatting FGM. However, they receive limited funding, must compete against one another, and can lack the capacity or expertise necessary to secure funding in complex application processes.

127 Q39 [Gillian Squires]

60. **RECOMMENDATION**
Given the ongoing risk of FGM in the UK, we recommend the Home Office restore funding to previous levels—we recommend an annual spend of at least £2 million—and commit to sustained funding for initiatives aimed at preventing and tackling FGM. Targeted support should be provided to local authorities with higher levels of FGM prevalence to ensure they can respond effectively to local needs. Funding should also continue to be allocated to public awareness campaigns and to services which play a key role in prevention and support, including by reinstating funding to the NSPCC FGM helpline.

61. **RECOMMENDATION**
The Government and local authorities should actively engage with and provide sustainable funding to small and grassroots organisations working on FGM to ensure they are able to carry out their work. The Government should ensure that applications for funding are accessible and inclusive for organisations that lack the resources to navigate complex tendering processes.

Education in schools

62. Evidence we received emphasised the need for education and awareness raising within communities as a tool for FGM prevention. Huda Mohamed, a Specialist Lead FGM Midwife, argued that there should be mandatory FGM education in schools, colleges,

and universities.[128] Educate Not Mutilate (ENM) suggested mandatory education in schools would equip at-risk girls with practical means of accessing legal protection. ENM added that educational resources need to be adapted to reflect the needs of practicing communities and to address their concerns sensitively.[129]

63. The Government's guidance on Relationships Education, Relationships and Sex Education (RSE) and Health Education includes FGM in its 'Secondary relationships and sex education curriculum content', in both its current guidance (valid until August 2026) and future guidance (valid from September 2026). Both sets of guidance contain advice on the physical and emotional damage caused by FGM, where to find support, and the law on FGM.[130]

128 Huda Mohamed MBE (FGM0003)
129 Educate not Mutilate (FGM0010)
130 Department for Education, Relationships Education, Relationships and Sex Education and Health Education guidance (for introduction 1 September 2026), gov.uk, July 2025 and Department for Education, Relationships Education, Relationships and Sex Education and Health Education guidance (for teaching until 31 August 2026), gov.uk, 2019

64. **CONCLUSION**

Education on FGM in schools is an essential means of preventing FGM. It can equip girls to advocate on behalf of themselves and to challenge prevailing orthodoxies on behalf of others. We welcome the current and future guidance on Relationships, Sex and Health Education which includes content on the physical and emotional damage caused by FGM, where to find support, and the law, to be taught by the end of secondary education.

Engagement with communities

65. Engagement with communities is a vital element of preventing FGM. Drivers of FGM can differ across communities but they often include beliefs related to controlling women's sexuality, sexual purity, marriage eligibility, increasing men's sexual pleasure, misconceptions about hygiene and religious teachings, and superstitions.[131] We heard that many people in the communities that promote FGM do not understand its health impacts.[132] Aissa Edon, FGM survivor, midwife and founder of the FGM Hope Clinic, observed how combatting FGM needs to include explaining its impacts; in her view, "education is the cornerstone of this campaign."[133] Educating the broader family and community can reduce pressure on mothers to have their daughters go through FGM.[134] However,

131 Q4 and UNFPA, Female genital mutilation (FGM) frequently asked questions, February 2025

132 Q7 [Valerie Lolomari] and Q11 [Aissa Edon]

133 Q11

134 Q15

Aissa Edon emphasised that such education cannot be "one talk" and that it would have to be consistent, persistent and non-judgemental.[135]

66. The individuals who promote FGM varies between communities.[136] Valerie Lolomari reported that it is particularly the elderly women in the family who encourage the practice in her community because they have also undergone FGM and they "just follow the culture and tradition" without necessarily being aware of the dangers and consequences of FGM.[137] Men's involvement in FGM also seems to vary by community. However, we heard that where men are not directly involved in FGM, they do not act against it, and that it is commonly asserted that FGM is being done "for the men", meaning men also have a role to play in prevention in these communities.[138] Similarly, in some communities, religious leaders have a role in preventing FGM, given their influence[139] and the role of religious beliefs in driving FGM.[140]

135 Q14
136 Q14 [Aissa Edon]
137 Q7
138 Q7 [Aissa Edon]
139 Q14 [Valerie Lolomari]
140 Q4 [Aissa Edon]

67. **CONCLUSION**

Education among communities can be an effective tool in challenging the beliefs that fuel FGM and in raising awareness of the serious health impacts of FGM. The effectiveness of these campaigns is likely to be increased when influential people within the community, such as religious leaders, are included in education and prevention efforts.

68. **RECOMMENDATION**

The Government and local authorities should fund community-led education programmes to challenge the cultural and social beliefs that drive FGM. These programmes must be tailored to reflect the specific drivers of FGM within different communities. Education must include the health consequences of FGM and be targeted at those who drive FGM within communities.

6 Preventing FGM: Police work

Convictions for FGM offences

69. Despite the number of women who have stated they underwent FGM in the UK or were born in the UK before undergoing FGM, there have only been three convictions for FGM offences to date in England and Wales, including assisting FGM and conspiracy to commit FGM.[141] We heard that the low number of prosecutions is for a number of reasons, including a lack of referrals to police or other services, a lack of doctors who are specialised in being expert witnesses in court for FGM, and issues with equipment used to collect evidence of FGM.[142] Another key challenge is that children do not want to give evidence against their parents or grandmother, and that it is not necessarily in the best interests of a child who is traumatised to have to testify against their family

141 The Crown Prosecution Service, Jail for legal first female genital mutilation conspiracy, 3 October 2024
FGM is illegal in England, Wales and Northern Ireland under the Female Genital Mutilation 2003 Act, which was amended under the Serious Crime Act 2015. It is illegal in Scotland under the Prohibition of Female Genital Mutilation Act (Scotland) 2005.

142 Q34 [Angela Craggs] and Q42 [Gillian Squires]

members.[143] Gillian Squires, a retired Detective Constable in the West Midlands and now Director of Honour Me Ltd, acknowledged:

> There is a lot of controversy around that, but it has to be that whatever is in the child's best interest comes first.[144]

70. We heard mixed evidence on the extent to which there should be an emphasis on prosecution over prevention. Aissa Edon, FGM survivor, midwife and founder of the FGM Hope Clinic, stated that when the UK started to prioritise the law, FGM affected communities viewed this as an attack rather than an effort to help and support FGM prevention and education, and that most survivors in the UK "are a little sensitive about the campaign against FGM".[145] She stated that while FGM is child abuse, the culture around it is "embedded".[146]

71. Mandatory reporting requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s.[147] Juliet Albert, Specialist FGM Midwife at the Imperial College Healthcare NHS Trust, argued that without FGM specialist training there can be an overemphasis on safeguarding when people access health services

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143 Q42 [Gillian Squires]

144 Q42

145 Q6

146 Q6

147 Home Office and Department for Education, Mandatory reporting of female genital mutilation: procedural information, gov.uk, 20 October 2025, updated 22 January 2020

in the UK and that the mandatory reporting duty needs to be evaluated to understand what impact it has on girls under 18 accessing specialist support services due to the fear of their parents being reported.[148]

72. However, Shamsa Sharawe, an FGM survivor, argued:

> And although my FGM is considered historical, there are survivors born or raised in the UK who, if given the right support by the NHS, police, and government, would have pursued justice against the family members responsible for their FGM. But systemic racism continues to treat FGM as a "cultural issue" rather than the sexual violence that it is. FGM is not a cultural practice—it is a form of sexual abuse and violence.[149]

An FGM specialist midwife, Huda Mohamed, also stated:

> […] if survivors had received the right support, many would have pursued legal action against family members who subjected them to FGM. However, the lack of safeguarding, police intervention, and survivor-centred policies means justice is rarely served.[150]

The Vavengers recommended that in order to frame FGM as a form of gender-based violence and to not associate it with any particular community, the

148 Juliet Albert (Specialist FGM Midwife at Imperial College Healthcare NHS Trust) (FGM0002)

149 Shamsa Sharawe (FGM0008)

150 Huda Mohamed MBE (FGM0003)

Government should remove all "cultural practice" or "religious" wording in FGM materials used by government officials.[151]

73. **CONCLUSION**

While some FGM survivors and campaigners believe more needs to be done to secure convictions against perpetrators of FGM, others believe a strong focus on criminalisation can hinder efforts to engage with communities to prevent FGM and support FGM survivors. It is evident that to tackle FGM, the Government, local authorities and police must strike a balance between prevention and prosecution. However, the message needs to be clear that cultural sensitivities are irrelevant when it comes to violent, gender-based abuse, that more often than not is perpetrated against a child, and that survivors will be supported in seeking justice.

74. **RECOMMENDATION**

The Government should continue to adopt an approach that looks at prevention and prosecution by funding and engaging with prevention efforts in local communities. Alongside this work, criminal justice agencies should review police intervention and CPS prosecution strategies with a view to increasing the prosecution rate for FGM. We acknowledge the challenges this involves, not least the willingness of survivors to testify against family members, but an effective criminal justice deterrent is a vital part of the process in tackling FGM and it is currently missing.

151 The Vavengers (FGM0005)

Safeguarding referrals

75. One key barrier to prevention we heard was a lack of reporting of FGM. Angela Craggs, Deputy National Lead for Harmful Practice at the National Police Chief's Council, explained:

> In terms of numbers of cases reported to police, it is very low. They are not coming from victims, survivors or witnesses but from professionals in health, education and social services, so we know we do not get a full picture of exactly what is happening. We know it is hidden. We are looking for opportunities around prevention: how do we maximise proactive opportunities to deal with those who are inflicting harm on young women? The information coming through is almost zero, so it is very difficult for us to think about what response should be in place across policing.[152]

76. Evidence suggested that there are a number of barriers to safeguarding referrals. Grainne Boyle, Helpline Practice Manager at the NSPCC, told the Committee that only 17 of 553 advice contacts since 2013 resulted in a referral which is a "disproportionately low statistic."[153] She explained that a key reason for this is because callers often lack information, so it is difficult to reach the evidential criteria for the NSPCC staff to refer.[154] Discussing

152 Q34
153 Q35
154 Q35 and Q43

professionals who contact the helpline, which is mostly schools, teachers and designated safeguarding leads, Grainne Boyle noted:

> Very often what we see is that they lack the confidence to even have very preliminary conversations with the family. We will say things like, "Have you spoken to the family to understand why the child has been absent from school?", and they will say, "No, no, we do not feel confident enough to do that."[155]

While there are a number of online materials available to teachers on FGM, Gillian Squires stated that professionals are not trained and do not feel confident enough to ask questions, reducing the number of referrals.[156] Gillian Squires pointed out that the signs people often look for are "very circumstantial" and

> That, along with cultural sensitivities and not wanting to be seen as being racist and jumping to conclusions, makes it really tricky for professionals.[157]

77. Equally, we heard that FGM is often wrongly assumed to only occur among African communities when FGM does not just affect only African women and those with dark, black or brown skin tones.[158] Naimah Hassan, Co-Founder and CEO of African Women Rights Advocates, stated that framing FGM primarily as an

155 Q43
156 Q42
157 Q34
158 Q3

"African issue" risks reinforcing harmful stereotypes.[159] However, FGM is a global issue and within the UK occurs among migrant communities from regions including Asia, Africa, and the Middle East, and to people of mixed heritage.[160] Naimah Hassan suggested that adopting a more inclusive approach that accurately reflects the global scope of the problem "would help build cross-community solidarity in addressing FGM".[161]

78. **CONCLUSION**

Evidence suggests that safeguarding referrals are low. Professionals often lack the confidence to ask questions and get the necessary information from the families of the women and girls affected. Some professionals may also be reluctant to ask questions due to fears of appearing to be culturally insensitive, and there is a lack of training around asking such questions.

79. **RECOMMENDATION**

The Government should ensure that professionals, such as teachers and healthcare professionals, are adequately trained to feel confident to ask questions around female genital mutilation in order to increase the number of successful safeguarding referrals for FGM. This training should include how to broach sensitive subjects, and make clear that FGM is practised across a wide range of communities.

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159 African Women Rights Advocates (FGM0006)

160 UNICEF DATA, Female Genital Mutilation (FGM) Statistics, 1 June 2025 and Q3 [Aissa Edon]

161 African Women Rights Advocates (FGM0006)

Border monitoring

80. A key concern is the taking of girls, sometimes less than three years old, from the UK under the premise of going to a special gathering, a ceremony, or a family affair in their parents' country of origin, to undergo FGM.[162] Dual nationals may use a British passport to travel to a transit country, then switch to their other passport to travel elsewhere to seek out FGM, particularly to avoid detection at British border control that they are travelling to a country which has a high prevalence of FGM.[163]

81. The Home Office told us that it has measures in place in recognition of the fact that "FGM is a crime which crosses borders".[164] The Forced Marriage Unit, which is a joint Home Office-FCDO unit, assists British nationals, including dual nationals, through FGM centres, providing consular assistance to victims and potential victims of FGM.[165] The Home Office told us about Operation Limelight, which is:

> a joint Border Force and police operation which takes place at airports, seaports, and international rail stations around school holiday periods. Officers target inbound and outbound

162 Q35 [Grainne Boyle] and Educate not Mutilate (FGM0010)
163 This concern was raised to the Committee during a private meeting.
164 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025
165 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025

traffic to and from countries with a high prevalence of FGM, to raise awareness about the crime.[166]

82. Valerie Lolomari, FGM survivor and founder of Women of Grace UK, which works to support FGM survivors and prevent FGM, told us that her work going to the airport to talk to clients going to and from the prevalent areas was "very effective".[167] However, she emphasised that there needs to be tougher monitoring at UK borders.[168] Educate Not Mutilate (ENM) also identified gaps within work at the border, stating that "border officials lack training, there is insufficient follow-up on suspected cases, and poor communication between agencies hampers enforcement."[169] ENM described their involvement in UK border safeguarding initiatives and how they successfully identified a girl whose guardians intended to take her abroad for FGM, which "underscores the urgent need for stronger enforcement and proactive intervention."[170] They advocated for Operation Limelight to be "a permanent, year-round safeguarding operation at all major UK airports and ports."[171]

166 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025
167 Q16
168 Q16
169 Educate not Mutilate (FGM0010)
170 Educate not Mutilate (FGM0010)
171 Educate not Mutilate (FGM0010)

83. CONCLUSION

Border monitoring is an effective mechanism for preventing FGM being carried out on UK citizens and residents taken abroad. However, evidence suggests that monitoring could be made better through improved training of border officials, better follow-up of suspected cases, and enhanced communication between different agencies.

84. RECOMMENDATION

The Home Office should ensure that border officials have sufficient training on FGM to ensure they can identify potential cases and intervene when necessary. There should also be close engagement between departments, such as the Foreign, Commonwealth and Development Office, Home Office, and the Department for Education, including social services, to ensure that suspected cases are monitored effectively.

Protection orders

85. FGM Protections Orders (FGMPOs) are a legal means to protect and safeguard victims and potential victims of FGM. These are granted by a court and contain conditions to protect a victim or potential victim from FGM, with the conditions unique to each case.[172] Conditions could include, for example, asking for the parents or girl to be worked with to educate them about FGM, a passport being surrendered to prevent the girl or woman at risk from being taken abroad for

172 UK Government, Female Genital Mutilation (FGM) Protection Orders, gov.uk, accessed 1 August 2025

FGM, or a girl having supervised or restricted contact with people who have been identified as a risk.[173] There is no court fee for applying for an FGMPO nor for any additional court procedures associated with the case.[174] Angela Craggs told us that protection orders are effective and a good way for police and children's social care to work collaboratively to come up with "the most holistic response".[175] We also heard that they are "really useful" because the threshold for obtaining one is quite low, unlike other protection orders,[176] and the police may also obtain one even if children's social care do not find there to be a risk of FGM.[177] Gillian Squires stated that FGMPOs are also an effective way for the UK authorities to get children back who have already been taken abroad.[178]

86. Nevertheless, the Ministry of Justice states that the number of applications and orders made for FGMPOs is "very small". At the last available update, the Ministry of Justice stated there had been 670 applications and 930 orders made up to end of March

173 National FGM Centre, FGMPO Leaflet, 2019 and UK Government, Female Genital Mutilation (FGM) Protection Orders, gov.uk, accessed 1 August 2025

174 UK Government, Female Genital Mutilation (FGM) Protection Orders, gov.uk, accessed 1 August 2025

175 Q45

176 Q46 [Gillian Squires]

177 Q45 [Angela Craggs]

178 Q46 [Gillian Squires]

2025 since their introduction in July 2015, with 21 orders and 21 applications made in the last quarter for which data is available.[179]

87. The number of FGMPOs is low compared to the number of girls who are estimated to be at risk of FGM in the UK. However, the Ministry of Justice has stated that FGM data is incomplete as it does not include all applications/orders made; the MoJ has pledged to modify the data tables in the next quarter.[180] We heard that some professionals in social services are not necessarily aware of FGMPOs or the criteria for them.[181] Angela Craggs told us that while they would like to have more protection orders, professionals can manage safeguarding risks in various other ways.[182]

88. **CONCLUSION**

FGM Protection Orders (FGMPOs) can be an effective way of supporting FGM survivors and preventing FGM. Although the data on FGM protection orders is incomplete, the number of FGMPOs appears low, especially when compared to estimations of the number of girls at risk of FGM in the UK.

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179 Ministry of Justice, Family Court Statistics Quarterly: January to March 2025, gov.uk, 26 June 2025. There remain data quality issues with the FGM statistics as outlined in the Quarterly Update, which means this does not include all FGM applications/orders made.

180 Ministry of Justice, Family Court Statistics Quarterly: January to March 2025, gov.uk, 26 June 2025

181 Q47 [Gillian Squires]

182 Q47

89. **RECOMMENDATION**

The Ministry of Justice should encourage the use of FGMPOs by working with the Department for Education to increase awareness among children's social services of FGMPOs and the criteria needed to obtain one. We welcome the MoJ's plans to ensure that its data on FGM Protection Orders is up to date.

7 Preventing FGM globally

90. While the Committee has primarily focused on FGM within a UK context, it is clear that many FGM survivors in the UK underwent FGM in their country of birth or another country before moving to the UK. In addition, UK citizens and residents continue to be at risk of being taken to countries to undergo FGM in practising communities. The UK is a signatory to the United Nations Sustainable Development Goals, which lists elimination of FGM as part of Goal 5: to achieve gender equality and empower all women and girls by 2030. Janet Fyle MBE, Professional Policy Adviser at the Royal College of Midwives, called on the FCDO to improve its funding globally to reduce FGM. She explained, "It is an imported problem and we have to stop it at source. Finally, we signed up to SDG 5, and 2030 is just around the corner."[183]

91. The UK has funded work on ending FGM internationally as part of the UK aid budget. The UK has funded the Africa-led Movement to end FGM since 2013 within two phases, the first running from 2013–2018 and the second from 2019–2027.[184] The current phase will

183 Q30

184 Foreign, Commonwealth & Development Office, Development Tracker, Supporting the Africa-led Movement to End Female Genital Mutilation (FGM): Phase II, gov.uk, accessed 26 June

receive up to £35 million in funding.[185] The Government told us that it focused on supporting survivor and community-led approaches to end FGM, including by improving laws and policies and improving the evidence base on what is effective. The FCDO told us:

> In Kenya, Senegal, Somalia and Ethiopia we are supporting activists and grassroots organisations to lead change in communities. This contributed to a new Somaliland National Anti-FGM Policy, approved in September 2024. Last year, the UK's diplomatic efforts and funding for CSO advocacy in The Gambia contributed to overturning a Private Members' bill seeking to repeal the ban on FGM. We are also supporting work with national governments to get laws, policies and costed action plans in place banning FGM across 17 countries. In Sudan our work has contributed to a historic new law criminalising FGM in 2020, and 1,880 Sudanese communities publicly committing to FGM abandonment.[186]

It is clear that the FCDO has undertaken some vital work in this area, including recently in The Gambia where its advocacy helped prevent a ban on FGM

2025

185 Foreign, Commonwealth and Development Office, Development Tracker, Supporting the Africa-led Movement to End Female Genital Mutilation (FGM): Phase II, Annual review (D0005530) 204768 (Published - August 2024), gov.uk, accessed 26 June 2025

186 Correspondence from Rt Hon Baroness Chapman of Darlington, Minister of State for Development, FCDO, re Female genital mutilation, dated 5 March 2025

being overturned—concerns about these proposals were raised specifically with our predecessor Committee when it attended the UN Commission on the Status of Women in 2024.

92. The UK aid budget has been significantly reduced in recent years; the percentage of Gross National Income spent on Official Development Assistance (ODA) was reduced from 0.7 to 0.5% in 2021,[187] and an increased proportion of the UK aid budget has been spent by the Home Office on costs for asylum seekers in this country rather than on international aid programmes.[188] In February 2025, the Government announced that the aid budget would be further reduced to 0.3% of GNI in 2027 to help fund increased investment in defence spending.[189] The Government has stated the reduction will be gradual until 2027/2028, with the first year in the transition being 2025/26.[190]

93. We wrote to the Foreign, Commonwealth and Development Office to express concern about the impact of the reduction of spending to 0.3% of GNI on women and girls, including specifically on

187 HC Deb, 26 November 2020, cols 1018–1021

188 Independent Commission for Aid Impact, UK aid to refugees in the UK, March 2023

189 HC Debate, 25 February 2025, cols 631–635

190 HM Treasury, Spring Statement 2025, gov.uk, March 2025 and Foreign, Commonwealth and Development Office, Equality impact assessment of Official Development Assistance (ODA) programme allocations for 2025 to 2026, gov.uk, 22 July 2025

any FGM related programmes.[191] In response, the Minister of State for International Development, Latin America and the Caribbean told us that detailed decisions on the aid budget would be decided as part of the Spending Review and departmental resource allocation processes, based on various factors including equality impact assessments. The Minister told us that the FCDO intends to publish final 2025/26 ODA programme allocations in the FCDO Annual Report & Accounts this summer;[192] however, the programme allocations do not specify funding for FGM.[193]

94. An Equality Impact Assessment of ODA programme allocation for 2025/26 was published in July 2025. While this did not mention FGM, it noted that "impacts on equalities are mixed but that overall the proposed 2025 to 2026 ODA allocations protect against disproportionate impacts on equalities." However, it identified that reductions to bilateral aid

191 Correspondence to Minister for Women and Equalities and Secretary of State for Foreign, Commonwealth and Development Affairs, re aid spending target reduction, dated 5 March 2025

192 Correspondence from Minister of State for International Development, Latin America & Caribbean re, reduction of spending on Official Development Assistance, dated 04.04.2025

193 Foreign, Commonwealth and Development Office, Foreign, Commonwealth & Development Office – Annual Report and Accounts 2024–2025, gov.uk, 2 July 2025

spending, including on health and equalities-targeted programmes, would have a negative impact on equalities.[194]

95. CONCLUSION

The continued prevalence of FGM globally increases the risk of FGM to current and future UK citizens and residents. Supporting international efforts to end FGM through aid programmes and diplomacy helps the UK fulfil its international obligations to achieving Sustainable Development Goal 5 and is a necessary step to reduce the risk of FGM occurring to UK citizens and residents. The planned reduction in Official Development Assistance (ODA) from 0.5% to 0.3% of GNI in 2027 after the prior reduction from 0.7% risks the effectiveness of these programmes and present a direct risk to the safety of girls in the UK and those overseas.

96. RECOMMENDATION

We call on the Government to protect FGM programmes from further reductions in funding. The Government should inform the Committee of its funding plans for programmes working on reducing FGM over the next spending period, including a comparison with previous periods. It should also provide the Committee with any wider Equality Impact Assessment on the reduction of ODA spending from 0.5 to 0.3% of GNI as a whole.

194 Foreign, Commonwealth and Development Office, Equality impact assessment of Official Development Assistance (ODA) programme allocations for 2025 to 2026, gov.uk, 22 July 2025

Conclusions and recommendations

Healthcare support for survivors of FGM

1. Survivors of female genital mutilation (FGM) experience profound physical, emotional and psychosexual consequences and require specialised care and support to manage these impacts. Despite this, survivors may not be aware that the health complications they experience are a consequence of FGM, meaning awareness among survivors of the long-term health implications of FGM is vital. (Conclusion, Paragraph 18)

2. Services for FGM survivors and access to them remains inconsistent across the UK. While some variation in access to services may be expected in line with local prevalence, there is a lack of effective referral pathways. This has created a postcode lottery that risks leaving women and girls without the essential support and care they need. (Conclusion, Paragraph 19)

3. The NHS should use Women's Health Hubs, as well as other relevant points of contact such as sexual health services and sexual assault referral centres,

to raise awareness among survivors of the potential consequences of FGM and the benefits of seeking medical advice. (Recommendation, Paragraph 20)

4. The Government should ensure that all FGM survivors can access the essential support and care they need in a timely manner. While some variation in service provision may be necessary to reflect local prevalence rates, higher-prevalence areas should offer funded multidisciplinary services that allow quick access to specialist care. In lower-prevalence areas, there must be clear referral pathways in all relevant healthcare settings including General Practice, Women's Health Hubs and sexual health services to ensure women can access care without delay. The NHS must take steps to ensure that advice on when certain procedures, such as deinfibulation, can be accessed reflects the latest NHS guidance. (Recommendation, Paragraph 21)

5. There is a notable lack of data on spending on FGM services but evidence to this Committee indicates that funding for FGM services may have reduced and remains precarious. There are also concerns that the integration of FGM services within the wider women's health agenda has led to a reduced focus. (Conclusion, Paragraph 22)

6. Integrated Care Boards (ICBs) should ensure sufficient funding is available to meet local demand for services tailored to the needs of FGM survivors. Spending on FGM services should be published and data collected at a local and national level to help build up a comprehensive picture of demand for and funding of FGM services. (Recommendation, Paragraph 23)

7. FGM survivors often suffer psychosexual, emotional and mental health complications from undergoing FGM. However, many FGM survivors do not have access to appropriate counselling services, with many FGM services not offering any counselling to FGM survivors and others offering counselling which is not appropriate or tailored for their needs. (Conclusion, Paragraph 27)

8. The Government should ensure that all FGM Support Clinics offer specialist counselling support to FGM survivors in appropriate settings, provided by counsellors who are trained in the specific challenges of FGM. There should be clear referral pathways to this counselling for women who access FGM services through Women's Health Hubs. (Recommendation, Paragraph 28)

9. Evidence suggests some FGM survivors are experiencing shame or humiliation in healthcare settings, reducing the likelihood of them engaging further with healthcare services essential to their physical and mental wellbeing. Training for midwives and healthcare professionals is not mandatory and often does not include practical advice on how to ask questions and discuss FGM in a culturally sensitive manner, which makes it difficult for healthcare professionals to deliver services effectively. (Conclusion, Paragraph 33)

10. FGM training should be made mandatory for midwives and other healthcare professionals working in services where they are likely to encounter FGM survivors. That training should include how to treat

survivors with appropriate sensitivity. Staff working in FGM Specialist Clinics and Women's Health Hubs should be able to signpost survivors to non-health related local services where necessary such as those that can offer support relating to gender-based violence, insecure housing, and language barriers. (Recommendation, Paragraph 34)

11. FGM survivors are not consistently being made aware that they are entitled to interpretation services. However, interpretation services that are available can be unsuitable and interpreters can lack the necessary proficiency to advocate on behalf of survivors. This can lead to survivors relying on family members which can prevent open communication. (Conclusion, Paragraph 36)

12. FGM Specialist Clinics and Women's Health Hubs should ensure that women are informed of their right to have an interpreter. Those interpreters must be appropriately trained and sensitive to the cultural sensitivities around FGM. (Recommendation, Paragraph 37)

Reconstructive surgery

13. Many women who have undergone FGM seek reconstructive surgery to reverse FGM as far as possible. It is clear that the NHS is equipped to perform this surgery as it delivers it for other medical conditions. We acknowledge that the current medical evidence supporting reconstructive surgery for FGM survivors may be limited. However, it is unreasonable

for the Government to cite a lack of evidence as a barrier to reconstructive surgery while simultaneously failing to invest in the research necessary to generate such evidence. (Conclusion, Paragraph 43)

14. The Government should facilitate and fund research into the effectiveness of reconstructive surgery for FGM survivors as a matter of priority. If evidence indicates that the surgery is effective, then the NHS should provide it. (Recommendation, Paragraph 44)

Estimating the prevalence of FGM

15. To tackle FGM and be able to provide services based on need, the Government, local authorities and healthcare providers need to understand the prevalence of FGM within the UK. The most recent study on FGM prevalence in England and Wales was published in 2015 and was based on 2011 census data. It is a significant oversight that the Government lacks up-to-date information on the current prevalence of FGM nationwide and per locality. This gap undermines the Government's, local authorities and healthcare providers' ability to provide services to women in need. (Conclusion, Paragraph 49)

16. The Government should immediately commission research into the number of women with FGM in the UK, including on prevalence within local areas. It must make this data accessible so that local authorities and health providers can provide their services

accordingly. The NHS should ensure that data on the country of birth and the country where FGM was undertaken for individuals is consistently recorded and published. This will help build a picture of how many women and girls born in the UK have undergone FGM and how many have undergone FGM in the UK. (Recommendation, Paragraph 50)

Preventing FGM

17. It is a matter of serious concern that evidence given to us and available data indicate both that FGM is taking place in the UK and that UK citizens or residents are being taken abroad to undergo FGM. The Government must allocate sufficient resources to tackle this form of gender-based violence and, in most circumstances, violent child abuse. While the UK Government has taken steps to prevent and address FGM, variations in funding on tackling FGM over recent years risk the consistency and long-term impact of this work. (Conclusion, Paragraph 58)

18. Grassroots organisations, often run by FGM survivors from the affected communities, perform vital work in supporting FGM survivors and combatting FGM. However, they receive limited funding, must compete against one another, and can lack the capacity or expertise necessary to secure funding in complex application processes. (Conclusion, Paragraph 59)

19. Given the ongoing risk of FGM in the UK, we recommend the Home Office restore funding to previous levels—we recommend an annual spend of

at least £2 million—and commit to sustained funding for initiatives aimed at preventing and tackling FGM. Targeted support should be provided to local authorities with higher levels of FGM prevalence to ensure they can respond effectively to local needs. Funding should also continue to be allocated to public awareness campaigns and to services which play a key role in prevention and support, including by reinstating funding to the NSPCC FGM helpline. (Recommendation, Paragraph 60)

20. The Government and local authorities should actively engage with and provide sustainable funding to small and grassroots organisations working on FGM to ensure they are able to carry out their work. The Government should ensure that applications for funding are accessible and inclusive for organisations that lack the resources to navigate complex tendering processes. (Recommendation, Paragraph 61)

21. Education on FGM in schools is an essential means of preventing FGM. It can equip girls to advocate on behalf of themselves and to challenge prevailing orthodoxies on behalf of others. We welcome the current and future guidance on RHSE which includes content on the physical and emotional damage caused by FGM, where to find support, and the law, to be taught by the end of secondary education. (Conclusion, Paragraph 64)

22. Education among communities can be an effective tool in challenging the beliefs that fuel FGM and in raising awareness of the serious health impacts of FGM. The effectiveness of these campaigns

is likely to be increased when influential people within the community, such as religious leaders, are included in education and prevention efforts. (Conclusion, Paragraph 67)

23. The Government and local authorities should fund community-led education programmes to challenge the cultural and social beliefs that drive FGM. These programmes must be tailored to reflect the specific drivers of FGM within different communities. Education must include the health consequences of FGM and be targeted at those who drive FGM within communities. (Recommendation, Paragraph 68)

Preventing FGM: Police work

24. While some FGM survivors and campaigners believe more needs to be done to secure convictions against perpetrators of FGM, others believe a strong focus on criminalisation can hinder efforts to engage with communities to prevent FGM and support FGM survivors. It is evident that to tackle FGM, the Government, local authorities and police must strike a balance between prevention and prosecution. However, the message needs to be clear that cultural sensitivities are irrelevant when it comes to violent, gender-based abuse, that more often than not is perpetrated against a child, and that survivors will be supported in seeking justice. (Conclusion, Paragraph 73)

25. The Government should continue to adopt an approach that looks at prevention and prosecution by funding and engaging with prevention efforts in local communities. Alongside this work, criminal justice agencies should review police intervention and CPS prosecution strategies with a view to increasing the prosecution rate for FGM. We acknowledge the challenges this involves, not least the willingness of survivors to testify against family members, but an effective criminal justice deterrent is a vital part of the process in tackling FGM and it is currently missing. (Recommendation, Paragraph 74)

26. Evidence suggests that safeguarding referrals are low. Professionals often lack the confidence to ask questions and get the necessary information from the families of the women and girls affected. Some professionals may also be reluctant to ask questions due to fears of appearing to be culturally insensitive, and there is a lack of training around asking such questions. (Conclusion, Paragraph 78)

27. The Government should ensure that professionals, such as teachers and healthcare professionals, are adequately trained to feel confident to ask questions around female genital mutilation in order to increase the number of successful safeguarding referrals for FGM. This training should include how to broach sensitive subjects, and make clear that FGM is practised across a wide range of communities. (Recommendation, Paragraph 79)

28. Border monitoring is an effective mechanism for preventing FGM being carried out on UK citizens and residents taken abroad. However, evidence suggests that monitoring could be made better through improved training of border officials, better follow-up of suspected cases, and enhanced communication between different agencies. (Conclusion, Paragraph 83)

29. The Home Office should ensure that border officials have sufficient training on FGM to ensure they can identify potential cases and intervene when necessary. There should also be close engagement between departments, such as the Foreign, Commonwealth and Development Office, Home Office, and the Department for Education, including social services, to ensure that suspected cases are monitored effectively. (Recommendation, Paragraph 84)

30. FGM Protection Orders (FGMPOs) can be an effective way of supporting FGM survivors and preventing FGM. Although the data on FGM protection orders is incomplete, the number of FGMPOs appears low, especially when compared to estimations of the number of girls at risk of FGM in the UK. (Conclusion, Paragraph 88)

31. The Ministry of Justice should encourage the use of FGMPOs by working with the Department for Education to increase awareness among children's social services of FGMPOs and the criteria needed to obtain one. We welcome the MoJ's plans to ensure that its data on FGM Protection Orders is up to date. (Recommendation, Paragraph 89)

Preventing FGM globally

32. The continued prevalence of FGM globally increases the risk of FGM to current and future UK citizens and residents. Supporting international efforts to end FGM through aid programmes and diplomacy helps the UK fulfil its international obligations to achieving Sustainable Development Goal 5 and is a necessary step to reduce the risk of FGM occurring to UK citizens and residents. The planned reduction in Official Development Assistance (ODA) from 0.5% to 0.3% of GNI in 2027 after the prior reduction from 0.7% risks the effectiveness of these programmes and present a direct risk to the safety of girls in the UK and those overseas. (Conclusion, Paragraph 95)

33. We call on the Government to protect FGM programmes from further reductions in funding. The Government should inform the Committee of its funding plans for programmes working on reducing FGM over the next spending period, including a comparison with previous periods. It should also provide the Committee with any wider Equality Impact Assessment on the reduction of ODA spending from 0.5 to 0.3% of GNI as a whole. (Recommendation, Paragraph 96)

Formal minutes

Wednesday 3 September 2025

Members present:

Sarah Owen, in the Chair

Alex Brewer

David Burton-Sampson

Kirith Entwistle

Natalie Fleet

Catherine Fookes

Christine Jardine

Samantha Niblett

Rebecca Paul

Rachel Taylor

Female genital mutilation

Draft Report (*Female genital mutilation*), proposed by the Chair, brought up and read.

Ordered, That the Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 96 read and agreed to.

Summary agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Adjournment

Adjourned till Wednesday 10 September at 2.00pm

Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

Wednesday 5 March 2025

Aissa Edon, Midwife and founder, FGM Hope Clinic; **Valerie Lolomari**, Founder, Women of Grace UK Q1-16

Janet Fyle MBE, Professional Policy Advisor, Royal College of Midwives; **Professor Hassan Shehata**, Senior and Global Health Vice President, Royal College of Obstetricians and Gynaecologists (RCOG); **Juliet Albert**, Specialist FGM Midwife, Imperial College Healthcare NHS Trust Q17-33

Gillian Squires, Retired Detective Constable, West Midlands Police, and Director, Honour Me Ltd; **Grainne Boyle**, Helpline Practice Manager, NSPCC; **Angela Craggs**, Deputy National Lead for Harmful Practice, National Police Chiefs' Council (NPCC) Q34-47

Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

FGM numbers are generated by the evidence processing system and so may not be complete.

1	African Women Rights Advocates	FGM0006
2	Albert, Juliet (Specialist FGM Midwife, Imperial College Healthcare NHS Trust)	FGM0002
3	Educate not Mutilate	FGM0010
4	Mohamed MBE, Huda	FGM0003
5	Manor Gardens Welfare Trust	FGM0001
6	Sharawe, Shamsa	FGM0008
7	The Five Foundation	FGM0009
8	The Royal College of Midwives	FGM0004
9	The Vavengers	FGM0005
10	Correspondence from Rt Hon Wes Streeting MP, Secretary of State for Health and Social Care, re Female genital mutilation, dated 20 March 2025	

11 Correspondence from Rt Hon Baroness Chapman of Darlington, Minister of State for Development, FCDO, re Female genital mutilation, dated 5 March 2025

12 Correspondence from Jess Phillips, Minister for Safeguarding and VAWG, re FGM, dated 5 March 2025

13 Correspondence from Rt Hon Bridget Phillipson, Secretary of State for Education, re FGM, dated 10 March 2025

List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

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5th	Misogyny in music: on repeat	HC 573
4th	Tackling non-consensual intimate image abuse	HC 336
3rd	The rights of older people	HC 414
2nd	Equality at work: Miscarriage and bereavement leave	HC 335
1st	Women's reproductive health conditions	HC 337
4th	Tackling non-consensual intimate image abuse: Government Response	HC 911

	Title	
3rd	The rights of older people: Responses from Government, Advertising Standards Authority, Ofcom and IPSO	HC 910
2nd	The prevalence of sexually transmitted infections in young people and other high risk groups: Government Response	HC 865
1st	Equality at work: Miscarriage and bereavement leave: Government Response	HC 803