

Perception and barriers: reporting female genital mutilation

Geetanjali Gangoli, Aisha Gill, Natasha Mulvihill and Marianne Hester

Abstract

Purpose – *The purpose of this paper is to explore the perceptions of and barriers to reporting female genital mutilation (FGM) by victims and survivors of FGM to the police in England and Wales.*

Design/methodology/approach – *The paper is based on 14 interviews conducted with adult survivors and victims of FGM. A combination of 1:1 and group interviews were used, based on the preference of the respondents. Respondents were recruited in collaboration with specialist non-governmental organisations and major stakeholders in the area of honour-based violence and black and minority ethnic communities.*

Findings – *A key finding in this research was that all victims/survivors the authors interviewed stated that they did not support the practice of FGM, and that they would not follow it for younger women in their own family. Second, the authors found that none of the respondents had reported their experience to the police. Third, they identified key barriers to reporting, which included: their belief that reporting their own experience would not serve any purpose because they had experienced FGM as children, and in another country; and that they did not feel able to report new incidents of FGM in the community because of a lack of trust in the police due to previous negative experiences. Finally, they believed that FGM could be prevented only by work within the community, and not through engagement with the criminal justice system.*

Originality/value – *This is, to our knowledge, one of the first papers that is based on victims and survivors' perceptions that explores barriers to reporting cases of FGM to the police, and offers levers for change.*

Keywords *Police, Female genital mutilation, England and Wales, Experiences and perceptions, Honour-based violence, Victims/survivors*

Paper type *Research paper*

Introduction

This paper explores the perceptions of victim-survivors of female genital mutilation (FGM) living in the UK towards reporting their experience to the police in England and Wales. FGM has been illegal in the UK since the mid-1980s and this includes cases where the procedure may have taken place outside the UK. However, to date, there have been no successful convictions. Drawing on interviews with 14 adult women, we consider what the experience of FGM means to victim-survivors who are living in England and Wales, and who have experienced FGM as a child overseas; how they understand the impact of criminalisation of FGM, whether and how they would seek justice for what happened; and how they believe the police (and policymakers) could best engage with communities on this issue.

Definitions

FGM is defined by the World Health Organisation (WHO, 2008) as follows:

FGM comprises all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons, with an increasing severity from partial clitoridectomy to removal and appositioning of the labia minora and/or majora, or other ways of damaging female genitals through e.g. pricking, piercing, incising, scraping and cauterization.

Geetanjali Gangoli is Senior Lecturer at the School for Policy Studies, University of Bristol, Bristol, UK.

Aisha Gill is Professor of Criminology at the Department of Social Sciences, University of Roehampton, London, UK. Natasha Mulvihill is Lecturer and Marianne Hester is Professor, both at the School for Policy Studies, University of Bristol, Bristol, UK.

Received 28 September 2017
Revised 4 January 2018
Accepted 7 January 2018

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This work was commissioned and funded by Her Majesty's Inspectorate of Constabulary (HMIC). On 19 July 2017, HMIC took additional responsibility for fire and rescue service inspections and was renamed HM Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS). We refer to "HMIC" in this report since the work relates to 2015, prior to the change of name. The analysis within this paper was also informed by work undertaken as part of the Justice, Inequality and GBV project (ESRC grant number ES/M010090/1). The authors finally wish to acknowledge and offer thanks for the interview and transcription work carried out by Dr Andrea Matolcsi, Dr Lis Bates, Sarah-Jane Walker, and Kurda Yar.

We identify FGM as a form of “honour”-based violence. While the definitions of “honour” and “honour”-based violence are contested (Chantler and Gangoli, 2011), for the purpose of this paper, we adopt the definition provided by the UK Crown Prosecution Service:

Honour-based violence (HBV) can be described as a collection of practices, which are used to control behaviour within families or other social groups to protect perceived cultural and religious beliefs and/or honour (CPS, n.d.).

The concept of honour acts as a justification for gender-based violence and abuse. Previous research indicates that victims of HBV can experience inequalities linked to wider structures, for example, insecure immigration status or language barriers that further complicate their experience of HBV (Hester *et al.*, 2008; Chantler and Gangoli, 2011).

Commonly stated reasons for carrying out FGM are: tradition, religion, protecting virginity and familial honour, aesthetics and hygiene, although these vary according to country and area. In some cultures, girls are circumcised during a rite of passage, in which FGM may symbolise their transition from childhood to adulthood (UNICEF, 2005, 2010; Berg and Denison, 2013). In several parts of the world, FGM is an accepted social expectation and families who do not follow this custom may be stigmatised and isolated (Bradley, 2011). It may also be difficult for girls and women who have not experienced FGM to get married (UNICEF, 2010). In this way, FGM, not unlike forced marriage, is in many instances clearly aligned to codes of honour, particularly because non-adherence can have serious consequences for the family (see Gill, 2016).

FGM is thus considered a form of gender-based violence and a human rights violation; further, because it is primarily perpetuated against young girls, it can also be considered a gendered form of child abuse (WHO, 2008). FGM is known to be most routinely carried out in specific populations in Africa and the Middle East, and less so in parts of Asia (WHO, 2008). There is recent evidence that forms of FGM are also prevalent in other parts of the world (World Bank, n.d.). An estimated 137,000 women and girls who have migrated to England and Wales are FGM survivors, (HSCIC, 2016). Between April 2015 and March 2016, 5,702 new cases of FGM were recorded in England, just 18 of these are reported to have been undertaken within the UK (HSCIC, 2016). However, there are concerns about the reliability of FGM statistics, as health practitioners can often only record historic cases of adult survivors of FGM that have surfaced as a result of a victim receiving medical treatment, and very few new FGM offences come to police attention (HSCIC, 2016).

Legal and policy interventions

Much recent academic literature on FGM is international, and focusses on its serious health effects for women and girls, including its long-term effects on sexuality, pregnancy and reproductive health (Kaplan *et al.*, 2011) and the severe psychological trauma it causes in victim-survivors (WHO, 2008; Shell-Duncan *et al.*, 2016). For instance, it has been suggested that there could be associations between FGM and adult women’s maternal morbidity in Gambia (Morison *et al.*, 2001). Some studies have also examined attitudes towards FGM, particularly among community practitioners and midwives (Kaplan *et al.*, 2011), and others have investigated barriers to adequately preventing FGM faced by professionals in other sectors – for example, health and social workers (Costello, 2015). These include awareness of different types of FGM, lack of confidence about how to respond to FGM victim-survivors in culturally sensitive and respectful ways and effective procedures for monitoring and screening girls and women who may be at risk of experiencing FGM. However, to our knowledge, there is little information about how victim-survivors conceptualise barriers to reporting.

The UK Government recognises that FGM is a violation of different human rights provisions and acts to which the UK is a signatory, including the Convention on the Rights of the Child (United Nations, 1990), the European Convention on Human Rights (Art. 2 and 14), the Universal Declaration of Human Rights (Art. 1 and 3) and the Convention on Preventing and Combating Violence against Women and Domestic Violence (See Gill, 2016). Several studies have addressed the legal implications of FGM (Gill, 2016; Jefferson, 2015). In the UK, FGM is treated as a criminal offence, and is prohibited under the Female Genital Mutilation Act 2003 (which replaced the

Prohibition of Female Circumcision Act 1985). Any person found guilty of an offence under the Female Genital Mutilation Act 2003 is liable to fine or imprisonment of up to 14 years, or both. The FGM 2003 Act was further amended under the Serious Crime Act 2015 to insert new provisions to: extend extra-territorial jurisdiction for FGM, provide anonymity for victims of FGM, create a new offence of failure to protect a girl from FGM, introduce FGM Protection Orders and introduce a mandatory reporting duty requiring regulated health and social care professionals to report known cases of FGM in under 18s to the police (see Gill, 2016).

However, there have been no successful prosecutions against FGM in the UK. This is a situation that criminal justice agencies are working hard to address at both national and local level (Gill, 2016). In February 2015, the UK's first prosecution of a medical professional for undertaking a FGM procedure collapsed amid accusations against the Crown Prosecution Service for staging a "show trial in response to political pressure" (Gill, 2016, p. 7). On 4 February 2015, Dr Dhanuson Dharmasena (together with another defendant) was found not guilty of performing FGM on a patient at the Whittington Hospital in North London. Dr Dharmasena, an obstetrics and gynaecology registrar, was alleged to have performed reinfibulation on a woman after she had given birth. Dr Dharmasena said that he had never before treated a woman who had previously undergone FGM, nor had he received any relevant training. He performed a single suture to stop postpartum bleeding. The woman herself made no request for Dr Dharmasena to be prosecuted (Gill, 2016; McCartney, 2015). Against the background of apparent inaction in view of the original 1985 legislation, the case represented something of a milestone and the Crown Prosecution Service at the time reported that it had many other potential cases under review (see Gill, 2016, p. 7; Jefferson, 2015).

A House of Commons Home Affairs Committee inquiry into FGM described it as "beyond belief" that 30 years after introducing legislation against FGM, no successful prosecution had been brought, and expressed fears that this would deter victims from reporting (Home Affairs Committee on FGM, 2016). The failure to convict perpetrators of FGM in the UK has often been associated with lack of political will, the collusion within communities where these practices take place and the stigma and shame associated with talking about female sexuality and related practices (Dailly and Mulcahy-Bowman, 2014).

In terms of the perceptions of, and barriers to, reporting gender-based violence to the police in England and Wales, there is a developing body of research on police attitudes towards domestic abuse (DA) and sexual violence (SV), but not on FGM. Reports on policing DA and SV including critiques of what is perceived as a masculine ethos or "cop culture" within the police force (Loftus, 2009; Reiner, 2010). This culture may encompass attitudes about how women should behave in general, and particularly during instances of DA and SV (Loftus, 2009). For example, police may ask women in relation to SV, "Why didn't you say no?" or "Why didn't you fight back?" (see Patterson, 2011). This is consistent with research from Myhill and Johnson (2016). As for low DA and SV reporting rates in England and Wales reasons vary between individuals, and include finding reporting "embarrassing", thinking the police will not do much to help and believing that the incident is "too trivial or not worth reporting" (Harrison and Gill, 2018, p. 3). Others may view the offence as a "private/family matter and not police business" (Ministry of Justice, Home Office and ONS, 2013, p. 6).

To our knowledge, therefore, there is no study that explores the views and experiences of victims-survivors of FGM on seeking justice through the criminal justice system, or how victims/survivors of FGM conceptualise the effectiveness of criminalising FGM and the role of the police in this process. This paper aims to address this gap in the literature by focussing on a recent study involving FGM victim-survivors' experiences, their perceptions and any previous contact with the police. We explore the extent to which both are impacted by women's positionality as first-generation immigrant women, and the intersections of race, faith and inequality. The paper draws on data from research conducted by Hester *et al.* (2015) to identify and interview victims of honour-based violence, and included forced marriage and other forms of honour-based violence, including domestic and sexual abuse committed in the name of honour (see Mulvihill *et al.*, 2018). This paper focusses on the UK resident victims-survivors of FGM, which we believe is a group that has received less attention than forced marriage and domestic violence-related HBV in the criminology, social policy and gender-based violence literature in the UK.

The paper is divided into the following sections. First, a brief description of the research methodology and sample; analysis and discussion of key themes, including what FGM means for victims/survivors; barriers to reporting to the police; and levers for change identified by victims/survivors. Finally, we end with conclusions, and recommendations for policy and practice.

Methodology

Due to the well documented issues of working with survivors of GBV and HBV (Hester *et al.*, 2008; Skinner *et al.*, 2004), we worked in collaboration with specialist non-governmental organisations (NGOs) and major stakeholders to access participants, and to ensure that participants were being supported during and after the interview. We also identified a small number of (supported) participants through recommendation: this is an approach to building (or adding to) a sample of research participants known as “snowball sampling” and is commonly used where potential participants are hard to reach.

For the wider project, we contacted 32 NGOs and were able to organise interviews through 9 of these organisations with 50 women who had experienced HBV, including 14 who had experienced FGM. Participants were offered the choice, where possible, of an individual interview or group interview. We are aware that the results of group interviews may be different from individual interviews, for instance, all members of group interviews may not participate equally, and more dominant respondents may take over the interview. Further, survivors of GBV may worry about loss of confidentiality in group interviews. However, we know also from our previous work that some survivors of GBV prefer group interviews, as they derive comfort and solidarity from shared experiences, and given the sensitive nature of the study, we were led by survivors as to the form our interactions would take.

From the sample of 14 FGM victim-survivors, four were one-to-one interviews, and ten were in group interviews (two groups with five participants each). Individuals were initially contacted by the NGO and provided with information about the aims and objectives of the project and an outline of the interview question schedule. Those who agreed to participate then signed a consent form, which included their right to withdraw from the research within seven days (which none exercised). The research project was granted ethical approval by the University of Bristol School for Policy Studies Ethics Committee.

The interview schedule was semi-structured, and questions were organised around the themes identified for the main inspection report, namely Awareness and Understanding, Protection, Enforcement and Prevention. Participants were also given the opportunity to share details of their experience and any other issues that they felt relevant to police practice in this area. Survivors of FGM were more difficult to recruit than the other survivors of HBV. In part, this was because we were commissioned by the funder to interview survivors who were adult (over 18 years of age) at the time of interview, and had experienced the HBV or had contact with the police in the past three years. Ethical constraints meant we were unable to interview young women aged 17 or under. However, on speaking to NGOs working with survivors of FGM, we found that most of their client base were adult women who had experienced FGM as children, and that none had made contact with the police regarding this experience.

The characteristics of the FGM sub-sample, therefore, required us to shift our focus from the reporting experiences of FGM by participants to their perceptions of, and barriers to, contact with the police on FGM in principle. The 14 women interviewed were from Sierra Leone, Somalia, Somaliland and Nigeria and had experienced FGM as children in their countries of origin between the ages of 5 and 14, mostly before they had come to reside in the UK. The majority of participants in this sub-sample were first-generation immigrant women from working-class backgrounds who were not fluent in English – therefore, we employed interpreters who were used regularly by the NGOs that enabled the interviews. The women shared personal and visceral accounts of their experiences, and some were passionately articulate about how police (and policymakers) could better facilitate justice. The interview transcripts were coded through NVivo, using the inspection report themes outlined above.

Findings and discussion

Meaning of FGM to victims/survivors

A key finding in this research was that all victims/survivors we interviewed stated that they did not support the practice of FGM, and that they would not and did not follow it for younger women in their own family. This was the case in both one-to-one and individual interviews. This is in line with other research that found low acceptance of FGM amongst adult survivors of FGM (Dailly and Mulcahy-Bowman, 2014) and it may well be because the sample we interviewed were through community and feminist organisations that work towards eradicating FGM, and against GBV in general. However, respondents found the legal and wider societal discourse around FGM in the UK at odds with the ways in which it was perceived in their own communities and families:

To be circumcised, yes it is a pride [for family] Even I am having a lot of problems with my family, because I did not take my children [to be circumcised] [...] This is our culture.

This participant was circumcised at the age of 14, and believed that the terminology around FGM was an issue for her, as it made her feel that she was at war with her family and culture:

[When she heard the term mutilation] I felt like a knife had gone in to my heart, to be honest. Because I think up until that point, I was living with my body quite freely, maybe naively. Until I heard that term. And that's when that intrusion of what happened to me became very raw. [...] I was reading this information and thinking so I am a freak, and my parents are the worst people ever, and my culture is disgusting, you know? And I felt that this doesn't ring true to me: I don't feel that my parents or my culture are bad but what I do feel is that my human rights have been taken away from me. My body was altered without my consent. [...] So those were the times when I felt like I was the "mutilated" lady. All power to survivors, but I don't know why they want to align themselves to those labels. [...] [But I would term it] "genital alteration" – to alter another person's body without their consent.

This discomfort may well be felt by survivors of other forms of gender-based violence, in terms of the emotional pain of recognising and "naming" their experience as abuse. However, we suggest that with survivors of FGM, this is further complicated by the othering of FGM as a cultural practice that is associated with certain demographics. Previous research on forced marriage suggests that when certain forms of GBV are associated with particular communities, they can be exoticised, and not seen as variant within wider experiences of gender-based violence (Chantler *et al.*, 2009). Some of the participants who had experienced FGM questioned its separate treatment in law and practice, arguing that rather than being treated as a specific offence, it should be considered child abuse. They felt it fuelled a preoccupation with "culture" and was seen as being prevalent in "certain communities", which distracted from the central task of protecting all children from all types of harm. Participants also alluded to how the criminalisation of FGM had driven the practice underground:

You know in Somalia, a long time ago, they used to know that this person was going to have the FGM – they used to have a celebration [...] but now, we can't [...].

These interventions in the group interviews were contradicted by statements that FGM did not take place any more in families in the UK, and assertions that communities now understood the harms of FGM:

Interviewer: Was there any case where the police has helped in a FGM case?

Participant: No, because most Somalis has stopped doing it now.

It is possible that the dynamics of the group interview played a role here, where lack of support for the practice amongst the more confident participants may have impacted responses of other participants. More broadly, it demonstrates the conflict around practices and values which might arise when individuals have to negotiate the demands of ethnicity, cultural heritage, gender, immigration status and so on.

Barriers to reporting

The key stated reason by participants for not reporting their experience of FGM to the UK authorities was because the incident happened many years ago in their childhood and in another country:

Interviewer: Was the police involved? Did anyone contact the police?

Respondent: Which police? In Somalia or here in the UK? No, because we already have done it. [...] Everybody knew and was doing it in Somalia.

There are interesting parallels with the ongoing and current increase in reporting of cases of historic child sex abuse in the UK, where the police and CPS are actively pursuing these cases (CPS, n.d.; Dean, 2014), and victims are increasingly being urged to come forward to report incidents of sexual abuse that may have taken place in the past. In contrast, victims of FGM are not encouraged, to our knowledge, to report historic cases. The reasons for this may well be because the perpetration took place in a different country, in the past and on victims/survivors who were not British residents or citizens at the time. Further, there is a possibility that survivors do not consider the criminal justice system as a valid route for justice. We have noted that in the case of forced marriage, criminalisation is seen as problematic for some survivors (Gangoli and McCarry, 2008), and indeed there is a wider body of literature (Menon, 2012; Smart, 1989) that suggests that legal or adversarial justice may not be always be conceived as justice by survivors.

Barriers to reporting new cases were twofold: fears of retribution from the wider community and concerns about interference in private family life:

Yes, but we cannot report to the police because I don't want to interfere with other people's lives. If I see someone is doing FGM, I don't want to interfere with other people. That's not fair. [...] If someone does FGM and I report to the police that family will come to me and I get into trouble.

While the study indicated that forced marriage and HBV cases are often well known to the community and wider family, in contrast, FGM was presented by participants as something that wider family members may be unaware of. Within the FGM cases, it was suggested by interviewees that this is a very private affair between the child and the parents. Participants said it would be very hard to speak to the police, unless they knew "for sure" that FGM had taken or would take place, in case, for example, it meant that the children were removed from the family. Overlaying the cultural code of protecting the family and community, was this extra level of secrecy. Interview participants recognised that this combination may make it particularly difficult to facilitate reporting of FGM:

You know, I'm not sure if you agree with me or not, but it's hard to know if they have done it or if they were going to do it [Murmur of agreement within the group]. Even my sister, I wouldn't know what she was going to do. We are a very close family but we don't talk about those kinds of subjects. Am I right? It's hard to know [...] until, when they come back, and you overhear them with the children [...] [...].

"Overhear" or "overhearing" is a very broad term and one that would imply particular difficulties for reporting – in order to be in a position to report something that one had overheard one would need to be in close enough proximity that it would be hard to maintain anonymity. Further, there are difficulties in trusting such accounts. We suggest that respondents felt that such "overheard" comments may not be taken seriously by the police, as they are unreliable; and that respondents were concerned that they may suffer retribution within the community if they were seen as reporting on these practices.

As noted above, the secrecy concerning FGM meant that traditional celebrations of FGM as a rite of passage for girls are no longer held in the UK, and therefore wider family, and community members may be unaware of FGM having taking place, or lacking concrete evidence it has. In contrast, with forced marriage, the community is often complicit, as they are invited to celebrate the marriage, and are often privy to discussions within the family (Hester *et al.*, 2008, 2009).

Research indicates that professionals working on FGM are paralysed by what has been called "race anxiety" (Burman *et al.*, 2004) because of fears of being labelled "racist" (Kwateng-Kluytse, 2004). Burman *et al.* (2004) suggests "race anxiety" emerges from notions of "cultural privacy" and produces particular barriers to intervention and provision. These may include cultural and language barriers, or more commonly "they feel themselves to be insufficiently culturally equipped to work with minoritised women" (Burman *et al.*, 2004, p. 301). However, with regard to FGM, our respondents believed far from displaying "race anxiety", that the police were insensitive to cultural and ethnic norms. In general, BME women often do not report experiences of domestic violence because they have previously witnessed or been subjected to racist interactions with the police (Mama, 1995; Thiara and Gill, 2010), and

this was supported by our interviews. Both group interviews with victims of FGM revealed negative experiences with the police. The first was a case where one family had made a false allegation to the police of FGM within another family, as part of an ongoing feud. Participants felt that the police had taken the report at face value and had searched the family's property without first establishing the "facts". This incident may well have fed into wider fears within the community that the police treats allegations of FGM insensitively.

In the second group, two participants-related experiences of police or social workers coming to the house, either to remove young girls temporarily to "check them" after a holiday to Somalia, or to question the children about FGM. Again, our research participants stated that this approach was disrespectful, not based in evidence and possibly unlawful police action.

Levers for change

Respondents were united in their opinion that change could be brought about only through community engagement, and not through increased policing, or criminal justice engagement on FGM. Separately interviewed participants stated that FGM could be prevented, not by an increase in reporting, but by working within and through the community, in a relationship of trust, preferably alongside "community sponsors" and NGOs working in these areas. Education for older women was also identified as particularly important, as participants felt that they were instrumental in the continued practice of FGM, and perhaps in colluding to hide it from the authorities. Clarifying the nature and consequences of FGM, the legal position in the UK, and how to report to police were highlighted as key areas by interviewees. One group described how this information was already being delivered effectively through a local NGO:

That's why we need the community raising awareness. [...] Not just the professional sitting in a big room talking about FGM. We need to take it outside, to the community areas, like parks, we talk about it. Some people don't know it is illegal in this country. Because they don't know what is FGM. [We need to explain] it to them the way they are calling it, in their own language, or in their own country. When you educate one woman properly in the community with strong awareness, then that woman will educate ten or fifteen in that same community.

Respondents further indicated that men often were unaware of the consequences of FGM for women in the community. This may well have to do with apparent male disengagement with women's reproductive and sexual life, while maintaining power and control over it through older women in the family (Gangoli and Rew, 2011). Younger men in particular had little information about FGM:

Because when you talk about FGM people don't know what FGM is. [and] Let's raise more awareness for the boys as well. Because for me, my children, my boys they know exactly, and they say "No way!" [laughs].

Yeah, we need to start with the young men.

Respondents also indicated that religious and faith leaders had an important role in educating the community about the dangers of FGM:

[...] We should work with the mosque more because the men are there – telling them how forbidden it is, how dangerous for the children.

It was notable that some respondents clarified (rightly) that FGM is a cultural and not a religious requirement in Islam. This important distinction could be seen as part of the ongoing "repair work" that Muslims can feel required to fulfil, given the prevailing currents of Islamophobia in British society.

Conclusion

This paper aimed to explore the perceptions of and barriers to reporting FGM by victims and survivors of FGM to the police in England and Wales. From our research, we found that immigration women's experiences of FGM may be mediated by the law, their previous experiences with the police and their marginality as first-generation immigrant women in the UK.

While we found that there was a generalised lack of support for FGM amongst the women we interviewed, it is impossible to conclude whether this was a consequence of our sample, or the fact that FGM was a criminal offence, and they were fearful of the consequences of any stated support for this practice. This was complicated by assertions that survivors accepted that FGM was being practiced (either within the UK, or by taking children to their countries of origin), but that these incidents were not talked about within the wider community.

FGM was conceptualised by some participants as a private matter between parents and child, even though a private matter that had tacit approval from the wider community. The lack of fit between the community perceptions of FGM – as a cultural practice, and a rite of passage for females from childhood to adulthood – and state perceptions – as a violation of child rights, a form of HBV and a form of gender-based violence – further complicated women survivors' experiences. In the light of similar concerns raised with regard to criminalising other forms of abuse associated with BME communities, for example, forced marriage (Gangoli and McCarry, 2008; Gangoli and Chantler, 2009; Gill and Hamid, 2016), we suggest that survivors of FGM may feel less conflicted about their experiences of abuse if it were considered within law and policy as generic gender-based violence, and perhaps treated as a form of gender-based child abuse, where it is perpetrated on children.

Based on our interview findings, we conclude that adult survivors of FGM did not consider reporting childhood experiences, and this was explained as being due to it happening in their country of origin. While the current law applied to cases of FGM that may have occurred outside the UK (as long as the victim is a British citizen or resident), we suggest that this decision – not to report – is not merely pragmatic, but may also be that survivors feel that the police are uninterested in abuse that may have occurred in their childhood. This, as stated above, is in contrast with ongoing media and state interest in highlighting and encouraging survivors to report historic cases sexual abuse. It may also be because survivors do not believe that the police or the criminal system can offer them the justice they seek.

Survivors of FGM also report distrust of the police and wider criminal justice system, because they feel that their communities are being targeted by the police and wider society. This is based on experiences where they – or someone close to them – have felt unfairly treated, and links to wider marginalisation of immigrant women in the UK. In general, respondents believed that the way forward was to engage, and educate communities on the law and more importantly on the dangers of conducting FGM on young girls and women. This included working with older women – who might be perpetrators, or at the very least, colluders in the act, and with young men – as future husbands and fathers. They also suggested that faith leaders needed to be engaged further with this process, but did not offer suggestions on how this may happen.

Finally, we suggest that the research indicates adult survivors of FGM do not consider the criminal justice system as the most feasible route to justice. For FGM victim-survivors who are first-generation immigrant women, these perceptions are often linked to their multiple marginalisations, including poor English language skills and previous negative experiences with the police. Others held in tension the horror of what they have endured with feelings of loyalty towards their family and/or community, and found the law unable to attend to their more pressing needs and desires – for example, to have a smear test without interrogation, gasps from the medical staff or attitudinal changes within their community. Their experiences offer an important insight into the intersections of gender, race, immigration status and religious faith that FGM victim-survivors must negotiate in their encounters with the state. To improve their access to justice, participants wanted police (and policymakers) to better understand the dynamics of “honour” and how it exerts psychological and physical control over the victim; how the wider family and community may be implicated in its perpetration; and the multiple barriers to reporting FGM, including the high risk of shame, personal conflict, ostracism and abuse for those who decide to approach the police. These could be achieved through more community engagement by the police and effective multiagency working on FGM (particularly with social services and the health and education sectors, which are likely to encounter with new cases of FGM, and may be subjected to mandatory reporting). Finally, we suggest that the police approach to FGM could move towards partnership, working for “prevention” rather than “prosecution”.

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Corresponding author

Geetanjali Gangoli can be contacted at: g.gangoli@bristol.ac.uk

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