



FEMALE GENITAL MUTILATION: A SOCIO-LEGAL ANALYSIS

A Critical Study of Social Norms, Bodily Autonomy, Religious Freedom, Child Protection and the Indian Legal Framework

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ABSTRACT :

Female genital mutilation (FGM), also known as female circumcision, *khatna*, *khafz* or *khafd*, involves the intentional alteration or removal of parts of the external female genitalia for nonmedical reasons. It is a complex socio-legal issue involving gender, religion, childhood, health and human rights. Beyond its physical effects, FGM may be sustained by social expectations relating to purity, marriageability, family honour and community identity.

FGM remains a significant global concern. The World Health Organization and UNICEF estimate that more than 230 million girls and women have undergone FGM, while recognising that the practice provides no health benefits and may cause serious physical and psychological consequences. In India, the practice is particularly associated with sections of the Dawoodi Bohra community and is commonly referred to as *khatna* or *khafz*.

India does not have a specific statute exclusively prohibiting FGM. However, depending on the circumstances, the Bharatiya Nyaya Sanhita, 2023, the Protection of Children from Sexual Offences Act, 2012, and constitutional protections relating to equality, dignity, privacy and bodily autonomy may become relevant. At the same time, the practice raises questions concerning the constitutional protection of religious freedom under Articles 25 and 26.

These competing considerations have been examined in *Sunita Tiwari v. Union of India*, W.P. (C) No. 286 of 2017, in the context of the broader constitutional debate concerning religious freedom and fundamental rights. FGM therefore requires examination not only as a physical procedure but also as a social practice sustained by community norms. An effective legal response must consequently address both individual rights and the social conditions that enable the practice to continue.

Keywords: Female Genital Mutilation; FGM/C; Khatna; Khafz; Bodily Autonomy; Religious Freedom; Article 25; Article 26; Article 21; Child Rights; POCSO; Bharatiya Nyaya Sanhita; Social Norms; Reproductive Rights; Social Norms; Constitutional Morality; Gender Equality; Human Right; Socio-Legal Analysis.

1. INTRODUCTION: FGM AS A SOCIO-LEGAL PHENOMENON

Female genital mutilation is a practice that cannot be adequately captured by a purely medical description. The physical act is performed upon the body of a girl or woman, but the reasons for which it is performed are frequently social. Families may understand the procedure through ideas of cleanliness, modesty, purity, discipline, sexuality, marriageability, identity or religious belonging. The social meaning attached to the procedure can become so powerful that parents who themselves understand the physical risks may nevertheless feel that refusing the procedure would expose their daughter to a different and potentially serious form of social harm. This is one of the central insights of a sociological analysis: individual conduct is often structured by collective expectations.

The World Health Organization defines FGM as procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs, for non-medical reasons. The definition deliberately focuses upon the absence of medical necessity and is broad enough to cover practices of substantially different physical severity. WHO classifies FGM into four broad types: Type 1 involves removal of the clitoral glans and/or prepuce; Type 2 involves removal of the clitoral glans and labia minora, with or without removal of the labia majora; Type 3, known as infibulation, narrows the vaginal opening by creating a covering seal; and Type 4 includes other harmful procedures such as pricking, piercing, incising, scraping or cauterising. The classification is important because the legal and health consequences may vary with the procedure, but the absence of medical justification remains common to the definition (WHO, 2025).²

The terminology surrounding the practice is itself contested. "Female circumcision" may be used by communities to emphasise its ritual or religious character and to distinguish it from the more extensive forms found in some African countries. "Female genital cutting" or FGC is sometimes preferred by scholars and advocates who seek terminology that is less judgmental while retaining recognition of harm. "Female genital mutilation" is the

¹ The authors are final year students at National Law Institute University, Bhopal.

²World Health Organization, 'Female genital mutilation', Fact Sheet (31 January 2025).

terminology adopted by major international organisations because it communicates the seriousness of the physical injury and its relationship to discrimination and human rights. A socio-legal paper must acknowledge this linguistic debate rather than treating terminology as neutral. Language shapes whether a practice is viewed as ordinary ritual, cultural identity, bodily injury or rights violation.

At the international level, FGM is now firmly situated within the framework of women's rights and children's rights. It engages the rights to health, physical integrity, dignity, equality and freedom from cruel, inhuman or degrading treatment. Because it is commonly performed on girls before the age of fifteen, it also implicates the principle that children require heightened protection against practices that cause irreversible physical injury. WHO states that FGM has no health benefits and can cause severe bleeding, urinary problems, infections, cysts, menstrual difficulties, sexual complications and childbirth complications, including increased risks for newborns. The psychological effects can include anxiety, depression, trauma and difficulties associated with sexual relationships and childbirth (WHO, 2025; UNFPA, current materials).³ The Indian debate has additional constitutional complexity. India protects freedom of conscience and the right to profess, practise and propagate religion under Article 25, subject to public order, morality, health and the other fundamental-rights provisions. Article 26 protects denominational rights to manage affairs in matters of religion, again subject to constitutional limitations. At the same time, Articles 14 and 15 guarantee equality and prohibit discrimination, while Article 21 protects life and personal liberty and has been interpreted to include dignity, privacy and decisional autonomy. The question is therefore not whether religion is constitutionally protected—it unquestionably is—but whether a particular physical practice imposed upon a child falls within the protected sphere and, if so, whether it can survive the constitutional limitations applicable to religious freedom.

The socio-legal approach is particularly appropriate because neither social custom nor law operates in isolation. Law can criminalise conduct, create reporting mechanisms and establish remedies, but compliance depends partly upon social legitimacy and institutional capacity. Conversely, social practices can influence legislation by creating political pressure, producing claims of cultural autonomy and shaping the way institutions interpret harm. FGM therefore presents a classic problem in the sociology of law: a practice may be perceived by insiders as an identity-preserving norm while being perceived by survivors, medical authorities and human-rights institutions as bodily violence. The central task of legal analysis is to determine how the State should respond without reducing an entire community to a stereotype or treating cultural identity itself as the problem.

2. CONCEPTUALISING FGM: DEFINITIONS, TERMINOLOGY AND SCOPE

2.1 The WHO definition and its legal significance

The WHO definition provides a useful starting point because it identifies the decisive distinction between medical treatment and non-medical injury. The practice is not defined by the identity of the community, the religious tradition claimed for it, the age of the person, or the instrument used. It is defined by what is done to the female genital organs and the absence of a medical purpose. This functional definition helps prevent two opposite errors: first, assuming that only the most extensive forms qualify as FGM; and second, assuming that a less extensive procedure is automatically harmless. WHO expressly recognises four types, and its position is that all forms have no health benefit and can cause harm (WHO, 2025).

The legal significance of a functional definition is substantial. A criminal statute that identifies only a particular anatomical act may leave room for evasion through changes in terminology or technique. A definition based upon intentional injury to female genital organs for nonmedical reasons can potentially capture a wider range of practices while allowing legitimate medical procedures to remain outside the prohibition. Any future Indian legislation would therefore need to define the prohibited conduct with sufficient precision to satisfy legality and fair-notice requirements while being broad enough to avoid circumvention.

2.2 FGM, FGC, khatna and khafz

The terms FGM, FGC, khatna and khafz are not interchangeable in every social context. In India, discussions concerning the Dawoodi Bohra community frequently use khatna or khafz to describe the ritual practice. The terminology used by community members can reflect an internal understanding of religious and cultural identity, whereas FGM is an international legal and public-health term. A scholarly treatment should therefore use the terms carefully and identify the underlying conduct rather than assuming that a preferred label settles the legal question.

The distinction is especially important because debates about terminology can become debates about legitimacy. Calling the practice "circumcision" can suggest an analogy with male circumcision, but the analogy is disputed because female procedures vary widely in anatomy, purpose and consequences. Conversely, the term "mutilation" carries an evaluative dimension and can be perceived by community members as an external judgement upon their identity. For this reason, international literature increasingly uses the combined expression FGM/C in contexts where sensitivity to terminology is important. This paper uses FGM as the principal legal and public-health term while using khatna or khafz when discussing the Indian community context.

3. HISTORICAL DEVELOPMENT AND ORIGINS OF THE PRACTICE

The precise geographical and historical origin of FGM cannot be established with certainty. The practice predates modern national boundaries and has appeared in different forms among communities with different religious and cultural identities. Historical references have been identified in relation to ancient Egypt and other regions of Africa and the Middle East, while later patterns of migration, trade and social interaction contributed to its spread. The absence of a single identifiable origin is important because it cautions against attributing FGM inherently to one religion or one ethnic group.

³ World Health Organization, 'Female genital mutilation', Fact Sheet (31 January 2025); UNFPA, Female genital mutilation (FGM): Frequently Asked Questions.

Historical accounts have proposed several explanations for the emergence and persistence of genital cutting. These include attempts to control female sexuality, beliefs concerning chastity and fidelity, ideas of cleanliness or aesthetic attractiveness, initiation into womanhood, marriageability, and the control of reproduction. Some historical accounts also connect forms of infibulation with slavery and control over enslaved women's sexuality. Such accounts, however, should be treated as explanations for particular historical settings rather than universal explanations for all forms of FGM. The practice has survived because its social meaning has changed and adapted across communities.

The history of FGM also demonstrates the danger of treating social practices as static. A practice can be reinterpreted through religious texts, local customs, family expectations and modern ideas of identity. In some settings, FGM has been represented as a religious obligation even though the principal religious texts relied upon by communities may not expressly prescribe it. In others, the practice has been understood as a cultural rite independent of religion. The socio-legal question is therefore not simply "where did FGM begin?" but "how did a practice acquire and maintain normative authority in a particular community?"

The original project correctly recognised that historical inquiry is necessary for understanding contemporary practice, but the historical record does not justify a single-cause explanation. Slave-trade theories, theories of population control, sexual regulation and marriageability may each illuminate particular contexts, but contemporary persistence is better understood through social-norm mechanisms. UNFPA explains that FGM is sustained by gender inequality and deeply entrenched social norms, including expectations relating to marriage and the fear of ostracism. Thus, history provides context, while sociology explains continuity.

3.1 The emergence of the term 'female genital mutilation'

The modern terminology emerged in the twentieth century alongside feminist, anthropological and international human-rights debates. Earlier writing frequently used "female circumcision", a term that placed the practice within a familiar ritual category. Feminist and human-rights movements increasingly preferred "mutilation" to emphasise the physical injury and gendered inequality involved. International institutions subsequently adopted FGM as the principal terminology. The linguistic development is significant because it reflects a shift from viewing the practice primarily as an anthropological curiosity to viewing it as a matter of rights, health and gender equality.

Anthropological scholarship also cautions against a simplistic binary between cultural relativism and universal condemnation. The cultural-relativist argument asks whether external institutions should judge practices according to standards developed outside the community. Feminist scholarship, however, points out that the invocation of culture can sometimes obscure unequal power relations within communities, especially where girls have no meaningful ability to refuse. The appropriate legal response must therefore respect cultural diversity while distinguishing respect for people and communities from immunity for harmful conduct.

SOCIOLOGICAL FOUNDATIONS: WHY DOES FGM PERSIST?

The persistence of FGM is best understood through the concept of a social norm. A social norm is more than a personal belief. It is a shared expectation about what people in a particular group ought to do, often accompanied by expectations about what others will do and by social sanctions for non-conformity. UNFPA and UNICEF's work on social norms and change treats FGM as a practice that can persist because individual families anticipate consequences if they abandon it alone. A family may privately doubt the value of FGM but continue because it believes that other families will continue and that an uncut girl may face stigma or reduced marriage prospects.

This produces a collective-action problem. If one family stops while everyone else continues, that family may bear the social cost of non-conformity. If many families stop together, the perceived social cost falls. UNFPA's community-based approach therefore emphasises ⁴ collective dialogue and coordinated abandonment rather than relying solely upon individual persuasion. The importance of this model for India is considerable. A criminal prohibition can identify the conduct as unlawful, but it cannot by itself remove the social expectation that gives the conduct its force.

4.1 Marriageability and family honour

Marriageability is repeatedly identified in the literature as a reason for continuing FGM. In settings where marriage is an important marker of family status and social security, parents may believe that an uncut girl will be considered less suitable for marriage. The decision can therefore be framed as an act of parental protection rather than intentional injury. This does not remove the harm, but it explains why purely punitive messages may be ineffective. The social incentive structure must also change.

The connection with family honour illustrates how gendered expectations operate. Female sexuality can be placed under heightened social surveillance, and bodily modification may be used symbolically to demonstrate that a girl has been raised according to accepted standards.

In this sense, FGM is connected to broader structures of gender inequality. The body becomes a site through which the community expresses its expectations regarding femininity, modesty and sexual conduct.

4.2 Purity, hygiene and aesthetic beliefs

Another recurring justification is the belief that the external female genitalia are dirty, excessive or aesthetically undesirable. Some communities associate cutting with cleanliness or purity. These beliefs are medically unsupported. WHO states that FGM provides no health benefits and instead damages healthy genital tissue. Yet misinformation can be transmitted through family networks, ritual specialists and informal community authority. The social legitimacy of a belief can therefore persist even when it lacks empirical support.

4.3 Religious identity and ritual authority

Religion requires particularly careful treatment in the Indian context. A legal scholar should distinguish between a religious identity, a religious interpretation, and the claim that a specific physical act is constitutionally protected as an essential religious practice. The existence of a religious justification does not automatically answer the constitutional question. Articles 25 and 26 themselves contain limitations, and religious freedom exists within the broader constitutional structure. The Supreme Court's jurisprudence on religious freedom demonstrates that the relationship between individual rights, denominational autonomy and State regulation is complex and remains contested.

At the same time, describing FGM as "a religious practice" should not be converted into a general statement about Islam or Muslims. International bodies such as UNFPA note that FGM is not endorsed by Islam or Christianity as a universal religious requirement, and the practice exists across different religious and cultural settings. In India, the legal dispute is specifically connected to the practice within sections of the Dawoodi Bohra community. The analysis must therefore remain community-specific and evidence-based rather than generalising from a particular practice to an entire religion.

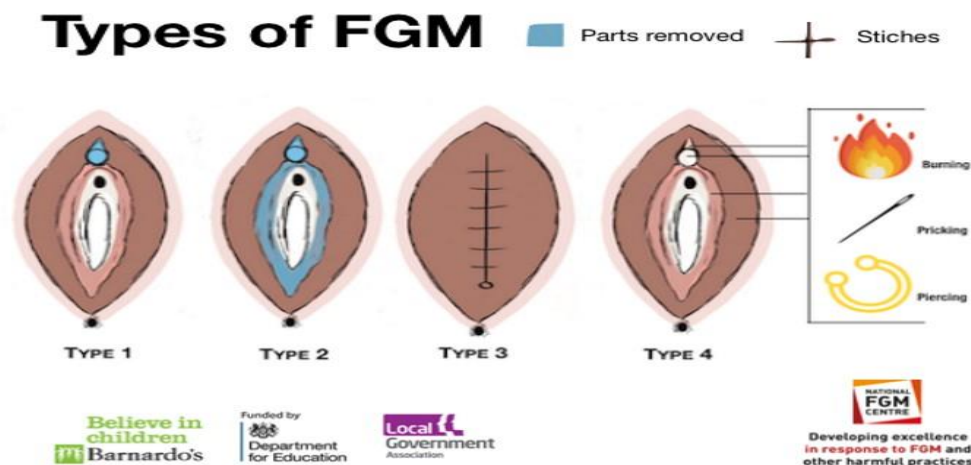
4.4 Fear of social exclusion and excommunication

The fear of social exclusion is particularly significant in tightly knit communities. The original project identifies excommunication and social sanctions as factors that may pressure parents to conform. Social exclusion can operate through loss of community relationships, difficulties in participating in communal life, stigma, or perceived consequences for marriage and family reputation. The sociological force of such sanctions can be greater than formal legal penalties because they affect everyday life and social belonging.

Indian law has recognised that social boycott can itself cause serious harm. Maharashtra enacted the Maharashtra Prohibition of People from Social Boycott (Prevention, Prohibition and Redressal) Act, 2016. The existence of such legislation is relevant to FGM not because the statute directly criminalises FGM, but because it demonstrates a legislative understanding that collective social sanctions can be coercive. A comprehensive policy against FGM should therefore address both the physical act and the social conditions that discourage victims or families from resisting it.

5. TYPES OF FGM AND THE NATURE OF THE HARM

WHO's fourfold classification is now the most widely used international framework. Type 1 involves partial or total removal of the clitoral glans and/or prepuce. Type 2 involves removal of the clitoral glans and labia minora, with or without removal of the labia majora. Type 3, infibulation, involves narrowing the vaginal opening through creation of a covering seal. Type 4 encompasses other non-medical harmful procedures such as pricking, piercing, incising, scraping or cauterising. The classification is descriptive rather than a scale that identifies one form as acceptable and another as unacceptable; WHO's position is that every form has no health benefit and carries risk (WHO, 2025).



Source: National FGM Centre, Developing excellence in response to FGM and other harmful practices.

The health consequences depend on the type of procedure, the skill and conditions under which it is performed, the age and health of the girl, and access to treatment. Immediate consequences can include severe pain, bleeding, shock, infection and urinary problems. Long-term consequences may include cysts, scar tissue, menstrual difficulties, chronic pain, sexual dysfunction and obstetric complications. The risk of complications increases with more extensive forms, but a less extensive procedure cannot be assumed to be medically harmless merely because the physical alteration is smaller.

The distinction between medical necessity and cultural practice is critical. A medically indicated procedure may be justified by therapeutic necessity under ordinary medical law and ethics. FGM lacks such medical justification. UNFPA expressly rejects the idea that performing FGM in a clinic makes it safe. Medicalisation can create a false perception of legitimacy and may undermine prevention. It can also involve health professionals in violating the principle of non-maleficence. The appropriate public-health response is therefore not to make FGM safer through routine medical performance, but to prevent the practice while providing compassionate care to survivors.

5.1 Physical and reproductive consequence

The physical effects of FGM extend beyond the moment of cutting. Scar tissue can interfere with urination and menstruation, and some survivors experience recurrent infections or cyst formation. Sexual intercourse can be painful, particularly where scar tissue or narrowing is significant. During childbirth, women who have undergone more extensive forms may require specialised obstetric care. WHO has reported an association between FGM and increased obstetric complications, including risks affecting newborns. These consequences demonstrate why FGM should be treated as a reproductive-health issue rather than merely a ceremonial event.

5.2 Psychological and social consequences

Psychological effects are more difficult to measure because survivors experience the practice differently and because stigma may inhibit disclosure. Some survivors report fear, anxiety, shame, anger, trauma and distress associated with the memory of the procedure. The social meaning of FGM can intensify these effects: a survivor may simultaneously experience harm from the procedure and pressure to defend it as part of her community identity. This creates a complex situation in which legal intervention must avoid treating survivors as passive objects while providing confidential and culturally sensitive support.

5.3 Medicalisation

Medicalisation has emerged as a significant global concern. UNFPA reports that approximately one in four girls and women aged fifteen to forty-nine who have undergone FGM had the procedure performed by a health worker, although the proportion varies substantially by country. The medical setting may reduce some immediate risks associated with unsanitary instruments but does not remove the underlying injury or human-rights problem. A health professional's participation can also confer institutional legitimacy. Accordingly, health policy should prohibit medical personnel from performing FGM while ensuring that healthcare workers are trained to identify survivors, treat complications and provide non-judgmental counselling (UNFPA).

6. GLOBAL PREVALENCE AND THE PROBLEM OF DATA

The global scale of FGM is now documented far more clearly than when the original project was prepared in 2023. UNICEF reported in 2024 that more than 230 million girls and women alive today had undergone FGM, representing a substantial increase over earlier estimates. The largest share of survivors is concentrated in Africa, followed by Asia and the Middle East. WHO's 2025 fact sheet similarly reports more than 230 million survivors in the countries where the practice is concentrated. These figures must be interpreted carefully: they are not an estimate of the number of people subjected to FGM in every country worldwide, and national prevalence varies considerably.

The increase in the absolute number of survivors does not necessarily mean that the prevalence rate is increasing everywhere. Population growth in practising countries can produce a larger number of survivors even where the proportion of girls undergoing the practice declines. UNICEF has therefore emphasised that the pace of decline must accelerate substantially to meet the Sustainable Development Goal target of elimination by 2030. The statistical lesson is that prevalence, incidence, population growth and absolute survivor numbers should not be conflated.

India presents a distinct data problem. There is no nationally representative official dataset that establishes the prevalence of FGM across the Indian population. Studies conducted by civil society organisations have attempted to document the practice among sections of the Dawoodi Bohra community, but their findings should not be treated as national prevalence estimates. The absence of official data creates two risks. First, it can lead to under-recognition and policy neglect. Second, weak data can be used to overstate the prevalence or to make claims that cannot be scientifically supported. A responsible socio-legal analysis must therefore distinguish between documented community-level studies, survivor testimony, media reporting and nationally representative evidence.

Data collection also raises privacy concerns. FGM is a sensitive practice involving minors, sexuality, family relationships and religious identity. Any national system must use strict confidentiality, survivor-centred procedures and safeguards against disclosure. Data collection should serve protection and policy design rather than surveillance of a community. The State should also avoid creating databases that expose survivors to retaliation. A rights-based information system must therefore balance statistical visibility with individual privacy.

6.1 Education, wealth and social change

UNICEF's research on FGM has repeatedly examined the relationship between the practice and education, residence, wealth and attitudes. Education is not a simple causal solution, but it can alter exposure to information, increase access to health services and broaden opportunities beyond traditional marriage structures. The relationship between household wealth and FGM is also context-specific. Social norms can remain powerful among educated or economically secure families because the practice is not reducible to ignorance or poverty. This is particularly relevant to India, where the community commonly discussed in relation to FGM is often described as relatively urbanised and educationally advanced. Socioeconomic status alone therefore cannot explain persistence.

The more useful analytical question is whether education changes social expectations. A girl may be educated and still be subjected to FGM if her family believes that every other family in the community expects it. Conversely, religious leaders, parents, women, men and young people can collectively alter expectations even without a complete transformation of socioeconomic conditions. This is why social-norm interventions increasingly emphasise collective deliberation rather than information campaigns alone.

7. THE DAWOODI BOHRA CONTEXT IN INDIA

The Indian debate over FGM is closely associated with the Dawoodi Bohra community, a Shia Muslim community with a long historical presence in western India. The original project describes the Bohra community as a trading community with historical links to Gujarat and Yemen. Contemporary scholarship and advocacy literature commonly describe khatna or khafz as a practice performed on young girls within sections of the community. The paper does not assume that all Bohras practise FGM, nor that every member of the community holds the same religious interpretation. The relevant sociological unit is the specific practice and the social structures that sustain it.

The practice discussed in the Indian litigation is generally described as involving the cutting of the prepuce or clitoral hood and is commonly associated with Type I FGM under the WHO classification, although the precise procedure may vary. The distinction matters because arguments about the practice sometimes rely on its limited physical extent to differentiate it from more extensive forms of FGM. WHO's definition, however, does not require extensive tissue removal; injury to female genital organs for non-medical reasons is included. Consequently, the legal question cannot be resolved merely by describing the practice as a "small" cut.

Community identity also shapes the debate. For some adherents, khatna is understood as a religious or cultural rite connected to purity and identity. For opponents within the community, including survivor-led organisations and reform advocates, the same practice is understood as an irreversible bodily injury imposed upon a child without meaningful consent. These divergent perspectives demonstrate why the law should avoid treating the community as internally homogeneous. The most constitutionally relevant distinction may be between the collective right to maintain religious identity and the individual right of a child to bodily integrity.

7.1 Social authority and the role of religious leadership

The original project places substantial emphasis on the authority of the Dai and on the fear of community sanctions. The broader sociological point is that religious institutions can influence behaviour through formal teachings, informal expectations and social networks. Where a religious leader or community institution is perceived as authoritative, families may follow a practice even when they have personal doubts. The same institutional structure can also become an instrument for reform if authoritative leaders publicly reinterpret the practice or support abandonment.

This is why legal reform and religious dialogue should not be treated as mutually exclusive. Constitutional law may determine the outer limits of permissible conduct, but social change often requires internal actors who can articulate change in terms that community members regard as legitimate. Survivor groups, women leaders, religious scholars, healthcare workers and youth organisations can play complementary roles. A legal prohibition without social engagement may drive the practice underground; social dialogue without enforceable protection may leave children vulnerable. Both dimensions are therefore necessary.

8. CONSTITUTIONAL FRAMEWORK IN INDIA

8.1 Article 14: Equality and non-arbitrariness

Article 14 guarantees equality before the law and equal protection of the laws. FGM raises an equality question because the practice is imposed upon female children on the basis of sex and is connected to gendered expectations concerning sexuality and purity. A constitutional analysis should, however, distinguish between formal sex classification and substantive gender inequality. The harm is not merely that girls receive a different ritual from boys; it is that the practice can operate as a mechanism for controlling female sexuality and modifying the female body to conform to social expectations.

The equality analysis can therefore be linked to substantive dignity. If a social practice perpetuates a gender hierarchy in which girls' bodies are treated as objects to be regulated for family or community purposes, it raises concerns that extend beyond classification. The Supreme Court's broader constitutional jurisprudence has increasingly recognised dignity, autonomy and equality as interconnected values. The precise doctrinal application to FGM remains for the Court to determine, but the constitutional concerns are identifiable.

8.2 Article 15: Sex discrimination

Article 15 prohibits discrimination on specified grounds including sex. FGM's gendered character makes Article 15 relevant, particularly where the practice is justified by expectations about female chastity, sexual restraint or marriageability. However, the legal analysis must account for the doctrinal question of who is discriminating against whom and whether the constitutional prohibition is directly applicable to private community conduct or operates through State action. A dedicated statute could address this gap by translating constitutional values into enforceable duties applicable to private actors.

8.3 Article 21: Life, dignity, privacy and bodily autonomy

Article 21 is central to the contemporary constitutional analysis. The Supreme Court has interpreted "life" broadly to include dignity and has recognised privacy as a constitutionally protected interest in *K.S. Puttaswamy (Retd.) v Union of India*. Bodily autonomy is closely⁴ connected to privacy, dignity and decisional freedom. When a child undergoes an irreversible genital procedure for non-medical reasons without meaningful consent, the practice directly raises questions about who has authority to make decisions concerning the child's body. The constitutional problem is intensified by age. Adult

⁴ Constitution of India, arts 14, 15 and 21; *K.S. Puttaswamy (Retd.) v Union of India* (2017) 10 SCC 1.

autonomy permits individuals to make many intimate decisions for themselves, subject to law. Children, by contrast, possess evolving capacities and require protection against decisions that permanently affect bodily integrity. Parental authority is important but not unlimited. Parents ordinarily make medical and welfare decisions for children because they have responsibilities toward them; parental consent does not automatically legitimise every physical injury inflicted upon a child. This distinction is particularly important in assessing whether parental or communal consent can justify FGM.

8.4 Article 25: Freedom of conscience and religion

Article 25 protects freedom of conscience and the right freely to profess, practise and propagate religion, subject to public order, morality, health and the other provisions of Part III. The text itself therefore recognises that religious freedom is not absolute. A claim that FGM is religious must first be examined as a matter of constitutional doctrine: is the practice religious at all, is it essential or integral to the claimed religious practice, and does the practice fall within the constitutional limitations? These questions have been debated in the *Sunita Tiwari* litigation and in the broader jurisprudence concerning essential religious practices.

The health limitation is particularly relevant. WHO and UNFPA identify FGM as having no health benefit and significant health risks. If a court finds the practice harmful to health, Article 25 expressly contemplates State regulation. Morality is more complex because constitutional morality cannot simply be equated with the personal morality of a majority. It must be grounded in constitutional commitments to dignity, equality and liberty. The challenge is to avoid using "morality" as a vague substitute for judicial preference while recognising that the Constitution itself places limits on religious practice.

8.5 Article 26: Denominational autonomy

Article 26 grants every religious denomination or section thereof the right to manage its own affairs in matters of religion, subject to public order, morality and health. The provision is important to the FGM controversy because the practice is defended as a denominational practice. Yet Article 26 protects religious affairs within constitutional limits; it does not create an independent sphere immune from rights-based scrutiny. The Supreme Court's treatment of denominational autonomy and religious practices has developed through several cases and remains a contested area of constitutional law.

A crucial distinction is between managing a religious institution and physically altering the body of a child. The latter directly implicates individual rights. The more a practice affects an individual's bodily integrity, the stronger the argument that the Constitution should scrutinise it as an exercise of community power rather than merely as internal institutional management. This does not eliminate the denominational-rights claim, but it changes the nature of the constitutional inquiry.

9. STATUTORY LEGAL FRAMEWORK IN INDIA

9.1 The absence of a dedicated anti-FGM statute

India does not presently have a dedicated central statute that defines and expressly criminalises female genital mutilation as a distinct offence. This was a central concern of the original project and remains relevant. The absence of a specific offence creates uncertainty concerning classification, investigation, reporting, victim support and responsibility for persons who facilitate or arrange the procedure. It also makes public awareness more difficult because the legal system does not communicate the prohibition through a single, identifiable statutory provision.

However, it would be inaccurate to conclude that FGM is therefore legally permissible. A recent legal analysis of the Indian framework has noted that the conduct may potentially attract provisions of the *Bharatiya Nyaya Sanhita*, 2023 and, where the victim is a child, the *Protection of Children from Sexual Offences Act*, 2012. The practical issue is therefore one of legal coverage, clarity and enforcement rather than a complete absence of legal remedies.

9.2 *Bharatiya Nyaya Sanhita*, 2023

The *Bharatiya Nyaya Sanhita*, 2023 replaced the Indian Penal Code with effect from 1 July⁵ 2024. Its provisions concerning hurt and grievous hurt are particularly relevant. Section 114 addresses voluntarily causing hurt, while Section 116 defines grievous hurt. Section 116 includes categories such as permanent impairment of the powers of a member or joint and injuries that endanger life or cause severe bodily pain or inability to pursue ordinary activities for the specified period. Depending on the facts and medical evidence, forms of FGM may therefore fall within the general offences of hurt or grievous hurt (*India Code*, BNS, 2023).

The general criminal-law route nevertheless has limitations. A prosecutor must fit the conduct into the statutory elements of the offence. Questions may arise concerning the nature of injury, intention or knowledge, causation, evidentiary proof and the role of parents or facilitators. A dedicated offence could expressly criminalise performing, arranging, aiding, procuring or facilitating FGM and could establish special rules for child victims. Such specificity could reduce ambiguity and improve institutional awareness.

⁵ *Bharatiya Nyaya Sanhita* 2023, including the provisions concerning voluntarily causing hurt and grievous hurt; *India Code*, Act No 45 of 2023.

9.3 Protection of Children from Sexual Offences Act, 2012

POCSO is highly relevant where the person subjected to FGM is below eighteen. The Act protects children against penetrative and non-penetrative sexual assault and contains provisions dealing with aggravated forms, reporting, medical examination, Special Courts and child-sensitive procedures. Whether a particular instance of FGM falls within a particular POCSO provision depends upon the factual and statutory elements of the offence. The important point is that the child's age creates an additional protective framework beyond general criminal law. Section 42A of POCSO provides that the Act is in addition to and not in derogation of other laws, subject to the statutory framework. The Act also contains mandatory reporting provisions. This can be significant where a healthcare professional, teacher, family member or other person becomes aware of conduct falling within POCSO. At the same time, reporting duties must be implemented with sensitivity because FGM often occurs within family and community networks. A survivor-centred system must ensure safety, confidentiality within the limits of law, counselling and protection against retaliation.

9.4 Child-rights legislation and constitutional protection

The child-protection framework must be read alongside constitutional rights. A child is not merely a future adult; the child possesses present rights to dignity, bodily integrity and development. The Juvenile Justice (Care and Protection of Children) Act, 2015 and child-protection institutions may become relevant depending on the circumstances, particularly where a child is at continuing risk. The legal system should not wait until permanent injury has occurred if credible information indicates that a child is about to be subjected to FGM.

9.5 Medical and professional regulation

Medical regulation is another important layer. The National Medical Commission framework and professional ethics principles require doctors to act in the patient's interest and avoid harmful practices. Because medicalisation can create a false appearance of safety, healthcare institutions should adopt clear protocols for identifying FGM, treating complications and refusing to perform non-medical genital cutting. Training is particularly important because healthcare professionals may encounter survivors during gynaecological, obstetric or paediatric care even when the patient does not initially disclose the history.

10. INTERNATIONAL HUMAN RIGHTS FRAMEWORK

FGM is addressed through multiple international human-rights instruments even though not every treaty contains an express provision using the term FGM. The practice engages the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Convention on the Rights of the Child (CRC), the International Covenant on Economic, Social and Cultural Rights, the International Covenant on Civil and Political Rights and broader international commitments concerning violence against women and harmful practices. The international framework is cumulative: equality, health, bodily integrity, dignity and child protection reinforce one another.

10.1 CEDAW

CEDAW requires States to eliminate discrimination against women and to modify social and cultural patterns that are based on ideas of the inferiority or superiority of either sex or stereotyped roles. FGM is relevant because it can operate as a mechanism for enforcing gendered expectations concerning sexuality and marriage. The Convention's framework therefore supports a state obligation not merely to punish individual perpetrators but to address social structures that reproduce discriminatory practices.

10.2 Convention on the Rights of the Child

The CRC is particularly important because FGM is frequently performed on minors. Article 3¹⁰ establishes the best interests of the child as a primary consideration in actions concerning children. Article 19 requires protection from physical or mental violence, injury or abuse, while Article 24 recognises the child's right to the highest attainable standard of health and directs States to take effective measures to abolish traditional practices prejudicial to children's health. These provisions provide a strong international legal basis for treating FGM as a child protection concern rather than simply a matter of parental choice.

10.3 International Covenant on Civil and Political Rights

The ICCPR protects rights relevant to bodily integrity, equality and freedom from cruel, inhuman or degrading treatment. The right to privacy can also be engaged where bodily integrity and personal autonomy are violated. The Covenant's protection of freedom of religion does not make religious practices immune from restrictions necessary to protect public safety, order, health, or the fundamental rights and freedoms of others. The international framework therefore, reflects the same basic balancing problem found in Articles 25 and 26 of the Indian Constitution.

10.4 Sustainable Development Goal 5.3

The global development framework reinforces the human-rights approach. Sustainable Development Goal target 5.3 calls for the elimination of all harmful practices, including child, early and forced marriage and female genital mutilation. UNICEF has observed that progress must accelerate significantly to meet the 2030 target. The inclusion of FGM in the development agenda demonstrates that the practice is connected not only to health but also to gender equality, education, poverty reduction and social participation.

11. JUDICIAL DEVELOPMENT IN INDIA

11.1 *Sunita Tiwari v Union of India*⁶

The principal Indian litigation concerning FGM is *Sunita Tiwari v Union of India*, W.P. (C) No. 286 of 2017. The petition challenged the practice of FGM or khatna and invoked constitutional and international rights. In September 2018, the Supreme Court recorded that the controversy involved significant questions concerning Article 21 and the claim that the practice was protected under Article 26. Rather than finally deciding the questions, the Court considered it appropriate that the matter be placed before a larger Bench. The order reflects the constitutional sensitivity of the dispute and its connection with the broader jurisprudence on religious freedom.

The case is important not because it has already produced a final constitutional answer, but because it frames the central legal conflict. The petitioner's position focuses on bodily integrity, privacy, dignity, equality and child protection. The opposing position has argued that the practice is a religious or denominational practice and that it should receive constitutional protection. The larger constitutional issue is therefore whether the State can restrict a practice claimed to be religious where the practice affects the body of a child and where health and gender equality are implicated.

11.2 *The 2026 constitutional hearings*

The constitutional debate became especially significant in 2026 when a nine-judge Constitution Bench considered questions concerning Articles 25 and 26 in connected litigation that included the FGM controversy. Reports of the May 2026 hearings record oral observations concerning health, sexual autonomy and the constitutional limitations upon religious freedom. These were oral observations during proceedings and should not be treated as a final judicial determination on the legality of FGM. As of September 2026, available case-status information continues to describe the *Sunita Tiwari* matter as pending rather than finally decided. Accordingly, the current legal position must not be misstated as though the Supreme Court has already issued a final judgment banning or upholding FGM.

This procedural status is crucial for legal research. A pending constitutional case cannot be cited as settled law on the proposition that FGM is constitutionally invalid. At the same time, the proceedings demonstrate that the issue has moved beyond preliminary litigation and is being considered within the Supreme Court's contemporary jurisprudence on religious freedom. A research paper should therefore distinguish between existing statutory provisions, prior judicial orders, oral observations, and a final ratio decidendi. The distinction is essential to doctrinal accuracy.

11.3 *Essential religious practices and bodily integrity*

The essential-religious-practices doctrine has historically asked whether a particular practice is essential or integral to a religion. The doctrine has attracted substantial scholarly debate because courts may be required to evaluate religious texts and internal religious practice. FGM presents an additional difficulty because the person whose body is altered may be a child who has not chosen the practice. Even if a community establishes that a ritual has religious significance, the constitutional inquiry may still ask whether the State can regulate the practice to protect health, dignity and the rights of others. The doctrine should therefore not be treated as an automatic trump card. Article 25 itself contains express limitations, and Article 26 is similarly qualified. The constitutional challenge is to design a test that respects religious freedom while ensuring that the individual does not become invisible within the community. This is especially important where the practice is performed upon a child who cannot meaningfully participate in the constitutional claim made on her behalf.

12. RELIGIOUS FREEDOM, CULTURAL RELATIVISM AND CONSTITUTIONAL MORALITY

The debate over FGM often becomes framed as culture versus rights. That formulation is too simplistic. Culture is not a fixed object that exists independently of individuals; it is produced and reproduced through human behaviour. Communities also contain disagreement, reform movements and internal criticism. Respect for cultural diversity therefore requires respect for community members as rights-bearing individuals, including women and girls who contest a practice associated with their own community.

Cultural relativism remains analytically useful because it warns against assuming that external observers possess an uncontested moral authority. Anthropological scholarship has shown that practices can carry meanings that are invisible to outsiders. However, cultural relativism does not necessarily require legal non-intervention. International human-rights law itself recognises cultural rights while placing limits where practices cause discrimination or serious harm. The legal challenge is therefore to avoid both cultural imperialism and cultural exceptionalism. Constitutional morality offers one possible

⁶ *Sunita Tiwari v Union of India*, W.P. (C) No 286/2017, Supreme Court of India; subsequent proceedings concerning the constitutional questions surrounding FGM.

framework for this balance, but it should be used carefully. In Indian constitutional jurisprudence, constitutional morality has been invoked to protect individual dignity and equality against social practices that conflict with constitutional commitments. Yet "constitutional morality" should not become an undefined licence for courts to substitute personal values for constitutional text. In the FGM context, its strongest foundation lies in express constitutional principles: equality, non-discrimination, dignity, privacy, bodily integrity, health and the qualified nature of religious freedom.

The constitutional issue may ultimately be framed as a conflict between two kinds of autonomy. Religious communities possess collective autonomy to organise aspects of communal life, while individuals possess bodily autonomy and dignity. When collective autonomy requires an irreversible physical intervention upon a child, the constitutional balance becomes particularly difficult. The legal system must decide how far collective rights can extend into the intimate bodily sphere of a non-consenting individual.

13. THE PROBLEM OF CONSENT

Consent is central to the FGM debate. The original project identifies the practice as frequently being performed upon girls at a young age. Where a child is the subject, parental consent raises a distinct question from personal consent. Parents ordinarily make decisions for children, but parental authority is fiduciary and welfare-oriented rather than absolute ownership over the child's body. The law permits parents to consent to beneficial medical treatment because children require representation; the justification is substantially weaker when the intervention has no therapeutic purpose and carries recognised health risks.

The concept of consent is also complicated by social pressure. Even an adult may experience pressure from family or community, but a child has far less ability to resist, understand long-term consequences or secure alternative social support. The possibility of social coercion means that a formal statement that the procedure was "voluntary" should not automatically resolve the issue. The legal system should examine age, information, circumstances, family pressure and the availability of meaningful alternatives.

For adult survivors seeking treatment or counselling, the law should recognise their agency and avoid treating them solely as victims. A survivor may identify with her community and simultaneously oppose FGM. Legal policy should therefore distinguish between prevention of future cutting, protection of children at risk and services for adults living with the consequences. A single punitive model cannot address all three situations effectively.

14. SOCIAL EXCLUSION, EXCOMMUNICATION AND THE LAW

One of the most significant contributions of a sociological approach is its focus on sanctions that are not imposed by courts. Social exclusion can be a powerful mechanism of legal and customary compliance. If families believe that refusing FGM will affect marriage prospects, religious participation or social relationships, the practice may continue even where legal rules discourage it. The phenomenon demonstrates that law competes with other normative orders: family expectations, community customs, religious authority and peer behaviour.

The law can respond to social sanctions in several ways. It can prohibit threats, coercion and retaliation; it can protect whistleblowers and witnesses; it can provide confidential reporting channels; and it can recognise social boycott as an independent form of harm where statutory elements are satisfied. The Maharashtra social-boycott legislation provides an example of the State treating collective exclusion as a legal concern. For FGM, such measures are relevant because families seeking to protect a child may themselves become targets of community pressure.

However, the State should not assume that every religious or community disagreement constitutes unlawful coercion. A careful legal framework must identify conduct that crosses the threshold into threat, harassment, intimidation or social boycott. Overbroad regulation may itself interfere with lawful freedom of association and religion. The objective should be to protect individuals from coercive sanctions while preserving ordinary community dialogue and dissent.

15. THE ROLE OF FAMILY, COMMUNITY AND GENDER

FGM is often carried out not by anonymous outsiders but through family and community networks. Mothers, grandmothers, fathers, relatives and traditional practitioners can all play different roles. This is sociologically important because it complicates a simple perpetrator victim model. A mother who experienced FGM herself may support the procedure because she believes it protects her daughter from social rejection. A father may agree because he associates the practice with family honour. A grandmother may treat it as a rite of passage. These motivations do not negate the child's injury, but they matter for designing interventions.

Gender relations within the family can also shape decision-making. Women may become custodians of a practice even when the broader social norm reflects patriarchal expectations. Therefore, describing FGM as something "men do to women" may overlook the mechanisms through which women reproduce social norms. At the same time, it would be equally misleading to treat female participation as evidence that the practice is free from gender inequality. Social norms can be reproduced by members of the very group constrained by them. Effective reform must therefore involve both women and men. Girls need safe spaces to discuss bodily autonomy; mothers need support to resist social pressure; fathers need accurate information about health and rights; community leaders need credible alternatives to ritual cutting; and boys and men need to understand that female sexuality is not a matter to be controlled through bodily injury. Reform becomes more durable when it changes the expectations of the entire social network rather than placing responsibility solely upon potential victims.

16. FGM AND REPRODUCTIVE RIGHTS

Reproductive rights encompass more than the right to avoid pregnancy. They include the ability to make decisions about one's reproductive and sexual life, access healthcare, and exercise bodily autonomy without coercion. FGM can interfere with these rights because it alters genital anatomy without a

therapeutic purpose and can produce consequences for sexual function, menstruation, childbirth and psychological well-being. The connection between FGM and reproductive rights is therefore direct rather than incidental.

The Centre for Reproductive Rights' framework on women's reproductive rights emphasises the relationship between reproductive autonomy and human rights. The same approach can be applied to FGM: a woman or girl cannot exercise meaningful control over her reproductive life if her body has been irreversibly modified without meaningful consent. The issue is not simply physical injury; it is the denial of agency in relation to an intimate part of the body.

At the same time, reproductive-rights analysis should not imply that the value of the girl's body lies only in future reproductive capacity. FGM is wrong, where prohibited by law, because of bodily integrity and dignity in the present. A child is entitled to protection even if the procedure does not later cause infertility or obstetric complications. The right being protected is therefore broader than reproductive capacity; it includes the integrity of the person herself.

17. FGM AND PUBLIC HEALTH

A public-health response must operate at three levels: prevention, treatment and institutional capacity. Prevention requires accurate information about the absence of medical benefits and the possibility of serious complications. Treatment requires accessible, confidential and nonjudgmental care for survivors. Institutional capacity requires training healthcare providers to identify risk, respond to complications and make appropriate referrals. WHO and UNFPA both emphasise the role of healthcare workers in prevention and survivor care.

Healthcare institutions should also recognise that survivors may present with symptoms that are not immediately disclosed as consequences of FGM. Menstrual pain, recurrent urinary problems, sexual pain, obstetric complications and psychological distress may have multiple causes. Providers should therefore use sensitive history-taking rather than assuming or forcing disclosure. Care should be trauma-informed and should avoid blaming families or survivors. The economic dimension is also relevant. WHO estimates that treatment of health complications associated with FGM costs health systems approximately US\$1.4 billion annually. Although this is a global estimate and cannot be directly applied to India, it demonstrates that FGM imposes costs not only on individuals but also on public health systems.

Prevention is therefore both a rights objective and a health-system objective.

18. LAW, SOCIAL NORMS AND THE LIMITS OF CRIMINALISATION

Criminalisation is important because it communicates a clear normative boundary and creates consequences for conduct that seriously violates bodily integrity. Yet criminal law alone cannot transform a social norm. If FGM is hidden because families fear prosecution, the practice may move to less visible settings. If survivors fear that reporting will lead to family separation or community retaliation, under-reporting may continue. A purely punitive framework can therefore produce unintended consequences unless accompanied by protection and social support.

The experience of other countries indicates that legal prohibition is most effective when combined with community engagement, education, health services and institutional enforcement. UNFPA and UNICEF's social-norm approach emphasises collective abandonment because no individual family should have to bear the social cost of being the first to stop. This insight is directly applicable to India. The State should create conditions in which choosing not to subject a girl to FGM does not place her family at a social disadvantage. Criminal law must also identify responsibility accurately. A future Indian anti-FGM statute could distinguish between the person who physically performs the procedure, persons who arrange or procure it, those who knowingly facilitate it, and persons who threaten or retaliate against families that refuse. It could establish enhanced protection where the victim is a child, while avoiding provisions that inadvertently punish survivors themselves. The law should focus on prevention and accountability rather than criminalising persons for having undergone the practice.

A carefully designed statute could also include duties for institutions, health professionals and schools, subject to privacy and due-process safeguards. Reporting mechanisms should be accessible, and authorities should receive specialised training. The objective should not be to create a broad offence that is rarely enforced, but to establish a coherent legal architecture that institutions can understand and implement.

19. COMPARATIVE LEGAL PERSPECTIVE

A comparative approach demonstrates that States have adopted different models to address FGM. Some countries have enacted specific criminal prohibitions; others rely substantially upon general assault or child-protection offences; some combine criminal law with specialised prevention programmes. The existence of a specific offence can improve visibility and provide a clear statutory definition, but criminalisation alone does not guarantee elimination. Enforcement, reporting, social acceptance and access to services remain critical.

In the United Kingdom, for example, specific legislation addresses FGM and related offences, including assisting or arranging the practice. Australia has also developed state and territory legislation and has used criminal law to address FGM. Several African States have enacted specific laws in response to national prevalence. These examples are not directly transferable to India because legal systems, constitutional structures and community dynamics differ. Their value lies in identifying design options: precise definitions, extraterritorial reach where appropriate, protection of children, duties of professionals, victim support and community prevention.

Comparative law also demonstrates the danger of focusing only on punishment. International experience shows that the practice may be displaced geographically or driven underground when families remain committed to the social norm. Effective programmes therefore combine legal enforcement with education, community declarations, engagement of religious leaders, survivor-led advocacy and healthcare. The comparative lesson for India is not that one foreign statute should be copied, but that legal reform should be embedded in a broader social-change strategy.

20. THE CASE FOR A DEDICATED INDIAN LEGAL FRAMEWORK

The strongest argument for a dedicated Indian legal framework is clarity. At present, possible prosecution through general offences requires authorities to translate FGM into categories such as hurt, grievous hurt or sexual assault. A dedicated statute could define FGM in terms consistent with international standards and expressly prohibit performing, assisting, arranging, procuring or facilitating the practice. It could also clarify jurisdiction, reporting, victim protection and professional duties.

The second argument is preventive capacity. A statute can authorise awareness programmes, institutional protocols, training and data collection. It can establish duties before an injury occurs, rather than relying only upon post-event criminal prosecution. Child-protection systems could receive clear guidance concerning risk indicators and emergency protective measures.

The third argument is constitutional communication. A specific law would make clear that the State respects religious freedom but does not treat religious identity as a defence to nonconsensual bodily injury to children. Such a law would need to be drafted with careful constitutional reasoning so that it regulates the harmful physical act rather than discriminating against a religion or denomination. The target should be the conduct, not the identity of the community.

A fourth consideration is survivor support. Dedicated legislation could provide for medical treatment, counselling, rehabilitation and confidentiality. It could also establish protections against retaliation and social boycott. These provisions would make the law more than a penal statute; they would turn it into a child-protection and public-health instrument.

Any new legislation must nevertheless satisfy constitutional requirements of proportionality, equality and procedural fairness. It should use precise language, define the mental elements of offences where appropriate, provide safeguards for accused persons, and avoid criminalising mere identity or belief. Religious or cultural belief should not be criminalised simply because it is unpopular; the prohibited conduct should be clearly identified as the non-medical injury to the genital organs of another person, especially a child.

21. DATA, REPORTING AND INSTITUTIONAL DESIGN

A major weakness in India's present response is the absence of reliable national prevalence data. However, the solution is not to collect information indiscriminately. Data collection must be designed around privacy, consent where possible, child protection and confidentiality. A national strategy could combine anonymised health surveillance, child-protection reporting, research partnerships and periodic representative surveys where ethically appropriate.

Police and prosecutors should receive standardised guidance on FGM. The guidance should identify relevant BNS and POCSO provisions, evidence collection, medical examination, age determination, child-sensitive interviewing and the protection of witnesses. Courts should be provided with medical and social-context materials that explain the practice without stereotyping the community. Training is especially important because unfamiliarity with the practice can produce either under-enforcement or insensitive investigation.

Schools can serve as an important prevention point. Teachers and counsellors may encounter children who disclose risk or who display fear concerning an upcoming ritual. However, school-based intervention must be designed carefully because careless disclosure can expose a child to family retaliation. The law should therefore establish clear referral mechanisms and child-safety protocols rather than encouraging informal confrontation by school personnel.

Community organisations can help bridge the gap between formal institutions and families. Survivor-led groups are particularly valuable because they can explain the social consequences of refusing FGM and develop culturally intelligible alternatives. The State should support such organisations without controlling their message or compromising their independence.

22. SURVIVOR-CENTRED JUSTICE AND REHABILITATION

A survivor-centred framework recognises that the person affected by FGM may have physical, psychological, social and legal needs simultaneously. Medical treatment should be available without requiring a survivor to participate in criminal proceedings unless legally necessary. Counselling should be confidential and culturally sensitive. Survivors should also be informed about their legal options in understandable language.

Legal proceedings must avoid re-traumatisation. Repeated questioning about intimate bodily details should be minimised, and investigators should receive training in trauma-informed interviewing. Where the survivor is a child, POCSO's special procedures become particularly relevant. The objective should be to obtain reliable evidence while preserving dignity and safety.

Survivor leadership should also inform policy. People who have undergone FGM possess knowledge about how the practice is organised, how social pressure operates and why families comply. Their experiences can help identify prevention points that are invisible in purely doctrinal analysis. Survivor participation should nevertheless remain voluntary; no survivor should be expected to disclose personal experiences for the benefit of public policy.

23. FGM, RELIGION AND INTERNAL REFORM

Internal religious reform can be an important component of social change. Where families believe that FGM is a religious obligation, authoritative clarification from religious scholars can reduce the perceived religious cost of abandoning the practice. International experience shows that religious leaders can become agents of change when they publicly distinguish faith from harmful customs. This does not mean that legal protection should depend upon religious approval. Rather, religious dialogue can complement the legal duty to protect children.

The Indian debate should therefore distinguish between respect for Islam and acceptance of every practice performed by Muslims. No religion is a monolithic institution, and religious interpretation evolves. The claim that FGM is religiously required is itself a matter of interpretation and evidence.

Courts should be cautious about becoming arbiters of theology, but they can examine whether a claimed religious practice is subject to constitutional limitations when it causes physical injury to another person.

Internal reform also reduces the risk of stigmatising the community. A law framed as an attack on a religious group may produce defensive mobilisation and reduce cooperation. A law framed as a general protection against non-medical genital injury to children applies equally regardless of religion. Such neutrality is both constitutionally safer and sociologically more effective.

24. CRITICAL SOCIO-LEGAL SYNTHESIS

The central insight emerging from the preceding analysis is that FGM is simultaneously a bodily act, a social norm, a gendered institution, a child-protection issue and a constitutional problem. Each perspective reveals something the others may miss. Medical analysis establishes physical harm; sociology explains persistence; constitutional law identifies competing rights; criminal law supplies sanctions; public health provides prevention and treatment; and humanrights law establishes broader normative commitments.

The practice persists partly because the perceived costs of non-conformity can exceed the perceived costs of conformity. A family may know that FGM is medically unnecessary but still believe that refusing it will harm the girl's social future. This means that information about health risks, while necessary, is insufficient. The intervention must alter the expected social consequences of abandonment. Collective declarations, community dialogue and public support for families who refuse can reduce the perceived risk of non-conformity.

The Indian legal framework illustrates a second structural problem: fragmentation. General criminal law, POCSO, constitutional rights, health regulation and social-boycott legislation each address part of the problem but none is specifically designed for FGM. Fragmentation can create uncertainty and inconsistent enforcement. A dedicated framework could provide coherence, but only if accompanied by institutional training and social support.

The constitutional problem is not simply "religion versus women's rights". Religious freedom and individual rights are both constitutional values. The more precise question is how collective religious autonomy should operate when it involves an irreversible physical intervention upon a child. Articles 25 and 26 themselves recognise limitations based on health, morality and other constitutional rights. The final judicial answer will therefore depend upon how the Supreme Court interprets the scope of those provisions and the relationship between denominational autonomy and individual dignity.

The 2026 proceedings demonstrate the continuing evolution of the legal debate. Because the case remains pending, the present paper deliberately avoids treating oral observations as settled law. What can be stated with confidence is that FGM has entered a serious constitutional examination in India and that the relevant legal framework has changed since the original project was written, particularly after the commencement of the BNS and BNSS in 2024. Any current academic paper must therefore avoid relying solely on the 2023 legal position. Finally, the analysis shows that the law should protect both bodily integrity and social belonging. A girl should not have to choose between physical safety and membership in her community. Effective reform therefore requires not only prohibition but also the creation of conditions under which families can reject FGM without fear of ostracism. In that sense, the sociology of law is indispensable: the success of a legal norm depends partly upon whether society develops new expectations capable of sustaining it.

25. POLICY AND LEGAL REFORM DIMENSIONS

A comprehensive response can be organised around several mutually reinforcing dimensions. First, the legal framework should define FGM clearly and prohibit the performance, arrangement, facilitation and procurement of the practice, with enhanced protection for children. Second, the law should preserve existing criminal offences where they provide stronger protection and should clarify how the dedicated offence interacts with the BNS and POCSO. Third, healthcare workers should be prohibited from performing FGM while being trained to provide treatment and support to survivors.

Fourth, the legal framework should address social retaliation. Families and girls who resist FGM should have access to confidential reporting, emergency protection and counselling. Threats, coercion and unlawful social boycott should be actionable under existing or specialised law. Fifth, national and state authorities should establish ethically designed data systems to understand prevalence and risk without exposing survivors or stigmatising communities.

Sixth, education should be integrated into the prevention strategy. Programmes should explain anatomy, health consequences, child rights and legal protections in age-appropriate language. Community dialogue should include parents, religious leaders, healthcare workers and young people. Seventh, survivor organisations should be recognised as partners in policy development. Their participation can improve both the cultural sensitivity and practical effectiveness of interventions.

Eighth, judicial and police training should be institutionalised. FGM cases involve intimate facts, minors, family relationships and religious sensitivity. Poorly trained officials may either minimise the harm or treat the entire community as suspect. Professional training should instead focus on conduct, evidence, child safety and constitutional rights. Ninth, government agencies should coordinate rather than leaving the issue exclusively to criminal justice institutions. Women and child development departments, health departments, police, education authorities and legal services institutions all have distinct roles.

Finally, reform should be evaluated through measurable indicators. The relevant indicators should not be limited to the number of criminal cases registered. They should include access to survivor healthcare, awareness among health professionals, community attitudes, schoollevel reporting pathways, reduction in intended future practice and the availability of protection for families resisting FGM. A reduction in reported cases alone cannot prove success because reporting may decline because the practice becomes more hidden. Social and health indicators must therefore be interpreted together.

26. CONTEMPORARY LEGAL POSITION IN INDIA: AN UPDATED ASSESSMENT

As of September 2026, the Indian legal position can be described in four propositions. First, there is still no dedicated central anti-FGM statute expressly creating an offence under the title of FGM. Second, general criminal law under the BNS can potentially apply to acts causing hurt or grievous hurt, depending on the evidence and statutory elements. Third, where the person subjected to the practice is a child, POCSO may become relevant depending on the facts and the elements of the particular offence. Fourth, the constitutional validity and religious-freedom dimensions of the practice remain before the Supreme Court and have not been finally settled in the Sunita Tiwari litigation.

The transition from the IPC to the BNS is particularly important for students and researchers using older literature. Earlier papers often cite IPC provisions on hurt and grievous hurt.

Current legal writing should identify the corresponding BNS provisions and note the date of commencement. Similarly, older procedural references to the CrPC should be updated where the BNSS now governs procedure. This does not mean that older judicial decisions become irrelevant; their reasoning may remain persuasive or binding where applicable, but statutory references must be read in the contemporary framework.

The legal status should also be distinguished from the social reality. The existence of potentially applicable criminal provisions does not establish effective prevention. The 2024 analysis by the Orchid Project and Asia Network to End FGM/C observed that India lacks a specific law and that no prosecution had been recorded under the FGM-specific framework because no such specific offence existed. This illustrates the difference between theoretical legal coverage and practical enforcement. Future research should therefore examine actual police complaints, prosecutions and judicial orders rather than assuming that statutory applicability automatically translates into protection.

The 2026 Supreme Court hearings further demonstrate that the constitutional question remains live. Reports indicate that the nine-judge Bench considered whether the practice could be restricted on grounds including health and discussed the significance of consent where the subject is a minor. Such observations are legally significant as part of the proceedings but are not a substitute for a final judgment. Academic writing should therefore use cautious language such as "the Court considered", "the petitioners argued", or "the Bench orally observed", rather than stating that the Supreme Court has conclusively declared the practice unconstitutional.

The contemporary position thus remains one of legal incompleteness rather than legal vacuum. There are constitutional protections, general criminal offences, child-protection provisions and international obligations, but no single coherent statutory framework specifically designed for FGM. The continuing litigation provides an opportunity for the judiciary to clarify constitutional limits, while Parliament and State legislatures remain capable of addressing the statutory gaps through constitutionally compliant legislation.

27. INTEGRATED ANALYSIS OF THE PRINCIPAL LEGAL AND SOCIAL ISSUES

The first issue is bodily integrity. FGM involves intentional injury to healthy genital tissue for non-medical reasons. This creates a direct connection with physical integrity, dignity and health. The second issue is childhood. Where the procedure is performed on a minor, the State's protective responsibilities are heightened. The third issue is gender equality because the practice is linked to social regulation of female sexuality. The fourth issue is religion because the practice may be defended as a religious or denominational rite. The fifth issue is enforcement because existing legal provisions are general rather than FGM-specific. The sixth issue is social norms because individual families may face pressure if they resist.

These issues should not be analysed independently. Bodily integrity explains why the State has a legitimate interest in intervention. Childhood explains why parental consent cannot automatically settle the issue. Gender equality explains why the practice has a structural dimension. Religious freedom explains the constitutional difficulty of intervention.

Enforcement explains why statutory clarity matters. Social norms explain why criminalisation alone may not end the practice. The socio-legal approach therefore produces a more complete account than either purely doctrinal constitutional analysis or purely sociological description. The most sustainable approach is one in which legal prohibition, public-health intervention and community-led social change reinforce one another. Law provides the minimum standard of protection; health systems provide treatment and prevention; education provides information; community dialogue changes expectations; and constitutional adjudication clarifies the limits of competing rights. No single institution can perform all of these functions. The problem requires coordination across institutions and across levels of society.

28. SYNTHESIS OF THE ANALYTICAL FINDINGS

The female genital mutilation is not merely a ritual involving a physical alteration of the female body. It is a social institution sustained through expectations about gender, sexuality, purity, marriageability, belonging and religious identity. Its persistence illustrates how powerful social norms can be even when individuals lack complete confidence in the practice. The family may act as the immediate decision-making unit, but the broader community environment can shape the perceived costs and benefits of compliance.

The legal framework must respond to the physical injury without criminalising cultural identity itself. The constitutional protection of religion is real but qualified, and the individual rights to equality, dignity, privacy, health and bodily integrity are equally part of the constitutional order. The particular difficulty of FGM lies in the fact that the person whose body is altered is frequently a child, making the question of consent and parental authority central. The legal system must protect the child as an individual while avoiding stereotypes about the community in which the practice occurs.

The contemporary Indian position remains incomplete. The BNS and POCSO provide potentially relevant routes for prosecution, but neither is designed as a comprehensive FGM statute. The absence of a specific law contributes to definitional, evidentiary and enforcement uncertainty. The Supreme Court's ongoing constitutional consideration of the practice makes the subject especially important for current legal scholarship. Until a final judgment is delivered, academic writing must distinguish carefully between established law, pending constitutional questions and oral observations during hearings.

The sociological evidence also indicates that durable change requires more than criminal punishment. Families must be able to reject FGM without losing social belonging. This requires The sociological evidence also indicates that durable change requires more than criminal punishment. Families must be able to reject FGM without losing social belonging. This requires collective rather than purely individual change. Community leaders, survivors, healthcare professionals, educators, parents and young people each have a role in changing the expectations that sustain the practice. Law can accelerate this transformation by protecting those who resist, penalising coercion and providing accessible services, but social legitimacy ultimately determines whether the new norm becomes self-sustaining. For legal scholarship, FGM therefore offers a broader lesson about the relationship between law and society. A formal prohibition is necessary where a practice causes serious and irreversible harm, but legal effectiveness depends on the social environment in which the prohibition operates. Conversely, cultural recognition cannot become a justification for denying individual rights. The challenge is to construct a constitutional and social order in which religious identity and cultural belonging can flourish without requiring bodily harm to children. This is the central socio-legal tension that continues to define the Indian debate over female genital mutilation.

BIBLIOGRAPHY

Books

1. Comfort Mamoh, 'Female Genital Mutilation- FGM issues of Gender and Human Rights of Women', (Radcliffe Publishing Ltd Oxford 2005).
2. Raya & Diana Patricia, 'Female Genital Mutilation and the Perpetuation of Multigenerational Trauma', (The Journal of Psychohistory, Spring 2010).

Reports

1. WHO, Female Genital Mutilation: Report of a WHO Technical Working Group, Geneva (Geneva: World Health Organization 1996).
2. UNICEF-UNFPA, Female Genital Mutilation/Cutting in Eritrea, (2012).
3. United Nations Children's Fund, Female Genital Mutilation/Cutting: A Statistical overview and exploration of the dynamics of change, UNICEF, July 2013.

Journal Articles

1. WHO, Effects of female genital mutilation on childbirth in Africa, Reproductive Health and Research, 2008.
2. Patricia Wheeler, Eliminating FGM: The role of the law, International Journal of Children's rights, Volume No. 11 (2004).
3. Valentina Rita Scotti, The Essential practice of religion Doctrine in India and its application in Pakistan and Malaysia, Stato, Chiese e Pluralismo confessionale, 2016.

Internet websites

1. Debangana Chatterjee, 'What Islam says about Female Genital Cutting and how far are these texts invincible?', Sahiyo, (2018) <https://sahiyo.com/2018/10/06/what-islam-says-about-female-genital-cutting-and-how-far-are-these-texts-invincible-part-1/>
2. UNFPA, Female genital mutilation (FGM) frequently asked questions (2022) <https://www.unfpa.org/resources/female-genital-mutilation-fgm-frequently-asked-questions>