

Title: Ban on Hymenoplasty Impact Assessment IA No: 9589 RPC Reference No: N/A Lead department or agency: DHSC Other departments or agencies: Home Office	Impact Assessment (IA)			
	Date: 19/07/2022			
	Stage: Final			
	Source of intervention: Domestic			
	Type of measure: Primary legislation			
	Contact for enquiries: Paddie Ingleton & Sarah Horne			
RPC Opinion: N/A RPC Opinion Status				

Summary: Intervention and Options

Cost of Preferred (or more likely) Option (in 2019 prices)			
Total Net Present Social Value	Business Net Present Value	Net cost to business per year	Business Impact Target Status
-£0.24m	-£0.04m	£0.004m	N/A

What is the problem under consideration? Why is government action or intervention necessary?

- Hymenoplasty is a procedure which is linked to virginity testing and for which there is no clinical or medical reason. It is a form of violence against women and girls and perpetrates harmful and repressive attitudes towards a woman's sexuality. It can cause long term physical and psychological, direct and in-direct damage to the victims. It is a form of so called 'honour-based' abuse, often the precursor to child/forced marriage, and other forms of abusive control. So long as the option of hymenoplasty is available, some women and girls will be placed under considerable pressure to undergo the procedure. Further education and clinical guidance will only tackle part of the problem. There is no regulation or current legislation that can provide this protection.

What are the policy objectives of the action or intervention and the intended effects?

- To safeguard women and girls and reduce the prevalence of violence against them. To aid education and bring about the cultural shift required to tackle the repressive and controlling attitudes to a women's sexuality. Intervention will give weight to existing and/or being developed guidance, position statements and education. Intervention will legitimise work of the agencies that work closely to support the women and girls impacted and at risk of this procedure.
- Indicators of success will include: health care professionals and clinics no longer offering or carrying out the procedure. This will lead to a reduction in violence against women and girls, who will no longer be subjected to this procedure and will feel safer within their communities. Families and community members will be less likely to force/coerce/shame women and girls into having the procedure.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

The expert panel on hymenoplasty considered several options including using;

- existing legislation – the Panel found that no existing legislation would prevent hymenoplasty taking place;
- guidance and education - if the government were only to ban virginity testing and not hymenoplasty, our messaging around the harms of virginity testing would be undermined and confusing; and
- regulation - this would imply that if certain standards were met. the government accepts the abusive and controlling connotations of the procedure.

The Panel recommended, and government agreed, that only new legislation can provide sufficient protection and for the purposes of this IA we considered two options:

Option 0 - Business as usual. The problem would persist with this option. Women and girls would still be at risk of harm and the dangerous misconceptions that surround virginity would continue to be reinforced and unchallenged.

Option 1 - Bring in legislation to criminalise the carrying out, offering, aiding and abetting of hymenoplasty. Primary legislation is required. Current regulation will not suffice nor are there existing powers to make secondary legislation nor existing offences which would cover hymenoplasty. Legislation to ban hymenoplasty will act as a significant deterrent to doctors and clinics offering and carrying out the procedure and deter individuals who coerce and control women and girls in to having this procedure.

Is this measure likely to impact on international trade and investment?	No			
Are any of these organisations in scope?	Micro Yes	Small Yes	Medium Yes	Large Yes

What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent) NA	Traded:	Non-traded:
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Will the policy be reviewed? It will be reviewed. **If applicable, set review date:** TBC

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:  Date: 19/07/2022

Summary: Analysis & Evidence

Policy Option 1

Description:

FULL ECONOMIC ASSESSMENT

Price Base Year 2019	PV Base Year 2022	Time Period Years 10	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate: -£0.24m

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Cost (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate	£0.24m	-	£0.24m

Description and scale of key monetised costs by 'main affected groups'

The main monetised costs of this policy are familiarisation costs for the NHS and social care. There will also be implementation costs for businesses, in terms of staff training and updating their website. As with other forms of so called 'honour-based' abuse (HBA) offences, like the 2013 Female Genital Mutilation legislation (FGM), this legislative change is intended to be a deterrent and to send a clear signal that hymenoplasty is an unacceptable practice. In line with experience with other HBA crimes, we expect to see very limited police investigations.

Other key non-monetised costs by 'main affected groups'

Hymenoplasty takes place, generally, in private health clinics. There could be a reduction in profits for these clinics, but business will seek to minimise this by providing more of their other services. There will be familiarisation costs to the police, but these are likely to be very small. The legislation is expected to have a deterrent effect and we therefore expect to see very limited police investigations, however if they take place, the costs could be high. Given this uncertainty we have not monetised this cost. The investigation and hearing costs for professional regulators are uncertain and are not estimated.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			NA

Description and scale of key monetised benefits by 'main affected groups'

Clinics offering hymenoplasty are not required to record the number of procedures and therefore we have used data from media investigations to estimate this. In the absence of studies quantifying the benefits of banning hymenoplasty we have presented a breakeven analysis, which compares the costs of banning hymenoplasty to the health benefit of preventing severe anxiety in the women and girls who would otherwise undergo the procedure. We estimate that between 2 to 16 women would need to experience health benefits through reduced harm to outweigh the costs of the policy. The exact number would depend on the duration of any psychological impacts. Physical harm avoided by these women would offer additional benefits.

Other key non-monetised benefits by 'main affected groups'

A ban would stop or reduce the number of procedures taking place, saving many girls and women from harm and abuse. It would convey a clear message that this practice is unacceptable in British society. It would empower women and girls and the wider community to speak out against this and other similar practices, and feel more able to report them. It would stop many women and girls having to be subjected to the procedure, saving them from long term physical and psychological harm.

Key assumptions/sensitivities/risks	Discount rate	1.5%
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There is no information on the number of women and girls affected, or the number of hymenoplasty procedures performed in the UK. The information on the numbers of doctors performing hymenoplasty and clinics advertising the procedure is taken from media reports, and so potentially incomplete. Enforcement activity is uncertain, with limited police investigations our most likely scenario. Key assumptions are on implementation costs to the police, the NHS and social care, and have been estimated following discussions with stakeholders. The IA contains sensitivity analysis, on the benefits of the policy and the costs to business.

BUSINESS ASSESSMENT (Option 1)

Direct impact on business (Equivalent Annual) £m:	
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Costs: £0.04m	Benefits:	Net: £0.04m	Score for Business Impact Target (qualifying

Evidence Base

Problem under consideration and rationale for intervention.

1. This impact assessment assesses the social costs, benefits and risks of implementing a ban on hymenoplasty. As set out below, hymenoplasty is a procedure which is linked to virginity testing and for which there is no clinical or medical reason. It is a form of violence against women and girls and perpetuates harmful and repressive attitudes towards women's sexuality. It can cause long term physical and psychological, direct and in-direct, damage to the victims. It is a form of so called 'honour-based' abuse (HBA), often the precursor to child/forced marriage, and other forms of abusive control. So long as the option of hymenoplasty is available, women will be placed under considerable pressure to undergo the procedure. Education and clinical guidance will only tackle part of the problem. The independent expert panel who reviewed this issue found that there is no regulation or current legislation that can provide this protection (see paragraph 15 onwards below).
2. Hymenoplasty¹, is a procedure undertaken to reconstruct a hymen. This is done by suturing hymenal remnants together at the vaginal opening, or surgically reconstructing the hymen with the purpose of making a woman bleed the next time she has intercourse (but it is not guaranteed that she will bleed), in order to give the impression that she has no history of vaginal intercourse. It can sometimes be advertised as 'virginity surgery'.
3. The World Health Organisation² is clear that the appearance of a hymen is not a reliable indication of absence of intercourse. The hymen also has very few blood vessels and therefore an absence of blood when having sexual intercourse for the first time is also not an indication that a woman has had previous sexual intercourse.
4. In early 2021, following widespread concerns that women and girls were being forced and coerced into undergoing virginity testing and hymenoplasty, the Secretary of State for Health and Social Care and the Home Secretary commissioned urgent policy work to determine if any government intervention was required. This included legislative options and, if required, an assessment of what the right legislative vehicle might be. The review's recommendations included the proposal to criminalise virginity testing. The reviews conclusions for hymenoplasty were not as clear. The majority of stakeholders agreed that hymenoplasty perpetuates harmful myths around virginity and that the procedure could constitute a form of violence against women and girls. As hymenoplasty is classified as a cosmetic procedure there were concerns that banning it would take away the right for women to make decisions about procedures they wish to have and run counter to the current regulation of cosmetic surgery. Therefore, the government committed to establishing an expert panel ('the Panel') to review the procedure in more detail.

¹ also known as Hymenorrhaphy or hymen reconstruction or hymen repair

² [WHO | Eliminating virginity testing](#)

5. The Panel's report was published on the 23 December [Expert panel on hymenoplasty - GOV.UK \(www.gov.uk\)](#), its main recommendation for government is that hymenoplasty should be banned alongside virginity testing.
6. A background paper which summarises the evidence gathered during the intensive review and several other sources of evidence was published alongside the report (see link above). This evidence has been used to inform this Impact Assessment and includes an extensive literature review, position statements from Royal Colleges, recent campaigns and lived experience case studies. This also includes the conversation and positions put forward by the Moral and Ethical Advisory Group (MEAG)³ who were consulted prior to the establishment of the Panel.
7. The Panel found that hymenoplasty is inextricably linked to virginity testing. Hymenoplasty is often undertaken by the same private clinics that offer virginity testing. If a woman or girl "fails" a virginity test, hymen repair surgery might be the logical next step. The continuing availability of hymenoplasty could serve as an incentive for families to seek illegal virginity testing of women and girls. A failure to prohibit hymenoplasty would undermine the Government's commitment to address the violence against women and girls by criminalising virginity testing. It is a harmful practice that creates and exacerbates social, cultural and political beliefs that a woman's value is based on whether or not she is a virgin before marriage.
8. As with virginity testing, hymenoplasty is prevalent in the same conservative cultures with women and girls often coerced, shamed, or forced into undergoing the procedure by family and community members. It is a form of HBA, which can be the precursor to child marriage and forced marriage, and other forms of family coercive control including physical and emotional control. So long as the option of hymenoplasty is available, women will be placed under pressure to undergo the procedure.
9. The Panel describes the physical and psychological risks of hymenoplasty as including:
 - Infection
 - Acute bleeding during the procedure
 - Scarring and narrowing of vaginal opening
 - Reduced sensation/ increased sensation (pain rather than pleasure)
 - Sexual difficulties
 - Depression
 - Anxiety

³ [Moral and Ethical Advisory Group - GOV.UK \(www.gov.uk\)](#)

- Post-Traumatic Stress Disorder
- Reduced or no libido
- Suicide

10. Hymenoplasty is a medical procedure that takes place in clinical settings and is regulated in line with other forms of cosmetic surgery. Online advertising suggests that hymenoplasty procedures are widely available at the cost of around £1,500 - £3,000.⁴ There is anecdotal evidence from one of the case studies provided in the background paper that suggests the procedure may have been carried out in the community by female relatives. Hymenoplasty is an invasive procedure, and the risks associated increase dramatically if carried out in non-clinical settings by unregulated community members.
11. As with virginity testing, the prevalence of hymenoplasty procedures is difficult to estimate as these practices, while currently legal, take place outside of the National Health Service. There is no requirement for the private sector to record numbers of procedures performed within private clinics. The Panel found that the practice is often part of a wider cycle of control and coercion on women and girls which goes undocumented until a woman seeks support and refuge.
12. The Panel confirmed that there is never a medical or clinical need to repair or reconstruct the hymen. The procedure is steeped in attitudes and myths that indirectly harm women and girls. In some very limited circumstances (not least because clinicians have other, non-surgical treatments available), there are procedures that are clinically necessary to remove hymenal remnants caused by external trauma or childbirth. This would involve removing any remaining parts of the hymen to prevent bleeding, infection or discomfort to a woman. Such a procedure does not involve any reconstruction of the hymen but rather removes any remaining traces of the skin. These types of procedures have a medical purpose and are not affected by the legislation.
13. As with virginity testing, it is vital that the harmful misconceptions that surround women's sexuality are challenged. As such, we are embarking on a programme of awareness and education in clinical, education and community settings. However, education and guidance will only help to tackle part of the problem. Only legislation can express the categorical disapproval required to create a cultural shift. A ban would give weight to education and guidance. It would also legitimise the work of the agencies who support women and girls who are placed under unacceptable pressure to conform to the expectations that surround virginity.
14. The government agreed with the Panel's main recommendation and announced its intention to ban hymenoplasty when Parliamentary time allowed in the Women's Health Strategy Vision Document published on the 23 December [Our Vision for the Women's Health Strategy for England - GOV.UK \(www.gov.uk\)](#). The Health and Care Bill has

⁴ Controversial 'virginity tests' sold by UK clinics, BBC Newsbeat, November 2020 <https://www.bbc.co.uk/news/newsbeat-55078634>

provided the earliest legislative vehicle to ban hymenoplasty and the amendment was tabled on the 24 January 2022.

Description of options considered

15. Several options were considered by the Panel, including using existing legislation, regulation, guidance, and focusing on the wider education around virginity. However only government intervention and introducing legislation to ban hymenoplasty met the policy objectives set out below.
16. The Panel found that it cannot be banned through existing regulatory frameworks or offences. As a cosmetic surgical procedure, hymenoplasty is not currently an offence if it is carried out with the patient's consent. No existing legislation prevents hymenoplasty. Sexual offences are not relevant because the surgery is not sexual in nature. The prohibition on female genital mutilation would not cover the surgery, because this only applies to mutilation of certain specific external genitalia. In relation to offences against the person, pressure placed on women to undergo the procedure might mean they are not able to give consent freely.
17. The Panel considered a range of regulatory options. These include regulation of individual practitioners offering hymenoplasty (General Medical Council (GMC)), and organisations providing the premises on which they might be performed (Care Quality Commission (CQC)). As hymenoplasty is currently a regulated activity it would be possible for the regulatory agencies to establish standards for the provision of hymenoplasty. However, whilst the implementation of standards may look to improve the method of the procedure and/or strengthen the safeguarding measures and rules around consent, the risk of psychological and physical harm would persist. Developing these standards would imply that the government accepts the procedure's links to controlling, abusive, and damaging attitudes towards women. This is contrary to the government's commitment to tackle abuse against women and girls in all its forms⁵.
18. During the Panel's discussions anecdotal evidence came to light of the procedure being carried out within the community, outside of regulated healthcare settings. Actions taken by healthcare regulators, such as the GMC, or professional bodies such as RCOG, alone, would not capture these community cases. This is particularly the case if someone who is not a medically trained undertakes the procedure.
19. Children under the age of 16 can consent to treatment if they're believed to have enough intelligence, competence and understanding to fully appreciate what's involved in their treatment. Otherwise, someone with parental responsibility can consent for them⁶. Evidence on hymenoplasty shows that it is the parents, or guardians, of girls and young women that apply pressure for them to undergo the procedure. Allowing parents to consent to the procedure on their child's behalf would not adequately meet the wider policy objective of safeguarding women and girls, and as such, the Panel felt this practice should not continue.

⁵ <https://www.gov.uk/government/publications/tackling-violence-against-women-and-girls-strategy>

⁶ [Consent to treatment - Children and young people - NHS \(www.nhs.uk\)](https://www.nhs.uk)

20. The Panel also considered if the virginity testing guidance or the programme of education would have an impact on hymenoplasty. The impact would be minimal, if any, and both the guidance and education would be undermined if hymenoplasty was to continue, with communities receiving mixed messages that would still perpetrate the damaging attitudes towards a woman's sexuality. Virginity testing and hymenoplasty are intrinsically linked, they are forms of abuse and may be an indication of further risks of harm. If a woman was to present having undergone or being coerced into having the procedure, then safeguarding measures should be put in place. Women would still be at risk of harm if these measures were in place for virginity testing but not hymenoplasty.
21. The government agrees with the Panel's conclusion that only the criminal law can hope to provide women and girls with adequate protection. For the purposes of this impact assessment, we have considered two options:

Option 0 – Business as Usual

22. Under this option, no changes would be made to the current sentencing framework. As a result, the problems stated would remain. Hymenoplasty would continue as it has, being offered and carried out in private healthcare clinics across the UK. Women and girls would be able to 'consent' to undergo the procedure in line with current regulation and guidance. Women and girls would still be at risk of direct and indirect harm from having to undergo the procedure and the dangerous misconceptions that surround virginity would continue to be reinforced and unchallenged.

Option 1 - Bring in legislation to criminalise the carrying out, offering and aiding and abetting

23. Under this option, it would be a UK wide criminal offence to carry out, offer or aid and abet hymenoplasty. Legislation to ban hymenoplasty will act as a significant deterrent to doctors and clinics from offering and carrying out the procedure and will deter those that wish to aid and abet, for example the community and family members that wish to coerce and control women and girls into having procedure to protect so-called family 'honour'.
24. Option 1 is our preferred option. We committed to bringing in legislation to ban hymenoplasty at the earliest opportunity in the Women's Health Strategy vision document⁷, and an amendment was tabled in the Health and Care Bill on the 24 January 2022.⁸

Policy objective

25. The overall policy objective is to safeguard women and girls and reduce the prevalence of violence against them. We will support education to bring about the cultural shift required to tackle the repressive and controlling attitudes to a women's sexuality.
26. Indicators of success will include health care professionals and clinics no longer offering or carrying out the procedure; and families and communities not being able to force, coerce or shame women and girls into having the procedure. Women and girls will no longer be subjected to this abusive procedure and will feel safer within their communities and families. Women and girls will not experience the physical and psychological risks of hymenoplasty outlined above. Police will see women coming forward to press charges,

⁷ <https://www.gov.uk/government/publications/our-vision-for-the-womens-health-strategy-for-england>

⁸ See 231H* <https://bills.parliament.uk/publications/44867/documents/130,1>

resulting in the arrests and convictions of perpetrators (however, we are aware that this number may be small due to the nature of the crime). We may also see the beginning of a cultural shift in certain communities where a women's worth isn't solely judged on virginity and their perceived 'purity'.

Summary and preferred option with description of implementation plan

27. The Panel on hymenoplasty found that the procedure is explicitly linked to virginity testing. It is a form of violence against women and girls and perpetrates harmful and repressive attitudes towards a women's sexuality. There is a no clinical medical reason for the procedure to take place and it can cause long term physical and psychological, direct and in-direct damage to the victims. As with virginity testing, it is a form of HBA, which can be the precursor to child marriage and forced marriage, and other forms of coercive control including physical and emotional control. So long as the option of hymenoplasty is available, women will be placed under considerable pressure to undergo the procedure. Only criminalisation can provide this protection.
28. Our preferred option is to legislate against hymenoplasty (option 1). As part of the Women's Health Strategy Vision⁹ published in December 2021, the Government committed to banning hymenoplasty at the earliest legislative opportunity. The Health and Care Bill provides that opportunity and an amendment was tabled on the 24 January in Committee stages of the Lords.
29. It will be a criminal offence to carry out, to offer to carry out or aid and abet hymenoplasty. Hymenoplasty is the reconstruction of a hymen. These offences will be triable either way (meaning they may be tried as either an indictable offence or a summary offence). They will have a similar seriousness to that of Actual Bodily Harm and each offence will carry a maximum of 5 years imprisonment. The offences will be UK-wide and carry extra territorial jurisdiction, so a UK national or habitual UK resident found committing the offences overseas on a UK national or habitual resident of the UK can be prosecuted. There are no transitional arrangements. The Health and Care Bill is due to receive Royal Assent in Spring 2022, coming into force two months afterwards.
30. As with all offences it will be the duty of the Police, the Crown Prosecution Service, the Courts, prisons and probation services to ensure the new law is enforced. Guidance is being developed and will be provided.
31. Given the objective to end hymenoplasty and so reduce violence against women and girls and bring perpetrators to justice, there is no flexibility or scope for experiments, pilots or trails.

Monetised and non-monetised costs and benefits of each option (including administrative burden)

Cost

32. This final stage IA summarises the main impacts of the preferred option (legislation to ban hymenoplasty) on individuals and groups in the UK. The costs and benefits are compared to the "business as usual" option. The approach is consistent with the HMT Green Book.¹⁰

⁹ <https://www.gov.uk/government/publications/our-vision-for-the-womens-health-strategy-for-england>

¹⁰ <https://www.gov.uk/government/publications/the-green-book-appraisal-and-evaluation-in-central-government>

33. IAs place a strong emphasis on valuing costs and benefits in monetary terms. However, there are often important aspects of a policy that cannot readily be monetised – e.g. certain effects on groups in society or changes in equity and fairness. In this case, it is not possible to monetise the benefits of this legislative change. As noted above, there are no figures on which to base an estimate of how often hymenoplasty takes place and how many women and girls are affected. Instead, a breakeven analysis is conducted to test whether the benefits of the policy could equal or exceed the costs.
34. The costs of banning hymenoplasty fall on the public sector, on business and on civil society organisations. In the public sector there will be costs to Health Education England, the NHS, the police and to local authorities providing social care. Costs to the private sector and civil society organisations are detailed below.

Costs of Policing and Prosecution

35. The costs to the police relate to familiarisation with the regulation and, potentially, investigations.

Police familiarisation

36. It is anticipated that the introduction of a new offence will generate familiarisation costs to the police following the implementation of the policy.
37. In the Ban on Virginity Testing IA¹¹ (BVTIA) we estimated that all police officers in England would need to be familiar with the new legislation, at an estimated cost of £2.2m. Further discussion with police stakeholders has led to a different approach to estimating costs in this IA.
38. Information from police stakeholders is that only some officers would need to be familiar with the legislation. Familiarisation activity is likely to be focused on those who work on so called 'honour-based' abuse (HBA) crimes, or in some public protection roles. As noted below, there are very few HBA related cases each year, and so the number of police who would need to be familiar with the legislation is very small. The potential scale of this cost is illustrated below.
39. The National Career Service reports that police officers have an average salary of between £19,000 and £41,500¹² and that the average working week for a police officer is between 37 and 40 hours¹³. Applying a mid-point of £30,250 and 38.5 hours per week gives an hourly cost of a police officer at £18.37. This has been uplifted by an additional 22% to account for employer on-costs, such as National Insurance Contributions, in line with the RPC guidance¹⁴.

¹¹ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1045537/VTIA.pdf

¹² National Careers Service (2021) *Police Officer*. Accessed [here](#)

¹³ National Careers Service (2020) *Police Officer*. Accessed [here](#)

¹⁴ Regulatory Policy Committee (2019) *RPC short guidance note - implementation costs, August 2019*. Available [here](#)

40. As an illustration, if between 50 - 100 police in England were required to spend 1 hour reading the statutory guidance, then this would lead to familiarisation costs of between £1,000 and £2,000 in total to the police.

Costs of police investigations

41. There may also be a cost to the police of investigating this new criminal offence. However, given the lack of information on the prevalence of hymenoplasty, very low rates of reporting of HBA crimes and issues around meeting the threshold of intelligence required to take forward a criminal investigation this cost has not been estimated.
42. In terms of prevalence, there is very limited evidence to show how common the practice of hymenoplasty is. The Independent Healthcare Provider Network informed the Panel that they were unaware of any members who carried out the procedure.¹⁵ Although journalists have identified a number of clinics who offer it, it is not clear how often they carry out the procedure or what proportion of women and girls who undergo the procedure do so within and outside the UK.
43. There are no data on whether hymenoplasty is being carried out in the UK by non-clinicians, but it is possible that this does occur. One of the case studies provided to the Panel described a woman who 'failed' a virginity test after being raped, she was then gang-raped by male relatives and subsequently forcibly 'sewn up' by her aunts in order to restore her honour and 'virginity'.
44. Secondly, information from stakeholders confirms that HBA is an under-reported and hidden crime. Even if there were prevalence data on hymenoplasty in the UK, there is no baseline against which to estimate the proportion of victims or at-risk women and girls who would come forward and report the issue to the police.
45. Finally, police stakeholders note that based on experience, the level of actionable intelligence in HBA cases is often low, and so the criminal threshold is unlikely to be met. In practice, this means that the police may be unlikely to have sufficient evidence to launch an investigation following a complaint, for this reason the number of investigations may be very low.
46. In order to estimate the cost of investigations in the BVT IA the economic and social costs of policing a violent crime, published by the Home Office,¹⁶ were applied. These estimate that the cost of policing per reported violent crime including injury was £2,938 in 2018, or £2,995 in 2019 prices.
47. However, information from stakeholders is that this is unlikely to apply in the case of hymenoplasty, where the most likely scenario is that few police investigations take place during the period. However, if the police were to receive credible intelligence that a

¹⁵ The Independent Healthcare Providers Network (IHPN) is the representative body for independent sector healthcare providers. IHPN England has 69 members drawn from a diverse range of healthcare sectors including acute, primary, community, clinical home healthcare, diagnostics and dentistry.

¹⁶ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/954485/the-economic-and-social-costs-of-crime-horr99.pdf

medical practitioner is breaking the law, any subsequent investigation would be highly specialist. Such an investigation has the potential to be complex and high cost, depending on the evidence and information uncovered and so the progress of the investigation.

48. Given the very high level of uncertainty, the cost of police investigations has not been monetised.

Costs of prosecution

49. We anticipate that there will not be substantial costs from prosecuting this offence. As with other forms of HBA offences like the 2013 Female Genital Mutilation legislation (FGM) - this legislative change is intended to be a deterrent and to send a clear signal that hymenoplasty is an unacceptable practice.

50. The consequences of breaking the law under option 1 are stark. A criminal prosecution could lead to up to 5 years in prison. For regulated healthcare professionals, action by the professional regulator could lead to the offending doctor being removed from the medical register, preventing them from working as a doctor in the UK. We expect that this will largely prevent regulated health care professionals from advertising, offering and carrying out hymenoplasty, and will therefore strengthen the position of women and girls to refuse the procedure.

51. There is a risk that the procedure could be driven underground and carried out in non-clinical setting by unregulated community members. However, hymenoplasty is invasive surgery and it would not be a simple matter for a layperson to conduct the procedure. A further deterrent is that the penalties for conducting the surgery would apply whether the surgery is conducted by a regulated medical professional or not. There is also a risk that families look overseas to have the procedure. As such, the legislation carries extra-territorial jurisdiction to minimise this risk and the policy team are investigating bringing in protection orders to mitigate this risk further.

52. In conclusion, in line with information from stakeholders above, it's likely that the number of prosecutions would be very limited. On that basis we have not monetised this cost associated with prosecution and imprisonment.

Costs to the NHS and social care providers

53. The main costs to the NHS and social care providers will be the implementation cost of updating and augmenting safeguarding training.

54. It is not yet determined how the NHS will ensure that the relevant staff members are made aware of the new hymenoplasty legislation. The costs estimated below relate to a likely scenario, informed by discussions with stakeholders at NHS England and Health Education England (HEE), that:

- a. the safeguarding content of the HEE e-learning for healthcare (HEE elfh) Statutory and Mandatory training is updated to include hymenoplasty; and

- b. (potentially) HEE produce a short non mandatory training course containing further information on hymenoplasty and safeguarding.

55. The UK Core Skills Training Framework sets out 11 statutory and mandatory training topics for all staff working in health and social care settings, including safeguarding¹⁷. The content of this framework is determined by independent intercollegiate groups¹⁸. We assume the safeguarding curricula is updated to reflect changes in the Health and Care Bill and the safeguarding training provided through the HEE elfh programme is updated accordingly.
56. There are 5 levels of safeguarding training¹⁹, which vary in intensity and are targeted at different staff groups. For example, L1 takes 15 minutes and is recommended for all those in the NHS working in a healthcare setting. L3 takes around an hour and is completed by registered health care staff who engage in assessing, planning, intervening and evaluating the needs of adults where there are safeguarding concerns. The courses are largely delivered online, with more in-depth courses including workshops delivered at trust level, and through self-study.
57. The content of the HEE elfh courses is reviewed annually, and the costs of updating is low. Information from HEE suggests that it would cost £10,000 - £20,000 to update each course.
58. HEE could also commission a new online training resource to provide further safeguarding information on hymenoplasty. This would be available for free and is most likely to be accessed by clinicians working with women and girls who've undergone or who are at risk of hymenoplasty. A new online course of this type would also cost £10,000 - £20,000 to produce and last for 15 minutes.
59. Overall, the total cost of updating training materials in this scenario is £60,000- £120,000 with a central estimate of £90,000.

NHS Staff Cost

60. There is likely to be no additional costs to the NHS from staff undertaking updated safeguarding training. As noted above, safeguarding forms part of the mandatory training undertaken by all NHS staff on a rolling basis.
61. There would be a cost to the NHS from staff completing an additional 15 minute training course. Information from NHS stakeholders suggests that, at a minimum, this may be completed by around 10 staff per trust, composed of the safeguarding leads for obstetrics and gynaecology, paediatrics and midwifery. We assume this includes 2 midwives and 8 consultants, which would give the cost below.

¹⁷ [Statutory and Mandatory Training - elearning for healthcare \(e-elfh.org.uk\)](https://www.elfh.org.uk)

¹⁸ <https://www.rcn.org.uk/professional-development/publications/pub-007069>

¹⁹ [Safeguarding Adults - elearning for healthcare \(e-elfh.org.uk\)](https://www.elfh.org.uk)

average salary of a midwife	£35,746 ²⁰
average salary of a consultant	£99,281 ²¹
on costs	22%
average working week (hrs)	37.5
Av. staff cost per 15 minute viewing	£13.50
Cost per trust	£135
Cost to Trusts in England	£32,000

Table 1: NHSE Trusts Safeguarding Costs

62. To estimate the additional cost of this non-mandatory training to general practice, we assume that one GP in each primary care network has a responsibility for safeguarding and undertakes this training. There are 1250 PCNs²² in England and the average hourly wage of a GP is £31 including oncosts²³. Giving an additional cost of £10,000.

63. The total NHS cost for England are below

NHS Cost	
HEE training module	£90,000
NHS Acute Trusts	£32,000
GP Practices	£10,000
Total NHS Cost	£132,000

Table 2: Total NHSE Safeguarding Costs

64. There are uncertainties to this cost. Firstly, individual trusts are free to choose whether to provide their own safeguarding training or to recommend the HEE elfh to their staff. Research for HEE suggests that a minority of acute trusts commission their own safeguarding training, and so would need to update the training to reflect the changes in the Health and Care Act, including hymenoplasty. This has not been monetised as it is likely to be small and to be part of an on-going business as usual cost, as the training may be reviewed and updated regularly in any case.

65. Secondly, uptake for a voluntary course is difficult to predict as it would be available for free to all within the NHS. Uptake beyond the safeguarding leads is likely to be dependent on external factors, for example if the content were publicised by an article in specialist media like the Nursing Times or promoted in emails to members by professional bodies like RCOG. Given the low staff unit cost for undertaking this voluntary training, a sensitivity analysis has not been undertaken.

Costs to Social Care

²⁰ National careers service(NCS) shows average midwife salary is £26k - £46k, On costs at 22% <https://nationalcareers.service.gov.uk/job-profiles/midwife>

²¹ Consultant pay scales £85k - £144k <https://www.bma.org.uk/pay-and-contracts/pay/consultants-pay-scales/pay-scales-for-consultants-in-england> On costs at 22%

²² <https://www.england.nhs.uk/primary-care/primary-care-networks/>

²³ NCS shows average GP salary is £60k - £90k, working week 45-50 hours and on costs assumed at 22%

66. There are two potential sets of costs for local authority social care services – familiarisation cost and a potential increase in case load.

Familiarisation Costs

67. Information from safeguarding board stakeholders suggests that familiarisation costs have two elements. Firstly, the principal social worker for children and for adult social care would need to be familiar with legislative changes which affect social care. Each local authority would need to determine whether there needs to be a new social care policy and procedure for hymenoplasty. Secondly, staff training may take place – in line with local priorities and experience of social care need.

68. There are 152 upper tier local authorities with social care responsibilities. To assess costs, we assume that each local authority has 2 principal social workers – one for adult and another for children social care services, so 304 in all. This may be an overestimate.

69. Each principal social worker will read the statutory guidance. They would then be responsible for determining whether local safeguarding policies and procedures are updated, and whether safeguarding training should be commissioned or provided. We assume this would take half a day, including 1 hour to read the statutory guidance.

70. According to Talent, the median wage for a principal social worker is £52,338²⁴. Once on costs are included this gives a cost of £123 per half day per principal social worker or £37,000 across all 152 local authorities.

Safeguarding training

71. Information from stakeholders involved in safeguarding boards is that safeguarding training in local authorities relating to a ban on hymenoplasty could take many forms, depending on local priorities and the likely impact of the change in legislation on local service need. Some areas won't provide training on hymenoplasty, in others it could be delivered as a voluntary lunch and learn session, and in local areas where the impact is greatest, it is possible that external training could be commissioned lasting half a day. This has not been monetised, as the costs are likely to be small.

Demand for social care

72. Not everyone at risk of hymenoplasty would be eligible for social care support. In practice, advice from stakeholders is that women and girls who approach social care for support are likely to be assessed and then referred or signposted to third sector organisations who may be able to provide support. As the prevalence of hymenoplasty is unknown, this increase in social care assessments has not been monetised.

Regulators

73. There are two regulators who could potentially incur costs as a result of the hymenoplasty legislation. The Care Quality Commission (CQC) who monitor, inspect

²⁴ <https://uk.talent.com/salary/?job=principal+social+worker>

and regulate services to make sure they meet fundamental standards of quality and safety,²⁵ and the General Medical Council (GMC).

74. The CQC do not expect to incur any additional costs once the ban on hymenoplasty is implemented. The offence is committed by the regulated medical professional conducting the hymenoplasty rather than the clinic within which they are operating. As such, the GMC is the appropriate regulator to investigate concerns regarding individual practitioners. If the CQC were informed of any illegal activity, their standard practice would be to inform the police.

75. The General Medical Council (GMC) is the regulator for the medical profession in the UK²⁶. Its role and responsibilities are defined by statute (the Medical Act 1983). The GMC:

- a. Maintains the public register of all doctors who are registered and licensed to practise in the UK.
- b. Oversees and quality assures UK medical education and training; and sets requirements for entry onto the medical register.
- c. Sets the professional standards for good practice; and makes sure that doctors demonstrate on a regular basis that they are up to date and fit to practise (through the process known as revalidation).
- d. Acts when it believes a doctor may be putting the safety of patients, or the public's confidence in doctors, at risk. This is often referred to as the "fitness to practise" process.

76. Advice from the GMC is that most of the work potentially arising from the hymenoplasty ban would be part of their core activity or 'business as usual'. For example the GMC:

- already require doctors to keep up to date with, and follow, the law and regulations relevant to their work²⁷
- will consider how best to support awareness and understanding of this significant change in the legal position within their existing resources, for example, by publishing explanatory materials on their Ethical Hub²⁸, or promotional activity via their social media channels.
- has already identified the current safeguarding provision in undergraduate and postgraduate curricula. It could use this information in any awareness raising work with education and training providers such as the relevant Royal Colleges and Faculties.

77. Costs have not been estimated for this 'business as usual' activity.

78. The GMC may incur additional costs in future if they receive a report that a doctor has performed a hymenoplasty procedure. Here, standard practice would be for the GMC to advise the reporting individual or organisation to inform the police if they have not already done so. The GMC would initiate a fitness to practice process²⁹ only when any police investigation and criminal case has completed.

²⁵ <https://www.cqc.org.uk/what-we-do>

²⁶ <https://www.gmc-uk.org/>

²⁷ [paragraph 12 of our core guidance *Good medical practice*](#)

²⁸ [Ethical hub - GMC \(gmc-uk.org\)](#)

²⁹ [Concerns - GMC \(gmc-uk.org\)](#)

79. The costs to the GMC would depend on the outcome of the criminal case. If the doctor is convicted of a criminal offence, a short fitness to practice hearing would take place, typically lasting less than a day.
80. If the police investigation were not taken forward, it is possible that the GMC would carry out a Fitness to Practise investigation if it was thought that the doctor's conduct or standard of practice may have fallen below expected standards. This process is likely to take months to complete.
81. The GMC have provided the average cost for each stage of the Fitness to Practice process below:

Investigation	£6,266
Case preparation	£15,716
Tribunal cost per day (in person)	£1,866

It's not possible to predict how many hearings would take place during the 10-year appraisal period or whether those hearings would follow a successful criminal prosecution or otherwise.

82. The GMC is funded primarily from the fees paid by doctors for initial or continued registration. The cost of any hearings would be funded from the registration fees of doctors working in both the public and private sector, creating the potential for a small additional private sector cost. However, given the uncertainty and the low value of the cost, this has not been monetised.

Costs to Business

83. In the private sector there will be costs to those businesses that currently offer hymenoplasty relating to staff training, menu costs and lost profits. As above, there will be increased registration fees for doctors to the GMC, as the GMC pass on the cost of investigating any complaints and holding hearings.

Costs to Private Clinics

84. Once the practice is illegal, private businesses will be unable to conduct or offer hymenoplasty, and in the absence of alternative business, would lose revenue and profit. However, the impact on business will depend on the number of hymenoplasty procedures currently performed per year by private businesses and the ability of those businesses to provide alternative services to maintain their revenue.
85. We have no information on the number of hymenoplasty procedures performed by private businesses each year. There is no data collection which contains information on the number of hymenoplasty procedures conducted each year or the number of clinics and clinicians in which they take place. However, media reports indicate that the procedure is available in at least 30³⁰ clinics and undertaken by at least 22³¹ clinicians. We don't know what fraction of the market these 30 clinics represents.
86. The sensitivity analysis below shows that a very large number of hymenoplasty procedures would need to be conducted each year in order for the costs to private clinics

³⁰ <https://www.theguardian.com/society/2021/oct/31/exposed-uk-clinics-still-offering-to-restore-virginity-before-marriage>

³¹ <https://www.thetimes.co.uk/article/restoring-virgins-is-a-big-earner-for-british-surgeons-58lb8xg0t>

of this legislation to be material. For example, if we assume these businesses make a 20% profit³² then a reduction in the number of hymenoplasty procedures conducted by private clinics of 100 per year would lead to a loss of profit of £30,000 to £60,000 across the industry.

Hymenoplasty procedures prevented in private clinics per year	Maximum lost revenue (£'000)		Max Profit Lost ('000)	
	£1500 each	£3000 each	£1500 each	£3000 each
50	75	150	15	30
100	150	300	30	60
200	300	600	60	120
500	750	1,500	150	300

Table 3: costs to business sensitivity analysis

87. As an alternative sensitivity analysis, it's possible to assess the plausibility of the costs to private clinics being large, in terms of lost profit. For example, in order for the cost to business in profit terms to equal £5m per year, between 8,333 and 16,667 procedures would need to be conducted annually at a cost of £1,500 - £3,000 each.

The girls and women who undergo hymenoplasty are predominantly in highly conservative communities, spanning all cultures and religions, and we have anecdotal evidence of it taking place in certain Muslim and Jewish communities. For the purpose of this IA, we have used these for illustrative purposes. The table below estimates the number of women aged 18-30 within these communities as a whole, using population level estimates on religion from the 2011 Census and 2020 mid-year population estimates.

Estimating number of Jewish and Muslim women aged 18-30 in England			£5m profit lost		% of Muslim and Jewish women aged 18-30 to undergo hymenoplasty each year for lost profit to equal £5m	
Women aged 18-30 (England)	% Jewish or Muslim (all ages)	Jewish & Muslim women aged 18-30 (calculated)	No. of HPs (£1500 each)	No. of HPs (£3000 each)	High	Low
3,820,050	6%	210,514	16,667	8,333	8%	4%

Table 4: costs to business, further sensitivity analysis

88. It shows that 4-8% of young women of these faiths (equivalent to between 8,333 and 16,667 young women) would need to undergo hymenoplasty annually in a private health care setting in order for the annual cost to business to be in excess of £5m in terms of lost profit. This number far exceeds the likely number of hymenoplasty procedures

³² 20% profit is a broad assumption and is in line with the rate of return on investment in the private healthcare market generally. Laing and Buisson, UK Healthcare Market Review, 32nd Edition

conducted each year. On that basis we conclude that the maximum ongoing cost to business of this policy, once implemented, would be less than £5m in terms of lost profits (see paragraph 86 above for profit assumption).

89. The costs are likely to be much lower than the 'lost' profit on hymenoplasty procedures. Private health clinics provide a range of health care services, ranging from hair removal and dermatology to cosmetic procedures like breast augmentation, and are likely to choose to provide more of these other services. As such, any drop in profit linked to a ban on hymenoplasty is likely to be reduced. Due to the lack of data this has not been quantified.

90. As a sense check on the assumption that these clinics could focus on alternative services, we can look at the range of services offered by clinics which offer hymenoplasty. A Sunday Times investigation³³ identified 22 private clinics offering hymenoplasty in the UK, including the Gynae Centre in London. Their website³⁴ shows that they offer a wide range of medical services including keyhole surgery and fertility services.

Transitional Costs

91. There are two transitional costs for private business. Firstly, clinics will need to adapt to this change by changing menus and training staff. Secondly, doctors may see a small increase in their registration fee for the GMC (see above).

92. We don't know how many people work in clinics offering hymenoplasty. The table below shows data for the industry, only a fraction of whom are likely to offer hymenoplasty. The table presents a snapshot of data taken on 13 March 2020 from the Inter-Departmental Business Register (IDBR) by ONS. It shows that private healthcare businesses are predominantly small and micro businesses³⁵.

Industry	Proportion of businesses in each employment size band							
	0-4	5-9	10-19	20-49	50-99	100-249	250+	Total
Hospital activities	67%	4%	3%	6%	6%	4%	10%	100%
Specialist medical practice activities	87%	7%	4%	2%	0%	0%	0%	100%
Other human health activities	81%	10%	5%	2%	1%	1%	1%	100%
All UK Businesses	78%	11%	6%	3%	1%	1%	0%	100%

Table 5 - Percentage of VAT and/or PAYE based enterprises by Standard Industrial Classification (SIC) class by employment size bands

93. The table shows that the median business in this sector has up to 4 employees. If we assume that these include a health services manager, a nurse and 2 receptionists, that

³³ <https://www.thetimes.co.uk/article/restoring-virgins-is-a-big-earner-for-british-surgeons-58lb8xg0t>

³⁴ <https://www.gynae-centre.co.uk/>

³⁵ [UK business: activity, size and location - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk/business/business-activity-size-and-location)

training takes 3 hours and that 30 clinics are affected, in line with media reports above. Then the cost would be as in the table below.

Staff	Annual wage (range)		Hours worked	On Costs	Cost of 3 hours training
Manager	£25,368	£63,862	37-39	22%	£83
Nurse	£25,654	£31,533	37-42	22%	£51
Receptionist	£15,000	£22,000	38-40	22%	£33
Cost per clinic					£170
Cost for 30 clinics					£5,100

Table 6 –retraining costs for the median private health clinic³⁶

94. Once the legislation comes into force, it will be an offence to advertise or offer hymenoplasty and so clinics will incur costs when updating their websites. We don't have a reference cost for updating the website of a private health clinic. The nearest comparator is provided in information from Go Daddy – a services platform for entrepreneurs, who publish a costing guide for designing, hosting and maintaining different types of commercial website³⁷. From the list of website types and their associated costs provided by Go Daddy, the closest comparators in terms of function are a hospitality website which would contain 'a menu page, photos, comments and reviews, a map and directions, as well as a way to contact and perhaps even book' or a small to medium ecommerce site which would contain 'supporting content, such as contact details, a returns policy, a blog, support pages and anything else that fits with your business, ...including a map and directions'.
95. Go Daddy suggest that the maintenance on a moderately sized hospitality or ecommerce platform website would be between £1,000 to £2,000 per year per website, if conducted by a web designer. Parrot Creative, a website design and marketing agency, estimate that support and maintenance for an ecommerce website ranges from £790 - £7,990 per year, depending on the complexity of the website and the scale³⁸.
96. As a change in the services provided is just one of the changes that a clinic might implement to its website in a year, we assume that a cost towards the lower end of the estimate of £1,000 per clinic would apply, as a maximum cost to update each clinics website once the legislation is passed.
97. If we assume that there are 30 clinics currently conducting hymenoplasty, then the transitional costs of staff training and website redesign would be $(£170 + £1000) * 30$ clinics = £35,100
98. There is a risk that both the initial and the ongoing annual costs are underestimated, but as the sensitivity analysis below shows, the scale of this risk is small.

³⁶ Using salary and average working week information from the National Careers website.

³⁷ <https://uk.godaddy.com/blog/how-much-does-it-cost-to-build-a-website-uk/>

³⁸ <https://www.parrotcreative.co.uk/how-much-does-an-ecommerce-website-cost-in-the-uk/>

99. Media reports have identified 30 clinics currently carrying out hymenoplasty. It is possible that there will be other clinics that have not been identified and who would face implementation costs. However, even an increase of 50% in the number of clinics would increase the estimated costs to business by only £17,550 at an England level. Equally, information from ONS shows that between ¼ and 1/3 of people working in health and care and other service industries move job each year³⁹. And so ongoing training may be required. We could assume that on average one new employee per clinic receives 1 hour of training from their manager on handling hymenoplasty enquiries each year. However, the costs here are very small, and have not been estimated.

Direct costs and benefits to business calculations

100. The direct costs to business calculation should take account of any transitional costs to business resulting from the legislative change. These could include the cost of lost profits, redundancy costs or the costs of recruiting or retraining staff.

101. Hymenoplasty is one of a range of services that private health clinics could offer. We anticipate that the clinics involved will adapt and concentrate on the provision of their remaining services, with the potential for a small loss of profit. However, given the lack of data this has not been monetised.

102. There will be transitional costs around familiarisation for receptionists and other clinic staff with the ban, and costs associated with updating the clinic website. We don't have a comprehensive estimate for the number of clinics offering hymenoplasty, details of their staff or the running costs for their websites. However, looking at general information on the industry as a whole and information on the cost of maintaining ecommerce websites from website providers, it is clear that the cost per clinic for transitional costs would be small, with an estimate of £1,170 per clinic, or £35,100 for the 30 clinics that we are aware of in England. Scaling these costs in line with population (see below), gives a total UK monetised cost to business of £41,500.

Cost Summary

103. The costs estimated above are for England, however, the ban on hymenoplasty will apply across the UK. In order to produce an estimate of UK costs, a scaling factor has been applied to the England costs, in line with the relative populations as follows:

$$\text{The scaling factor} = \text{UK population/England population}^{40} = 67.1\text{m}/56.5\text{m}$$

A summary of the costs of this policy is below.

³⁹

<https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/employmentandemployeetypes/adhocs/10685employeeeturnoverlevelsandratesbyindustrysectionukjanuary2017todecember2018>

⁴⁰ 2020 population estimates

<https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/bulletins/annualmidyearpopulationestimates/mid2020>

2019 prices	Annual costs 2022/23 (£m)	Annual costs 2023/24 onwards (£m)	Total 2022/2032 (£m)
Transitional Costs			
NHS familiarisation	0.13		0.13
Social Care	0.04		0.04
Private Clinics	0.04		0.04
England Total Transitional Costs	0.21		0.21
UK Transitional Cost	0.24	0.0	0.24
Ongoing costs			
England total ongoing costs	0.0	0.0	0.0
UK total ongoing costs	0.0	0.0	0.0
UK total costs			0.24

Table 7 –summary of costs

Benefits

104. The section below describes the benefits of a ban on hymenoplasty to women and girls at risk of the procedure, to civil society organisations, and in terms of consumer protection. It has not been possible to monetise these benefits. A breakeven analysis is presented which estimates the number of women and girls who would need to benefit from this policy during the appraisal period in order for the costs to equal the benefits. Finally, as a sense check on this, the benefits assumed in the sensitivity analysis are compared to a comparator offence – domestic violence.

Preventing violence against women and girls

105. A ban on hymenoplasty would have a number of benefits, for example:

- Hymenoplasty is a form of violence against women and girls. A ban would stop or reduce the number of procedures taking place in the UK. It will stop many women having to be subjected to the procedure, saving them from immediate and long term physical and psychological, direct and indirect harm. This will enable women and girls in this communities to live more freely with reduced fear of being subjected to HBA.
- A ban would convey a clear message that this practice is unacceptable in British society. It would send an important message to perpetrators that this practice is not acceptable, and to victims that the government is committed to tackling and reducing violence against women and girls in all its forms. Hymenoplasty perpetrates harmful and repressive misconceptions about a women’s virginity and sexuality, only legislation can express the resounding disapproval required to bring about the cultural shift needed to begin to tackle these misbeliefs.
- A ban would give weight behind any educational work. This will help to empower women and girls to resist pressure to undergo the procedure and enable them to live their lives without the shame and fear. It would also legitimise the work of the agencies who support women and girls who are placed under unacceptable pressure to conform to the expectations that surround virginity.
- A ban would empower women and girls, and the wider community, to speak out against this and other similar practices and be safe to report them. This will enable women and girls in this communities to live freely and to their full potential without fear of being subjected to abuse.

Civil Society

106. A ban will also benefit organisations which support women and girls at risk of and who have undergone hymenoplasty. The majority of these organisations are currently focusing resources on campaigning to ban hymenoplasty. An end to the practice will allow them to focus on alternative activities, including for example campaigning in other areas of inequality and harm, education work within communities, and providing support to the women and girls that are impacted by such abuses.
107. The ban will legitimise the work of the agencies that work closely to support the women and girls affected and at risk of this procedure, including civil society organisations. A ban will give weight to existing and/or future guidance, position statements and education provided by these organisations. The ban will empower women and girls who might be at risk of other forms of HBA, such as forced marriage, to come forward and seek help. It will give agencies powers to put safeguarding measure in place for those women and girls that may be at risk of other forms of HBA. It will also empower those in the communities that are witness to this and similar practices, to take a stand and report perpetrators.
108. There will also be a benefit to the professional medical bodies currently campaigning to ban hymenoplasty. This includes the Royal College of Obstetricians and Gynaecologists, the British Society for Paediatric and Adolescent Gynaecology, the British Society of Urogynaecology, and The British Society for Gynaecological Endoscopy. A ban on hymenoplasty will free up the resources currently devoted to campaigning in these organisations for other uses, which benefit society, their members and registrants.
109. These benefits have not been quantified. Information on the current level of campaigning expenditure is not publicly available, for example, in these organisations' annual accounts (see SAMBA below for more detail).

Consumer Protection

110. A ban will also enhance consumer protection. Demand for hymenoplasty is predicated on two incorrect assumptions. Firstly, that there is a test which can reveal a woman or girl's sexual history. Secondly, that women who fail to bleed after their first marital sex had a previous sexual history. As RCOG note, neither is true⁴¹.
111. Only around half of women with unruptured hymen or who've undergone hymenoplasty will bleed at first coitus⁴². So, women who have undergone hymenoplasty in order to bleed on their wedding night are not guaranteed to do so despite spending £1,500 - £3,000 and undergoing invasive surgery. There is also increased potential for HBA in these circumstances. IKWRO Women's Rights Organisation⁴³ note:

⁴¹ <https://www.rcog.org.uk/globalassets/documents/news/position-statements/rcog-virginity-testing-hymenoplasty-position-statement-august-2021.pdf>

⁴² [Virginity Does Not Define Me – IKWRO](#)

⁴³ <https://ikwro.org.uk/virginity-does-not-define-me/>

'If a girl or woman undertakes hymenoplasty because she is relying on bleeding to try to prevent "honour" based abuse and does not then bleed when she then has intercourse for the first time, she may be left vulnerable to violence'.

Break Even Analysis

112. It is not possible to monetise the benefit above. To do so would require information on the number of women and girls affected, and a quantitative assessment of the harm done by undergoing hymenoplasty. This evidence is not available. Instead, a breakeven analysis has been conducted to sense check whether the potential benefits could equal the costs, in terms of the benefit of preventing psychological harm associated with hymenoplasty. In addition, there are potential physical risks described in the following paragraphs.
113. The quantified costs for this policy are £0.2m over 10 years. The benefits are to prevent violence against women and girls which would prevent the long term physical and psychological harm associated with hymenoplasty.
114. There is no clinical benefit to hymenoplasty, nor any other procedure under a different name that seeks to reconstruct or repair the hymen. RCOG does not provide any training or clinical guidelines on how to undertake this procedure, and the clinical risks of undertaking it are unknown, with no evidence to prove it has no adverse effects.
115. The Panel describe the physical and psychological risks of hymenoplasty as including:
- a. Infection,
 - b. Acute bleeding during the procedure,
 - c. Scarring and narrowing of the entrance to the vagina,
 - d. Reduced sensation/ increased sensation (pain rather than pleasure),
 - e. Sexual difficulties,
 - f. Depression,
 - g. Anxiety,
 - h. Post-Traumatic Stress Disorder,
 - i. Reduced or no libido, and
 - j. Suicide
116. Hymenoplasty is often undertaken by the same private clinics that offer virginity testing, and the two are linked. If a woman or girl "fails" a virginity test, hymen repair surgery might be the logical next step.
117. Although prevalence is unclear, the Panel found that there is significant evidence of women and girls being under intense pressure to undergo hymenoplasty, including in order to enable families to place them under further pressure to marry a person of the family's choice. This is not limited to young women and there is anecdotal evidence presented to the Panel of women in their 30s being subjected to a hymenoplasty.

Valuing the psychological benefit of a ban on hymenoplasty

118. The quality adjusted life years methodology (QALYs) enables a monetary value to be placed on the difference between health states across 5 domains. The QALY methodology, allows values to be placed on moderate and severe impairment within those domains (see table below), based on the valuation of health states made by a representative sample of the UK population⁴⁴.

119. In the table below, 1 QALY represents 1 person spending 1 year in full health, and each scale quantifies the QALY loss, associated with spending one year in a worse health state.

Starting from 1.00 for full health	QALY Loss
Any dimension higher than 1	-0.08
Any dimension at level 3	-0.27
Mobility level 2	-0.07
Mobility level 3	-0.31
Self-care level 2	-0.10
Self-care level 3	-0.21
Usual activities level 2	-0.04
Usual activities level 3	-0.09
Pain or discomfort level 2	-0.12
Pain or discomfort level 3	-0.39
Anxiety or depression level 2	-0.07
Anxiety or depression level 3	-0.24

Table 8: EQ5D 3L QALY values

120. DHSC estimate a societal valuation of a QALY at £70,000 per year⁴⁵. If we assume that by preventing violence against women and girls the ban on hymenoplasty would reduce the depression and anxiety of the women and girls affected, then table below shows the value of this benefit if it were to persist for a year.

Life State	QALY Value	QALY Loss (compared to full health)	Benefit from preventing QALY loss for 1 year
Full health	1	0	£0
Mild anxiety	0.85	0.15	£10,640
Severe anxiety	0.41	0.59	£41,020

Table 9: Illustration of QALY benefit per person per year using EQ5D 3L scale

121. However, we don't know how long the psychological harm associated with hymenoplasty lasts. It may vary between individual women and girls depending on their individual circumstances. Given this uncertainty, the breakeven analysis below considers a reduction in depression and anxiety from severe to mild that lasts for 6 months, 1, 2 or 5 years.

⁴⁴ <https://www.york.ac.uk/che/pdf/DP138.pdf>

⁴⁵ Estimated at £60k in 2014 prices (see HMT [Green Book](#), p86), adjusted for inflation and rounding to avoid spurious accuracy. HMT Green Book,

122. The table shows that for the costs to equal the benefits 16 young women would need to experience a reduction in their anxiety from severe to mild for 6 months each during the 10-year appraisal period. Alternatively, 2 women would need to experience the same reduction in anxiety but for a duration of 5 year during the appraisal period.

Duration of benefit	Benefit of reduction from severe to mild anxiety			
	6 month	1 year	2 years	5 years
Benefit per woman or girl (£)	15,190	30,380	60,760	151,900
Breakeven - No of women/girls benefitting – across the appraisal period	16	8	4	2
Total benefit over 10 years (£m)	0.2	0.2	0.2	0.2

Table 10: Sensitivity analysis of benefits

123. This analysis does not vary if we incorporate the profits foregone by clinics as a sensitivity. We estimate above that the maximum profit lost per procedure is £600. The table below shows that including the lost profits to business in the sensitivity analysis doesn't change the results. It would require one additional woman to benefit for 6 months within the 10-year appraisal period in order for the increased cost to equal the benefit of the policy.

Duration of benefit	6 month	1 year	2 years	5 years
No of women benefitting during 10 year appraisal period	16	8	4	2
Total loss of profit (high) (£)	9,600	4,800	2,400	1,200
Additional women benefitting across 10 years	1	0	0	0

Table 11: Sensitivity analysis of benefits when including cost of lost profit

Sense Check on Benefits of Banning Hymenoplasty

124. In order to sense check the scale of the benefit per person assumed above, we can look at evidence from other comparable offenses. For example, the Home Office publishes a document titled “the economic and social costs of domestic abuse”⁴⁶, which could, in some senses, be taken as a comparator offence. This covers the costs to individuals of domestic abuse, e.g. psychological harm, the cost to the public sector, e.g. police costs, and conversely the equivalent benefits to society of reducing or stopping domestic abuse.

125. The Home Office estimate that the average duration of domestic abuse is 3 years, and that the recovery time varies depending on the type of abuse. For example, the combined duration of abuse and recovery period for anxiety is 6 years for violence with injury and 2.97 years for stalking.

126. The average social cost of an occurrence of domestic abuse is £34,015. Which is composed as follows:

⁴⁶ <https://www.gov.uk/government/publications/the-economic-and-social-costs-of-domestic-abuse>

Costs in Anticipation	Costs in consequence				Costs in response				Total
	Physical and emotional harm	Lost output	Health services	Victim services	Police costs	Criminal legal	Civil legal	Other	
£5	£24,300	£7,245	£1,200	£370	£645	£170	£70	£5	£34,015

Table 12 - Average unit costs of physical and emotional harms of domestic abuse⁴⁷

127. However, as the report notes, there is substantial variation within this average, particularly relating to physical and emotional harm. As shown in the table below.

Domestic abuse type	Emotional	Physical	Total unit cost
Domestic homicide		£1.9m	£1.9m
Violence with injury	£53,410	£830	£54,240
Violence without injury	£22,630		£22,630
Rape	£58,750	£110	£58,860
Indecent exposure and/or sexual touching	£9,950		£9,950
Stalking	£21,920		£21,920

Table 13 - Estimated unit costs of physical and emotional harms of domestic abuse⁴⁸

128. The evidence suggests the estimates of the level of benefit needed from a ban on hymenoplasty above are reasonable. Particularly when this is considered in the context of the evidence presented in the hymenoplasty background document⁴⁹ which contains from paragraph 41 onwards a series of case studies which demonstrate the severity and duration of the impact of hymenoplasty on the lives of some women and girls. An example is reproduced below:

Case Study 'LH'

LH went to university. In her second year, her parents would often visit with men to meet her as potential matches for arranged marriage.

LH entered a serious relationship, which she kept hidden from her parents. She became pregnant and both she and her partner, a fellow student, wanted to keep the baby. However,

⁴⁷ P25, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918897/horr107.pdf

⁴⁸ P25, https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/918897/horr107.pdf

⁴⁹ <https://www.gov.uk/government/publications/expert-panel-on-hymenoplasty/hymenoplasty-background-paper>

LH knew that her parents would not support the relationship. LH ended up having an abortion and went back to live with her parents.

LH's parents discovered that she had been in an intimate relationship and pressured her into having hymenoplasty and then into a marriage of their choice to an older man. LH went ahead with the hymenoplasty and the marriage. LH had children with her husband.

LH suffered extreme coercive control from her husband. Ultimately, he used this method of abuse to get full custody of their children. LH attempted suicide by jumping from the roof of their flat and broke both legs. Looking back LH sees that the hymenoplasty played a key role in enabling the abusive forced marriage.

Conclusion

129. The breakeven analysis and sense check on the scale of benefits above demonstrates that, on reasonable assumptions, this legislation would need to prevent only a small number of women from undergoing hymenoplasty in order for the costs over 10 years to be outweighed by the benefits.

Risks and assumptions

130. There are risks associated with option 1 if legislation is not accompanied by a programme of complementary measures, such as community engagement and education. As UNICEF set out in their 'Review of Evidence on Effectiveness of Interventions designed to prevent or respond to FGM'⁵⁰:

'evidence suggests that legislation works more effectively where there is political will, the existence of locally appropriate enforcement mechanisms, a combination of other interventions that are acceptable to the target community, sufficient resources for implementation, and sensitization. ... Evidence suggests that legislation alone is not effective in changing attitudes towards FGM and its prevalence. Rather, legislation must be implemented in tandem with enforcement mechanisms, as well as other interventions, to show impact in knowledge, attitudes and norms driving the practice'

131. A ban could indirectly increase the risks to women and girls if the practice is driven underground and carried out in non-clinical settings by unregulated community members. As the Panel's background paper notes:

*'A ban will not alter centuries of culture and so it is fair to argue that it will still occur in non-healthcare settings. Not only will women remain trapped in a cycle of coercion, but women will be at risk from infection and anatomical damage and further psychology harm or stress.'*⁵¹

132. Equally, clinicians interviewed as part of the original review into virginity testing and hymenoplasty and who perform hymenoplasty as part of their private practice outlined that the procedure could be a way to provide options for women who wish to

⁵⁰ P34 <https://www.unicef.org/media/106831/file/FGM-State-of-Evidence.pdf>

⁵¹ Para 55, <https://www.gov.uk/government/publications/expert-panel-on-hymenoplasty/hymenoplasty-background-paper>

have a sexually active life before marriage, and/or to save them from future stigma or abuse.

133. The evidence base on the prevalence of hymenoplasty in the UK is sparse. This has been addressed earlier in this document, including discussions with a wide range of UK stakeholders. However, there are still gaps:

- a) We have no information on the number of hymenoplasty procedures performed on women annually in the UK, and no comprehensive estimate of the number of private health care clinics offering this procedure.
- b) We have been unable to engage with anyone who conducts hymenoplasty in a private healthcare clinic about the impact this legislation could have on their business model. We have drawn conclusions by looking at the sector as a whole and having conducted the sensitivity analysis above.

134. In addition, there is a risk that the costs of police investigations are too low. Stakeholders in police provided information which suggested that the most likely scenario is that there would be very limited police investigations during the appraisal period. However, if an investigation is launched and successful, the costs are likely to be high.

Direct costs and benefits to business calculations

135. The direct costs and benefits to business, including voluntary and community bodies are addressed in the body of this impact assessment and, where estimated, total £0.04m. These include:

- transitional costs to businesses,
- increased costs to regulators, funded by registrant fees, and
- benefits to civil society organisation, where resources previously devoted to campaigning against hymenoplasty can be devoted to alternative uses, to the benefit of society.

Impact on small and micro businesses

136. The ban on hymenoplasty will affect small and micro businesses in two ways. Firstly, private healthcare businesses will no longer be able to advertise or carry out hymenoplasty. Secondly, civil society organisations will benefit as they no longer need to campaign for legislation on this issue and are able to focus their resource on other priority areas.

137. The ban on hymenoplasty will affect some private healthcare businesses, who will no longer be able to provide or offer this procedure. We have no information on these businesses, but as table 5 at paragraph 93 shows private healthcare businesses are predominantly small and micro businesses⁵².

138. We anticipate the impact on individual businesses will be small. Private healthcare firms provide a range of services. We anticipate that firms will adapt and

⁵² [UK business: activity, size and location - Office for National Statistics \(ons.gov.uk\)](https://ons.gov.uk)

increase the amount of other services that they offer, where possible, rather than lose revenue.

139. Given the structure of the private healthcare industry (see table 5 at paragraph 93), to exempt small and micro firms from this legislation would markedly reduce the impact of the legislation by enabling hymenoplasty to continue, legally in the UK. Small and micro firms are where hymenoplasty is predominantly undertaken. There cannot be any exemptions or defence for carrying offering or undertaking hymenoplasty.
140. Secondly, charities who campaign for legislation to ban virginity testing will benefit, because they will be able to use the funding currently directed towards this campaign to fund other activities, including education campaigns on virginity testing which will strengthen the benefits of this proposal.
141. The 2020 annual reports⁵³⁵⁴ of two leading charities in this area (Karma Nirvana and IKWRO) show that they had annual expenditure of between £0.5m and £0.7m in 2019/20. This expenditure funded a range of activities including campaigning, helplines, advocacy, training, education and in the case of IKWRO, refuge and resettlement provision. It is not possible to identify what proportion of this expenditure was exclusively allocated to campaign against hymenoplasty. To make a blanket assumption on each charity's expenditure on campaigning against hymenoplasty without any basis could be misleading and speculative. So, although it's clear that there will be a benefit to these organisations – it is not possible to quantify that benefit.

Wider impacts (consider the impacts of your proposals)

142. An equality impact assessment taking the Public Sector Equality Duty (PSED) section 149(1) Equality Act 2010 is attached as Annex A.
143. There is likely to be minimal impact on the other employees within the clinics where hymenoplasty is carried out. The clinician performing or offering the procedure will stop and is likely to increase the number of other procedures performed.
144. However, the impact on consumers will vary. As hymenoplasty will no longer be offered or performed in any clinic. There is a risk of increased harm to the women that choose to have the procedure as a way of navigating abusive environments, with hymenoplasty seen as the lesser of two evils. The expert Panel was mindful of this issue and recommended that the government invest in resources and training to those agencies that work the most closely with the women and girls affected by this change. The government fully accepts this recommendation. We have already committed to a programme of education to help tackle the myths that surround virginity and are working with stakeholders to assess what other resources and training is required in the short time whilst communities adjust to the new legislation.

⁵³ [Karma Nirvana Annual Report](#)

⁵⁴ [IKWRO Annual Report](#)

145. Those most affected by this ban are likely to be the perpetrators who aid and abet, for example family and community members, rather than carry out or offer the procedure. These individuals will be mostly within the communities where this is most prevalent and may seek other form of abuse as a show of control including verbal and physical abuse, shaming and disownment. The resources and training highlighted above should help to safeguard these women and girls in the short term, while in the long term the wider educational piece should help dispel the myths and bring about the cultural shift required to tackle these misogynistic attitudes.
146. Following the Panel report the government has also agreed to undertake a review of the legislation after a yet to be agreed period. The purpose of this review is to not only measure the impact of the legislation but to monitor the potential risks of harm outlined above in paragraphs 146 and 147. The review will assess the effectiveness of the safeguarding measures and if the cultural shift in attitudes can be seen.
147. As mentioned in the above sections, the impact on private clinics offering the service will be small. The indirect impact for businesses that form part of the supply chain to that private clinic, or those that are in the surrounding locality that may potentially benefit from the passing footfall, will be negligible.
148. There will be no direct or indirect impact on the environment.
149. The cost of prosecution and of policing has previously been discussed. The wider impact on the public sector will be related to safeguarding. Where appropriate they must ensure that guidance and training is provided to those that may encounter a victim of hymenoplasty so they are able to spot the signs, ask the right questions, and support and signpost people to the most appropriate services. As with virginity testing, hymenoplasty is often part of wider so-called HBA and early intervention may potentially save a girl or women from further harm. Guidance informed by working groups of experts in HBA will accompany the legislation.
150. The ban also has implications for the third sector organisations that have been campaigning for a ban. The ban will allow them to focus on alternative activities, including campaigning in other areas of inequality and harm, education work within communities and providing support to the women and girls that are affected by such abuses.

A summary of the potential trade implications of measure

151. There are no trade implications of this measure.

Monitoring and Evaluation

152. The Panel recognised that there is limited research on hymenoplasty in the UK and that there are risks of undesirable consequences when criminal offences are created. These may include driving the practice 'underground', with the procedure being conducted in non-clinical settings by unregulated community members, possibly reducing contact between services and women and girls who are at risk. They recommended that

a ban on hymenoplasty should be formally reviewed after an agreed period to consider its impact and implementation. Issues to be considered would include whether the desired cultural change has been achieved, whether prohibition has led to unregulated practice, enforcement successes and challenges, and the effectiveness of safeguarding of the women and girls affected.

153. In a written ministerial statement published 15 March 2022⁵⁵ the government fully accepted this recommendation and all the expert Panel's recommendations. It has committed to review the impact of the ban to consider whether its objectives have been achieved. The details and timescales for the review are to be decided following wider engagement with relevant stakeholders.

⁵⁵ [Written statements - Written questions, answers and statements - UK Parliament](#)

Equality Impact Assessment

Title: Banning Hymenoplasty in the United Kingdom

What are the intended outcomes of this work? *Include a brief outline of the policy and the main aims. What changes are you proposing, and why?*

In early 2020, following widespread concerns that some young women and girls are being coerced and forced to have their virginity tested, and subsequently undergoing hymenoplasty, the Government undertook an intensive review to determine if any government intervention, including legislation, would be required, and if so, what the right legislative vehicle might be.

The review's recommendations included the proposal to criminalise virginity testing, but not to legislate to ban hymenoplasty at the same time. The arguments for a ban were not clear enough at the time. While the Government remained concerned that the demand for hymenoplasty is driven by a repressive approach to female sexuality, and that the procedure perpetuates harmful myths around virginity, there were concerns about taking away a woman's right to make decisions around their own healthcare by banning a cosmetic procedure. As such, Government committed to establishing an independent expert panel to review the legal, clinical and ethical aspects of the procedure in more detail and consider whether it should, ultimately, be banned in the United Kingdom.

The Panel found that hymenoplasty is inextricably linked to virginity testing. Hymenoplasty is often undertaken by the same private clinics that offer virginity testing. If a woman or girl "fails" a virginity test, hymen repair surgery might be perceived to be a logical next step. The continuing availability of hymenoplasty could serve as an incentive for families to seek illegal virginity testing of women and girls. A failure to prohibit hymenoplasty would undermine the Government's commitment to address the violence against women and girls by criminalising virginity testing. It is a harmful practice that creates and exacerbates social, cultural and political beliefs that a women's value is based on whether or not she is a virgin before marriage.

As with virginity testing, it is a form of HBA, which can be the precursor to child marriage and forced marriage, and other forms of family coercive control including physical and emotional control. So long as the option of hymenoplasty is available, women will be placed under pressure to undergo the procedure. The Panel was clear that the benefits of an outright ban outweigh any argument that the autonomy of women and girls would be undermined by no longer having access to the procedure. In many cases, women and girls will be faced with extensive pressure from their families and communities to undergo hymenoplasty.

The Panel describes the physical and psychological risks of HP as including:

- Infection

- Acute bleeding during the procedure
- Scarring and narrowing of vaginal opening
- Reduced sensation/ increased sensation (pain rather than pleasure)
- Sexual difficulties
- Depression
- Anxiety
- Post-Traumatic Stress Disorder
- Reduced or no libido
- Suicide

Hymenoplasty is a medical procedure that takes place in clinical settings and is regulated in line with other forms of cosmetic surgery. Advertising online suggests that hymenoplasty procedures are widely available at the cost of around £1500 - £3000. There is anecdotal evidence from one of the case studies provided in the background paper that suggests the procedure may have been carried out in the community by female relatives.

As with virginity testing, the prevalence of hymenoplasty procedures is difficult to estimate as these practices are currently legal and take place outside of the National Health Service. There is no requirement for the private sector to record numbers of procedures performed within private clinics. The Expert Panel (the Panel) found that the practice is often part of a wider cycle of control and coercion on women and girls which goes undocumented until a woman seeks support and refuge.

The Panel have confirmed that there is never a medical or clinical need to repair or reconstruct the hymen. The procedure is steeped in attitudes and myths that indirectly harm women and girls. In some very limited circumstances (not least because clinicians have other, non-surgical treatments available), there are procedures that are clinically necessary to remove hymenal remnants caused by external trauma or childbirth. This would involve removing any remaining parts of the hymen to prevent bleeding, infection or discomfort to a woman. Such a procedure does not involve any reconstruction of the hymen but rather removes any remaining traces of the skin.

The Government agreed with the Panel's main recommendation and announced its intention to ban hymenoplasty when Parliamentary time allowed in the Women's Health Strategy Vision Document published on the 23 December 'Our Vision for the Women's Health Strategy for England' - GOV.UK (www.gov.uk).

The Health and Care Bill has provided the earliest legislative vehicle to ban hymenoplasty. As such, the Government has introduced a package of amendments to the Bill to ban hymenoplasty in the United Kingdom. Three new offences will be created, which are:

- carrying out hymenoplasty;
- offering to carry out hymenoplasty; and
- aiding or abetting the carrying out of hymenoplasty.

The offence may be tried either summarily or on indictment. In England and Wales and Northern Ireland, this means that it may be tried either in the Magistrates' Courts or the Crown Court. In Scotland, this means that it may be tried either in the Justice of the Peace courts or by a judge alone in the sheriff court, or by jury in the sheriff court or in the High Court of Justiciary. Each offence carries a maximum penalty of 5 years imprisonment.

Alongside this legislative solution, we will also put into place a programme of education in community, education and clinical settings to tackle the harmful misconceptions and misbeliefs surrounding virginity.

Who will be affected? *E.g. staff, patients, service users*

Healthcare professionals who work in clinical settings (particularly within the private sector), and family members or members of the community that carry out, offer or aid and abet another to carry out hymenoplasty.

Women and girls (including trans men, non-binary and intersex people) who are subjected to the procedure.

Evidence

What evidence have you considered? *List the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each protected characteristic. This can include national research, surveys, reports, research interviews, focus groups, pilot activity evaluations etc. If there are gaps in evidence, what you will do to close them.*

The Department's internal review used a 'mixed methods approach' and included analysis of qualitative literature (academic papers, grey literature and media coverage), data from published and unpublished sources, and evidence submitted to the Tackling Violence Against Women and Girls (VAWG) Strategy call for evidence by third sector organisation, Karma Nirvana.

There is a lack of published data on virginity testing and hymenoplasty, and very few first-hand accounts of women in the UK who have undergone hymenoplasty surgery.

The Department's review included qualitative analysis of the interviews with over 25 stakeholders from across the health and care system including with NHS clinicians, professional bodies, the Royal Colleges, and third sector organisations.

7 clinics offering hymenoplasty were approached, but the team were only able to speak to one clinician who had performed a hymenoplasty, and none who had performed a virginity test.

The Expert Panel on Hymenoplasty met twice and considered a plethora of evidence, ranging from academic journals, news articles, position statements and personal experiences by way of case studies. A background paper accompanied the Panel's final report, which detailed this evidence to help inform the Panel's discussions.

Final Report of the Expert Panel on Hymenoplasty: Ethical, Legal and Clinical implications - <https://www.gov.uk/government/publications/expert-panel-on-hymenoplasty>

Expert Panel on Hymenoplasty: Background Paper - <https://www.gov.uk/government/publications/expert-panel-on-hymenoplasty>

Analysis of impacts. For each protected characteristic below, and based on the evidence you have gathered, consider impacts for each of the three aims of the Public Sector Equality Duty – eliminating unlawful (direct and indirect) discrimination, advancing equality of opportunity, and fostering good relations.

Disability - *attitudinal, physical and social barriers for both visible and hidden disability*

This legislation will offer much-needed protection to women and girls to ensure that they are not subjected to hymenoplasty - a practice which is not predicated on ability or disability.

Women and girls with visible or hidden disabilities are potentially more vulnerable and susceptible to risk of coercion and control within their families and wider community. Introducing legislation will advance equality of opportunity around protecting all women and girls (with or without a disability) from undergoing a virginity test, it will empower them and give them the opportunity to live full lives without short and long term psychological and/or physical effects that hymenoplasty can inflict.

It would also empower those individuals within the community/family that witness this practice to come forward to report those carrying out, offering and aiding and abetting the practice.

This legislation, and the wider education piece that will accompany it, shines a light on the need to protect the women and girls who are most vulnerable. As such, the Government's work fosters and promotes good relations between different groups, including those with disabilities.

Sex - *men and women*

The ban on hymenoplasty intends to safeguard women and girls. Hymenoplasty, like virginity testing, is a harmful practice that is predicated on gender – it is a form of violence against women and girls, which helps to subvert and control female sexuality and autonomy.

Hymenoplasty reinforces misogynistic views, gender stereotypes and patriarchal values. Hymenoplasty, like other forms of HBA, is often justified with references to various socio-cultural factors. Other common justifications are closely linked to fixed gender roles and perceptions of women and girls as 'gatekeepers' of their family's honour. This, in many cases, directly relates to women's sexual "purity" and harmful misconceptions surrounding virginity.

As a result of all that is stated above, it is clear that hymenoplasty reflects the deep-rooted inequality between the sexes. Banning hymenoplasty, therefore, will not only protect women and girls from abuse, but it will have a positive effect on advancing equality of opportunity between the sexes. Further, women and girls will be empowered to live full, autonomous, lives without the damaging short and long term psychological or physical effects from being forced or coerced to undergo this procedure

The accompanying guidance will ensure that the public sector and third-sector organisations will be better prepared to identify someone potentially at risk of hymenoplasty. The guidance will provide relevant professionals (e.g., doctors and the police) with the tools and understanding necessary to support women and girls who have been victims of the practice. Therefore, the introduction and implementation of this legislation will contribute to eliminating unlawful discrimination against women and enhance equality of opportunity – allowing them to seek out the support they need.

We are also embarking on a programme of education to tackle the harmful misconceptions that surround virginity. It is hoped that by implementing new legislation, along with a strong education policy, will contribute to a cultural shift and change in male attitude towards female sexual sexuality, and women in general, and lead to better relations between men and women.

Sexual orientation - *heterosexual, homosexual or bisexual*

Hymenoplasty, like virginity testing, often takes place as a precursor to heterosexual marriage, and is aimed at ensuring that a woman or girl is a virgin (and bleeds) on her wedding night.

Communities that partake in this practice are unlikely to recognise or accept an individual's sexual orientation if they are not heterosexual. These women and girls are more at risk of HBA offences, particularly if they are rejected by the communities in which they live. For example, it might be the case that women and girls are forced into a heterosexual marriage and, as a precursor for that marriage, they could be forced to undergo hymenoplasty – particularly if they have 'failed' a virginity test or the individual's family suspects that they have been sexually active.

The proposed legislation protects all women and girls, irrespective of their sexual orientation. This advances equality of opportunity by strengthening the legislative framework around protecting women and girls, allowing all women and girls to live their lives freely.

Race - *ethnic groups, nationalities, Gypsy, Roma, Travellers, language barriers*

There is no data available that breaks down the prevalence of hymenoplasty in the UK among particular races, ethnic groups or nationalities.

The Government's internal review into virginity testing and hymenoplasty, however, did find that hymenoplasty is most prevalent in conservative communities and it is likely, therefore, that those communities seeking out hymenoplasty in the UK are disproportionately likely to belong to certain ethnic groups.

The Government will therefore need to ensure that the policy to ban hymenoplasty will not stigmatise certain communities. We will continue to engage, and support, third sector organisations and the communities they operate in to counteract this.

We will also publish guidance, which will accompany the legislation, to provide advice and support to public sector organisations, such as the NHS, the police and local authorities. The guidance will not discriminate against, nor single out or target, any particular race or community, and will be focussed on the safeguarding **all** women and girls. This guidance will ensure organisations will have accurate and correct information about hymenoplasty, which will allow a more considered approach to tackling the issue, helping to foster good relations.

While hymenoplasty has a higher rate of prevalence amongst certain communities, the policy objective is to fulfil the Government's overarching aim to protect, and reduce harm to, all women. This policy builds upon, and reinforces, the Government's proposed ban on virginity testing, and aims to break the cycle of abuse that women and girls, from these communities, face. As such, the ban on hymenoplasty will advance equality of opportunity, by enabling them to live freely and without fear of being subjected to such abuse.

We do recognise, however, that while this policy will be beneficial, members from communities where the practice is prevalent may feel that this has affected them negatively. Therefore, we are implementing a policy of education in community and clinical settings to tackle the deep routed perceptions and myths around virginity. The accompanying education policy aims to foster good relations between those who share the protected characteristic and those that do not, by reducing hostility between groups and increasing understanding.

Age - age ranges, old and young

Hymenoplasty is aimed at girls and young women, usually as a precursor to marriage. A woman may be forced to undergo the procedure to ensure that she bleeds on her wedding night (although there is no guarantee of this) to demonstrate 'purity'. We have anecdotal evidence of girls as young as 13 undergoing a virginity testing, meaning they are susceptible to undergoing hymenoplasty if they "fail" that test.

The ban on hymenoplasty, as such, will primarily protect women and girls between the ages of 13-30 years. In many communities where virginity testing is prevalent, women are usually married before the age of 30, with many women being coerced into child marriages long before this (or forced marriages when legal majority is reached). A woman of any age, however, is at risk of being subjected to hymenoplasty. Particularly within communities where this practice is most prevalent, stakeholders have informed us that adult women are still seen as children, in the eyes of their parents, until they are married. As such, they live at home and, until they are married, they are at risk of being subjected to the procedure.

The Panel briefly considered whether it would be appropriate to include a provision to allow girls and young women (i.e. those under 18) to undergo the procedure if parental consent was in place. This was swiftly rejected, as evidence shows that it is the parents, or guardians, of girls and young women that apply pressure for them to undergo hymenoplasty. In essence, this would allow the procedure to continue, at any age, and would not adequately meet the wider policy objective of safeguarding women and girls.

While we anticipate the ban will disproportionately affect girls and young women, the policy is beneficial and will ensure that all women are protected from being subjected to hymenoplasty. Further, girls and young women will be able to live their life freely, without fear of being subjected to a hymenoplasty, advancing equality of opportunity.

Gender reassignment (including transgender) - transgender and transsexual people

The offence is focussed on reconstruction of the hymen, with or without consent. This means that an individual that has female genitalia would be protected by this offence. For example, a transgender man with female genitalia could be subjected the procedure by their family, or community, and would suffer the detrimental effects of having to undergo such an invasive controlling procedure that a women and girl would experience. There is an added potential risk that where families/communities refuse to recognise the individuals' chosen identity, they may subject them to a hymenoplasty as another means to humiliate, control, shame and force them into a heterosexual marriage.

The guidance, which will accompany the legislation, will make clear that anyone with female genitalia, irrespective of their gender identity, will be entitled to the protection this offence offers. Further, organisations and professionals will be able to consult this guidance and take the appropriate steps to safeguard the individual, fostering good relations and increasing understanding.

Religion or belief - people with different religions, beliefs or no belief

The ban on hymenoplasty contributes to the Government's overarching policy objective to reduce harm to all women and girls. This policy will protect all women, irrespective of their religious belief, and will have beneficial effects on their wellbeing, enabling them to live freely without fear of being subjected to abuse.

There is no data available that breaks down the prevalence of hymenoplasty in the UK among particular religious groups. Evidence does suggest that conservative communities where the practice is particularly prevalent have significant Muslim, Christian and Jewish populations. However, it should be noted that it is a common misconception that virginity testing and hymenoplasty are religious requirements – they are not. These practices stem from cultural and social norms associated with the communities that practice them. The Community Engagement Roundtable, that we are setting up, will include engagement with faith and community groups. This will help to positively reinforce the Government's messages within communities where hymenoplasty is prevalent.

It is, however, likely that individuals from conservative communities, who place a high value on female purity, are disproportionately likely to also have these religious beliefs. However, the guidance and the educational policy present an opportunity to dispel some of these myths and, therefore, contribute to eliminating the stereotypes attached to certain religions. From a religious perspective, therefore, the proposed offence to ban hymenoplasty will have a positive effect on fostering good relations.

The programme of education will be in place to dispel the detrimental and pervasive myths that surround a woman's virginity. This programme does not target religious beliefs themselves and for example, will not encourage, or discourage, the concept of celibacy.

Pregnancy and maternity - *working arrangements, part time working, infant caring responsibilities*

Hymenoplasty is usually carried out on women and girls before they are pregnant, as a precursor to heterosexual marriage.

Hymenoplasty can have a number of physical consequences, including infections and narrowing of the introitus (the opening of the vagina). These side-effects have the potential to cause difficulty in conceiving and giving birth and, as such, a ban on hymenoplasty would reduce these risks.

The ban on hymenoplasty will, therefore, enhance equality of opportunity by ensuring that all women are able to make choices about their own reproductive healthcare, unencumbered with the additional risks hymenoplasty can bring.

Marriage and civil partnership - *married couples, civil partnerships*

Hymenoplasty predominately takes places as a pre-cursor to heterosexual marriage, with the aim of ensuring that women bleeds when she has sexual intercourse on her wedding night. While less common, we have heard anecdotal evidence that women may undergo hymenoplasty if they are remarrying and want a 'fresh start'.

Hymenoplasty is strongly linked to the cycle of HBA and the Panel heard anecdotal evidence that suggested that the marriages that follow the procedure are often emotionally, physically, and sexually abusive.

Due to the level of shame associated with hymenoplasty, the women undergoing and the families/communities supporting the procedure, will hide it from the future husband and his family. As a result, if the woman is found out to have undergone a hymenoplasty, there is further risk of harm and shame.

The ban on hymenoplasty, accompanied with the ban on virginity testing, can be seen as an opportunity to break this chain of abuse. The ban could also be seen as an aid to help, and legitimise, the work of the agencies that support these women and girls. The ban will aid and reinforce the policy of education, which is aimed at dispelling the myths around female sexuality and virginity. This will advance the equality of opportunity and women will eventually be able to

lead both single and married life freely – free from fear, abuse, and repression. Further, it is hoped that the ban will facilitate stronger marriages that are formed on the bedrock of mutual respect, rather than based on the subjugation of women and the need for her to be ‘pure’ for marriage.

Other identified groups

We have considered if an intersex person (or a person with variations in sex characteristics) could be a victim of hymenoplasty. We concluded that there is a risk that these individuals would still be subjected to the procedure, with similarities to the issues experienced by transgender and non-binary persons. The offence ensures these individuals are protected, thus working towards fostering good relations between intersex and endosex people, eliminating discrimination and advancing equality of opportunity.

As before, further detail and advice will be provided within the guidance.

Engagement and involvement

How have you engaged stakeholders in gathering evidence or testing the evidence available? *For each engagement activity, please state who was involved, how and when they were engaged and the key outputs*

During the review process over 25 key stakeholders were interviewed from across government, arm’s length bodies, police, third sector organisations and media. The list of organisations engaged with can be found below.

- Karma Nirvana
- Iranian and Kurdish Women’s Rights Organisation
- The Middle Eastern Women & Society Organisation
- Freedom Charity
- MHRA - Devices Regulatory Group
- NHSE/I
- NICE
- Advertising Standards Agency (ASA) and Committee on Advertising Practice (CAP)
- Public Health England
- Care Quality Commission

- British Association of Plastic, Reconstructive and Aesthetic Surgeons (BAPRAS)
- British Association of Aesthetic Plastic Surgeons (BAAPS)
- The Royal College of Obstetricians and Gynaecologists
- Nursing and Midwifery Council
- MHCLG
- DfE
- The Home Office
- MoJ
- BBC
- Teenage Pregnancy Knowledge Exchange
- GMC
- Met Police

Each interview was conducted using a standardised template and lasted approximately 45min. Each interview asked the same key questions surrounding participants' understanding of the procedures, the circumstances women and girl undergo such procedure and if government intervention was needed. Some of the questions asked are listed below.

- What do you know about virginity testing and hymenoplasty?
- How are virginity testing and hymenoplasty defined? Are there accepted definitions?
- Who is subject to virginity tests and hymenoplasty? Do virginity testing and hymenoplasty take place in certain communities, and/or age groups?
- How prevalent is virginity testing and hymenoplasty?
- In what settings does virginity testing and hymenoplasty take place (NHS, private healthcare clinics, non-healthcare settings)?
- What reasons do clinicians/ clinics / others give for offering these procedures?
- Who is carrying out virginity tests and hymen repair surgery?
- Under what circumstances do women and girls undergo virginity testing and hymenoplasty?
- Is virginity testing and hymenoplasty generally carried out before marriage?

- Do women undergo hymenoplasty and virginity testing through personal choice or are there other reasons? Are women and girls coerced into these procedures?
- In what ways is virginity testing related to hymenoplasty/ hymen repair surgery, or vice versa - do they happen sequentially?
- What impact does virginity testing and hymenoplasty have on women and girls who are subject to these examinations or procedure?
- Can virginity testing or hymenoplasty viewed as a form of violence against women and girls? Why do you think so?
- What are the potential positive impacts from banning virginity testing and/or hymenoplasty?
- Could banning virginity testing/ hymenoplasty have any negative impacts on women and girls or other unintended consequences?

Moral and Ethical Advisory Group (MEAG)

MEAG provides independent advice to the UK government on moral, ethical and faith considerations on health and social care related issues. They are drawn from a range of backgrounds, disciplines, communities and religions. The policy team presented the ban on hymenoplasty to MEAG, who provided input and comments. Several MEAG members were also recruited to the Panel. Members of MEAG played an invaluable role in the drafting the background paper, by offering their expertise to analyse the supporting evidence. Further information on MEAG and their membership can be found here - [Moral and Ethical Advisory Group - GOV.UK \(www.gov.uk\)](http://www.gov.uk)

Expert Panel on Hymenoplasty

Many of the experts on the Panel were engaged in internal review. The Panel met twice, with each session lasting between 2 – 2.30 hours.

The Panel's members can be found within the Terms of Reference, which are available here - <https://www.gov.uk/government/publications/expert-panel-on-hymenoplasty/terms-of-reference-expert-panel-of-hymenoplasty>

How have you engaged stakeholders in shaping the policy or programme proposals? *For each engagement activity, please state who was involved, how and when they were engaged and the key outputs*

Many of the stakeholders we engaged with as part of the internal review process were also members of the Expert Panel on Hymenoplasty. These stakeholders discussed, at length, the legal, clinical and ethical aspects of hymenoplasty and whether it should be banned. A final report was drafted, which sets out the evidence, explores the options available to the Government and sets out the Panel's recommendations. Further, a detailed background paper

accompanied the report. The Panel's members reviewed the background paper and provided input where necessary. The Panel's Terms of Reference can be found using the following link: <https://www.gov.uk/government/publications/expert-panel-on-hymenoplasty/terms-of-reference-expert-panel-of-hymenoplasty>

Government Legal Department - prepared detailed legal instructions which outline the legal and policy rationale for the offence. **The Office of Parliamentary Council** has been engaged for the drafting of the clause, informed by the legal instructions.

The Home Office and Ministry of Justice - involved throughout the review and development of the policy and clause. Regular weekly update meetings.

Ministry of Justice, Crown Prosecution Service and Attorney General's Office - have been heavily involved with the core development of the offence including the sentencing and jurisdiction.

Devolved Administrations – engagement with the Scottish, Welsh and Northern Irish Governments to obtain UK-wide agreement for the offence.

Royal College of Obstetricians and Gynaecologists - regular updates and direct link with clinicians and experts.

NHS England and Improvement – direct link with clinicians, to discuss the possible implications the offence could have on other procedures and the medical implications of the procedure.

Richard Holden MP and Baroness Sugg – Richard Holden initially introduced a private member's bill to ban virginity testing in December 2020. Throughout DHSC's internal review we actively engaged with Richard and his team of stakeholders, who are third-sector organisations (and were members of the Panel) in the violence against women and girls and HBA space. Richard Holden tabled two amendments to the Health and Care Bill to ban virginity testing and hymenoplasty. The Team regularly met with Richard to update him on progress of the Government amendment. Further, the Team have worked closely with Baroness Sugg, who has tabled Richard's amendment to ban hymenoplasty in the House of Lords.

The Moral and Ethical Advisory Group (MEAG)

Summary of analysis

Considering the evidence and engagement activity you listed above, please summarise the impact of your work. *Consider whether the evidence shows potential for differential impact, is so state whether adverse or positive and for which groups. How you will mitigate any negative impacts. How you will include certain protected groups in services of expand their participation in public life.* How the proposals have an impact on elimination of discrimination, harassment and victimisation, advance the equality of opportunity and/or promote good relations between groups.

Overall, we believe that the proposal to ban hymenoplasty will have a positive effect on particular groups with protected characteristics under the Equality Act 2010. When there are negative aspects, our policy solutions alongside the ban aim to address them.

When considering the characteristics most affected by the ban, the positive consequences outweigh any negative consequences that may arise from the policy. The policy will enhance equality of opportunity to many people with protected characteristics, as they will be able to live their life freely without the fear of being subjected to hymenoplasty and the physical or psychological harm that accompanies the procedure.

When there is a risk of negatively affecting good community relations (i.e., putting one community at odds with another), or stigmatising certain ethnicities or religious beliefs (e.g. around celibacy before marriage) the policy of targeted education and sensitive guidance should mitigate this risk, effecting long term change which, ultimately, will benefit many women and girls across the United Kingdom. The education policy will aim to increase understanding and reduce hostility between groups of people who share these characteristics and those that do not, by explaining why it is important to dispel the myths around virginity.

Our policy will not cause direct or indirect discrimination. It is likely that the ban on hymenoplasty will prevent discrimination – by reaching traditionally ‘under-served groups’ that may be more susceptible to coercive control and HBA offences, such as those with disabilities.

What is the overall impact? *Consider whether there are different levels of access experienced, needs or experiences, whether there are barriers to engagement, are there regional variations and what is the combined impact.*

The overall impact of the intervention is positive.

Due to the nature of hymenoplasty, there are several barriers for victims and witnesses when coming forward to report a crime. Many communities hold deep-rooted cultural beliefs around the validity of the practice and the necessity for a woman to be ‘pure’ before marriage. The procedure is strongly associated with pervasive coercive and controlling behaviour and abuse, which women are subjected to within family and community structures. These issues feed into a woman or girls’ self-worth and contribute to a reluctance to come forward (due to fear of reprisals, ostracisation and lack of support) and report the crime. We recognise that, given these communities are under-served groups, there may be some regional variation in terms of effectiveness of the policy.

Strong, comprehensive and informative guidance, in conjunction with the programme of education will be vital to help dispel the myths that surround virginity and support organisations that come into contact with victims (or potential victims – as a preventive step).

The guidance will also help to ensure that there is a consistent approach taken across all of the UK, to reduce regional disparities that may arise. DHSC will continue to work with devolved partners to ensure this is the case.

Addressing the impact on equalities - *Give an outline of what broad action you or any other bodies are taking to address any negative impacts identified through the evidence*

The overall impact of the intervention is positive. Any negative impacts, or perceived negative impacts, will be addressed in the accompanying guidance and education policy. For example, the education policy will make clear that virginity testing and hymenoplasty are not a requirement of any particular religion and, as such, we will make clear that individuals from those religions (or communities) are not targeted.

The guidance offers the opportunity to begin to dispel the myths surrounding the practice and virginity as a whole. We are holding a series of focus groups with individuals from across Government, the NHS, healthcare regulators and the devolved administrations to ensure our guidance is effective and will help to produce the best possible outcomes for women and girls.

A formal review into the procedure will take place, where the Government will assess the effectiveness of the ban on hymenoplasty and that the safeguarding mechanisms in place adequately protect women and girls. Equalities impacts will form part of this review.

Monitoring and evaluation - *Give an outline of what processes will be put in place to monitor the policy, including the impacts set out in this assessment, once it is implemented*

The impact of the ban will be monitored through the number of women and girls coming forward and pressing charges and ultimately, the number of successful convictions. We are aware that by the very nature of HBA, such as FGM, the number of convictions will be small. The main purpose of this legislation is to stop the procedure, safeguard women and girls, aid education and a cultural shift, act as a deterrent, and empower women and girls that they do not have to be subjected to any forms of abuse.

We anticipate that the key third sector organisations that currently support victims of HBA will see an increase in women and girls contacting them for advice and support once the ban comes into force. We could also see more reports of the procedure when victims of this offence come into contact with other statutory services, such as the health and care system and the forced marriage unit. We will continue to engage with these organisations, the NHS, Home Office and other key stakeholders, to monitor this, and we will review any anecdotal evidence provided as to the effectiveness of the policy.

As with similar abuses, there will be a risk that some perpetrators will try to continue the practice under a different guise. The drafting of the offences attempts to minimise this risk and, through our engagement with the Panel, we have been informed that the hymenoplasty definition used captures all available procedures to reconstruct the hymen. However, this cannot be completely mitigated against and we cannot anticipate how this may manifest. Any evidence that the wording of the legislation is not effective will require review.

The secrecy surrounding these offences makes it difficult to evaluate their effectiveness - there has never been a formal review into the FGM legislation, for instance. However, the message this legislation will send to both the perpetrator and the victims is powerful and should not be underestimated.

To strengthen this message, and tackle the harmful misconceptions that surround virginity, DHSC, in conjunction with the Home Office, has committed to a programme of wider societal education and community awareness, aimed at schools, communities and clinicians. This programme begins with an official-led Community Engagement Roundtable. This will be attended by key stakeholders and delivery partners to discuss what targeted work with communities is needed and how this fit in with wider work on preventing and tackling HBA.

The Expert Panel on hymenoplasty recommended that *“the impact of a ban on hymenoplasty should be formally reviewed after an agreed period to consider its implementation, including whether the desired cultural change has been achieved, prohibition has led to unregulated practice, enforcement, and the effectiveness of safeguarding of the women affected.”* The Government accepts this recommendation and, in addition to the ongoing engagement that will continue to take place with stakeholders and delivery partners, will commit to a formal review.