

Female Genital Mutilation in the UK population: a serious crime.

Keywords: Female genital mutilation, female genital cutting, Female Genital Mutilation Act 2003, Serious Crime Act 2015, education to end FGM.

Abstract: This article considers the definition of female genital mutilation (FGM) in the context of United Nations work which aims to end this practice. The piece focuses on the prevalence of FGM in the UK and on legal provisions outlawing cutting in England and Wales. It argues that FGM is now relatively commonplace in the UK and ends with a call for greater public education about FGM and better support for survivors of mutilation.

The article begins by looking at international ideas about FGM, drawing on knowledge from UNICEF and considering the realities of the practices carried out on young girls. It is acknowledged that there is a risk of alienating traditions that value cutting, inherent in the western view of FGM as child abuse. Nevertheless, the article argues that FGM must be eradicated.

A review of information on the prevalence of FGM in UK populations follows, showing that there are many thousands of women and girl survivors now resident in Britain. FGM has been a criminal offence in England and Wales since the Prohibition of Female Circumcision Act 1985. However this legislation proved impractical and it has now been replaced by a Female Genital Mutilation Act in 2003 and that, in turn, is now amended by the Serious Crime Act 2015. An outline of the newer legislations suggests that there are signs of usefulness within the latest amendments.

However the article ends with some warnings about the risks of criminalisation without appropriate levels of support and public discussion.

Introduction

In 2012 the United Nations agreed to “intensify global efforts for the elimination of female genital mutilation”.¹ Within the UK this has been followed by legislative change and Government initiatives which aim to provide some measure of the incidence of female genital mutilation (FGM) in the UK population. This article reviews the legal and policy changes, giving some brief insight into the global context of FGM. It concludes by considering what needs to be done to create meaningful change, with a view to eventually eradicating this form of child abuse.

There is a central conflict in responding to FGM as a crime, whilst valuing the lived realities of the UK populations who perpetuate the practice. This article argues that there is a need to offer support and information to adult survivors of FGM in the UK, as a key element of

policies which aim to stop FGM. However, the article begins with a look at the meaning and impact of FGM and a brief review of some of the recent history, here in the UK.

The term FGM or female genital cutting covers a range of levels of mutilation of girls' genitalia, as explained below. The practice is sometimes referred to as female circumcision. This is considered to be an unhelpful term as it suggests a parallel with the (relatively) harmless tradition of male circumcision. This comparison is also given further consideration in what follows.

The development of the legislation in England and Wales gives an illustration of this change in nomenclature. The act of mutilation of female genitalia has been a criminal offence in England and Wales since the Prohibition of Female Circumcision Act 1985. This act was replaced by a Female Genital Mutilation Act in 2003 and that, in turn, is now amended by the Serious Crime Act 2015. The President of the Family Division has described FGM as “barbaric” and “beyond the pale”.² Sadly, despite all of this there is no sign that the criminal legislation is effective and it has been widely reported that there have been no successful prosecutions to date.³ The article returns to consider the latest legislation, after outlining the meaning and context of FGM.

Explaining Female Genital Mutilation

‘FGM is not an act of hate. It is carried out because parents believe it is in the best interest of their daughters.’⁴ Despite this, FGM is accurately recognised as a profound attack on female autonomy, as an offence against human rights⁵ and as a form of violence against women and girls.⁶ It has been an issue of concern to international bodies, such as the United Nations, for a number of years.⁷ In the UK, the authorities are now doing more to try to protect young girls who are at risk of this violation. In 2015 for example, on the International Day of Zero Tolerance for FGM (6 February), police at Heathrow airport undertaking an awareness-raising exercise, arrested a woman and an 8-year-old girl travelling with her was subsequently taken into care.⁸ Whilst the 2003 Act may not have produced prosecutions, there has clearly been a change of intent, within the government and law-enforcement agencies, in terms of moving to end FGM.

The act of mutilation is traditionally carried out on girls under the age of 15, by women within an extended family or community group.⁹ This is most common in a range of African and Middle-Eastern countries and there is some evidence that prevalence rates within these countries is declining.¹⁰ There is conflicting data on the influence of education, but it appears possible that a mother’s education, in Africa, can lessen the chance of FGM in her family.¹¹ However, with global migration, mutilated populations within a number of western destination countries are growing¹² and it is also thought that FGM is being carried out in the UK, though this is not something that is easy to prove.¹³

The type of FGM varies in different societies with some removing the entire clitoris, inner labia, labia majora as well as infibulating (narrowing or sewing up) the vaginal opening. Other cultures use only some of these horrific practices and yet others have different practices (such as scraping or burning the genitals).¹⁴ These mutilations are all harmful. They do nothing to promote health. Pain and health complications are inevitable results of these mutilations.¹⁵ The FGM ritual is usually completed without anaesthetic, with the child physically restrained whilst a knife, razor blade or even a piece of glass is used to perform the mutilation.¹⁶

[My Grandma] caught hold of me and gripped my upper body. Two other women held my legs apart. The man, who was probably an itinerant traditional circumciser from the blacksmith clan, picked up a pair of scissors. [...] Then the scissors went down between my legs and the man cut off my inner labia and clitoris. A piercing pain shot up between my legs, indescribable, and I howled. Then came the sewing: the long, blunt needle clumsily pushed into my bleeding outer labia, my loud and anguished protests. [... My sister] Haweya was never the same afterwards. She had nightmares, and during the day began stomping off to be alone. My once cheerful, playful little sister changed. Sometimes she just stared vacantly at nothing for hour.¹⁷

Quite apart from this physical and psychological pain, the removal of genitalia will lead to other complications, for many women. These are likely to include a reduction in the possibility of achieving sexual pleasure. However, the other issues may well outweigh this, in terms of their effect on the quality of life of survivors of FGM. These other medical implications can include: difficulty in urinating; repeated infection; kidney disease; problems with pregnancy and possible flashbacks during childbirth.¹⁸

As already mentioned, the term FGM is arguably preferable as this practice is indeed mutilation, not to be confused with the relatively non-invasive circumcision carried out on male babies within various cultures.¹⁹ Given the clear difference between these practices, the term "female circumcision" is no longer commonly used, to describe FGM.²⁰ However, it is also important to think about the possible negative effects of the term 'female genital mutilation'. FGM is a pejorative name for a practice that is deeply traditional in a number of cultures worldwide.²¹ UNICEF publications refer to Female Genital Mutilation or Cutting as FMG/C.²² The use of the neutral term "cutting" is sometimes considered more appropriate as a way of responding to the conflict between the wish to eradicate a set of harmful practices, whilst engaging communities who consider cutting to be a traditional necessity.

As indicated above, the procedure is carried out in families where it is believed to be the right thing to do for a young girl. There has, therefore, to be a risk of backlash against a western-led movement against FGM. It is noted, however, that at least 26 African and Middle Eastern countries have now enacted legislative bans on the practice and so it may be that cultural norms are beginning to shift.²³

Whatever the scale of the removal, the mutilation is considered necessary, within the home culture, to ensure female respectability. Hence, parents truly believe this to be what their daughter needs. UNICEF discuss the relationship between various social reasons for FGM and the role of religion, in their 2013 review of the research.²⁴ These reasons may relate to notions of sexual fidelity, although it is difficult to generalise across the cultures where this mutilation is practised.²⁵ In reality the act of cutting is so traditional in some cultures that it has been more or less unthinkable to resist or reject. For example, according to UNICEF, 98% of girls in Somalia suffer FGM.²⁶ In such a culture, where the majority of the women are mutilated, dominant understandings of the nature of female genitals must be inhibited by the lack of intact examples. The practice of cutting may tend to be little discussed and so the routine is reproduced, perhaps simply because it is traditional. If this is so, then public discussion, description, explanation and resistance is extraordinarily important in terms of creating change, wherever that debate takes place. In an increasingly connected world, all truthful disclosure of the reality of FGM can only serve to bring its demise a little closer. It is, in reality, a horrific butchery which is supported by silence and secrecy.

The quotation above, where a survivor described her own experience of cutting, also helps to illustrate that, given the space to recount their own stories, women who have been mutilated can become articulate supporters of efforts to bring these practices to an end.

FGM in the UK

There are a number of ways in which families in the UK can be connected to the practice of FGM. Women who live in the UK may have experienced FGM in their country of origin. They may have family members who have suffered FGM but might not have been cut themselves. They might have sisters, daughters, nieces, and/or granddaughters who are expected to undergo mutilation. These youngsters may live in the UK or in the country of origin. In addition, women come to the UK seeking asylum because of FGM or the threat of it. To illustrate this, here is just one case study, taken from the report of an immigration tribunal case.²⁷

FB is a young woman from Sierra Leone who sought asylum in the UK. At the time of appeal in 2008, she was 21 years old, she arrived in the UK when she was 16. She was the daughter of a soweï (a woman who is charged with practising FGM). After FB had undergone FGM her mother died and she was expected to undertake the role herself and to become one of the chief's wives. She refused and ran away.²⁸ FB's story gives a glimpse into the complexity of young women's experiences of FGM. At a young age she had already experienced cutting and lost her mother. Her courage in refusing the traditional role of soweï is striking.

In addition, the presence of women and girls who have suffered FGM has implications for British institutions. In common with FB, other women who live in the UK also experience all of the complications of FGM mentioned above. All of these realities present issues for health care providers, education bodies and employers here, in the UK. Until very recently,

it was probably fair to suggest that many of these bodies were simply ignoring or were actually ignorant of these considerations. There have been some clear exceptions to this as healthcare providers are sometimes bound to be or become aware that a patient has been mutilated, during childbirth or other gynaecological procedures.²⁹

The government have now implemented a requirement on acute hospitals to provide statistical data on the numbers of women they are treating who have undergone FGM³⁰ and this data is discussed shortly. Work is also going on within education and so it is also likely that some youngsters at school also disclose the reason for their trips home to their countries of origin. Students at university might also want to discuss the difficulties they face because of FGM. All of these institutions can do more to educate staff and others about the truth about FGM and to protect youngsters from mutilation. Women survivors also need support to help them to live well, despite the effects of this practice. This article returns to these themes shortly.

Prevalence in UK populations

It is difficult to work out how many women and girls there are, within the UK population, who have experienced FGM. However international and national research studies do offer some established data which is surveyed here before moving on to examine what can be learned from the newer research and government figures.

Recent research by the UNHCR examines asylum trends in the EU and attempts to predict the level of female immigrants who have suffered FGM.³¹ According to this study, approximately 20,000 women and girls, from FGM-practising countries of origin, seek asylum in the EU each year.³² Around 2,400 of these come to the UK. The report goes on to examine how many women and girls were offered asylum (during the 4-year study) and to estimate FGM rates, based on what is known about their countries of origin. The UNHCR estimate that 1,085 women and girls aged 14 to 64, who are likely to have suffered FGM, came to the UK between 2008 and 2011.³³ If around a 1,000 FGM sufferers are arriving in the UK every 4 years, then it is clear that the population living with this mutilation must be sizeable.

In fact, research by City University and *Equality Now*, published in 2014 estimates that over 100,000 women living in the UK (and aged between 15 and 49) are likely to be survivors of FGM.³⁴ The final report from this research project suggests that every local authority in England and Wales is likely to have women and girls living there, who are affected by FGM.³⁵ These estimates were produced by considering the rates of FGM in home communities (based on data from household surveys³⁶) and combining this with what is known about numbers of women of child-bearing age moving to the UK. It is easy to see that this method is fraught with difficulties and the authors of the *Equality Now* research discuss some of these problems.³⁷ It may be, for example, that families emigrate when they have female

members who wish to avoid FGM or who have not been cut. In other words, it may be false to assume that it is possible to predict the rates of FGM in migrant populations. In addition, of course there are difficulties with census data and with the underlying household surveys that can also lead to inaccuracies³⁸. That said, this has been the only method of estimating UK incidence to date. However, that is now changing with the health statistics that are being published by the government.

The Department of Health has now embarked on an *FGM Prevention Programme* and a part of this is the collection of data. The *Experimental Statistics* on FGM have been published monthly since hospitals were asked to start collecting data on 1 September 2014.³⁹ A gradually increasing number of hospitals are taking part in this exercise and the data is being published regularly. At the time of writing this has revealed that in just 6 months (September 2014 to March 2015) 3,742 cases of FGM have been identified by UK hospital trusts.⁴⁰ In the future more information will become available as an “enhanced data set” has begun from April 2015, with more healthcare practitioners taking part and with patient level information being collected.⁴¹ However it is already possible to see that FGM can hardly be rare within UK populations if approaching four thousand women who are survivors seek medical treatment in UK hospitals in a six-month period.

Legislation and role of the law

It is interesting to keep this in mind whilst considering the legislation which bans the practice in the UK. The Female Genital Mutilation Act 2003 (‘the Act’⁴²) created offences in connection with committing an act of mutilation (section 1), helping a girl to mutilate her own genitals (section 2) and with the ‘aiding, abetting, counselling and procuring’ of an act of FGM (section 3). Section 3 also had extra-territorial application and could have led to prosecutions of those involved in commissioning or practicing FGM, even when this took place abroad. In reality, as this article has already commented, the legislation has not led to convictions. There are clear reasons for this failure. Most strikingly, the Act required testimony as to the identity of the person(s) involved in the offence. In practice this means that the law required victims of FGM to come forward and give evidence in court against their family members. Not surprisingly this has not proved possible.⁴³ It is even arguable that this would not be in the best interests of the child concerned and that the successful prosecution of a parent or grandmother (for example) might not have any impact on future practice of FGM in that community.

At best then, the 2003 Act has been a marker in the sand, to indicate that this practice is not tolerated in the UK. The last government acted, in 2015, to amend the 2003 Act and so it is appropriate to review the changes in the law to evaluate signs of progress. The first important changes created by the 2014 amendment came into force in May 2015. Firstly, section 70 of the Serious Crime Act 2015 (‘SCA’) extends the range of people to whom sections 3 and 4 of the 2003 Act apply, to include a wider range of UK ‘residents’ so that the former evidential burden of proving that a defendant was a ‘permanent UK resident’ is

removed. Section 71 of the SCA next provides anonymity for complainants who are victims of FGM, modelled on the provisions creating anonymity for victims in serious sexual offence cases. This might well prove useful where a youngster is required to give evidence in an FGM case.

The amended Act also now includes a new offence of 'failing to protect a girl from risk of genital mutilation' (S.72 SCA). People found to be responsible for a girl who is mutilated will face liability under this new offence. Those covered are people with parental responsibility (and frequent contact) for the girl and those who have assumed caring responsibilities as parents (although not parents). The example given in the explanatory notes are grandparents, with whom the child is staying over the summer.⁴⁴ The maximum sentence for a section 72 offence, on conviction on indictment is 7 years' imprisonment.

For the first time it will be possible to prosecute parents (or those in loco-parentis) who offer up young girls for FGM, without the testimony of the girl herself. If there is medical evidence that she has suffered FGM then it may be possible to prosecute those who should have protected her. There could be temporal difficulties with prosecutions, where it is unclear how long ago the FGM took place (proving just who had responsibility for her, when it happened). However, this is a new possibility for prosecutions that might succeed.

This is rendered all the more powerful by the remaining new provisions of the SOA 2015 which relate to FGM. Section 73 has created an FGM protection order which can be made to protect a girl at risk of FGM or on whom FGM has been perpetrated. The order may be for a specified period or indefinite and could apply (for example) where a younger sister of a girl involved in a criminal case regarding FGM is considered to be at risk. The High Court has a wide discretion to make these orders, where it considers that there is a need to do so. This provision came into force in July of 2015 and was immediately used by police to stop girls being taken to their countries of origin, over the summer holidays, where they were believed to be at risk of FGM.⁴⁵

Finally, section 74, will require teachers, healthcare professionals and social workers to notify the police when they discover that a girl under 18 appears to have suffered FGM. It is possible that this provision could mean that a school teacher, who becomes aware what has happened to a young girl, will contact the police and that this action could result in parental prosecution and the protection of the girl's younger sisters. This mandatory reporting provision is not yet in force and it is not yet clear when it might be brought in.⁴⁶

In the meantime, the Department of Health are providing a range of training and awareness-raising materials and opportunities to "health practitioners, health visitors, school nurses, practice nurses, GPs and safeguarding leads"⁴⁷ to make sure that those within healthcare know enough to comply with this duty, when it is brought in.

It seems possible that these provisions and the training now being put together could lead to real change in the UK, for women and girls who have suffered FGM or who are at risk of FGM. However, all of this does leave some rather large questions unanswered.

Risks of Criminalisation

UNICEF point out that “unless legislation is accompanied by measures to influence cultural traditions and expectations, it tends to be ineffective, since it fails to address the practice within its broader social context.”⁴⁸ This comment is made in the context of the home countries where FGM is traditionally practiced. However, it is worth pausing to wonder whether legislation in the UK will also have risks attached.

It is possible, for example, that mandatory reporting, child protection orders and increased likelihood of successful prosecution will simply scare people within communities where FGM is still valued as a traditional ritual. The women in these groups may speak little English and may not readily understand the intentions of UK law. It could be that girls who are at risk will simply be taken out of the school and that secret illegal cutting rituals will become more common, within the UK. Clearly schools, social services and health professionals will need sensitive and skilled strategies for putting these rules into practice.

UNICEF’s review considers a range of techniques for work to end FGM and shows that a number of techniques appear to contribute favourably. One of these is working with boys and men within communities to promote more discussion within family groups.⁴⁹ This perhaps suggests that more informed public discussion of FGM might begin to create change here, in the UK.

Another area that is of concern is the lack of support agencies skilled at working with survivors of FGM. There are some small and underfunded voluntary groups who have worked on this issue for a number of years. However, with the NHS now identifying women in their reporting systems it is fair to assume that many women might appreciate having other women to talk to, who have also experienced FGM. A better understanding of the cutting they experienced might mitigate health difficulties and reduce psychological pain associated with memories of the ritual itself. Perhaps, it could be argued that, having raised this topic with women in routine health visits, the NHS owes a duty of care to the women to respond appropriately to their ongoing needs for support. It is certainly clear that there is a lack of such support across the country as a whole.⁵⁰

Conclusions and recommendations

FGM is a profound attack on girls’ rights and work to eradicate the practice on a worldwide scale is to be applauded. Research and personal testimony makes it increasingly clear that the practice is no longer isolated to countries in Africa and the Middle East. A sizeable

number of women in the UK are living with the effects of FGM and an unknown number of girls are at risk of suffering FGM.

Legislation in the UK has so far been wholly unsuccessful but new legislative moves appear more useful. However, these carry risks of alienating people who still believe in the cultural value of the practice of cutting. There is, therefore a real need for wider social discussion of FGM. In particular, it is important that information and support reach adult survivors of FGM, in order that they can become the protectors of future generations of girls.

Women who are living in the UK and who were mutilated as girls deserve support, information and the chance to share their experiences with others. This will need resourcing and there may be possibilities to ally a public education campaign with some form of funding for support services.

¹ United Nations, <http://www.un.org/press/en/2012/gashc4061.doc.htm>, accessed 26.5.15.

² *Signh v Entry Clearance Officer, New Delhi* [2004] EWCA Civ 1075, at para 68.

³ This is confirmed by the government's own factsheet on FGM, at page 1. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/416323/Fact_sheet_-_FGM_-_Act.pdf, accessed 20.8.15. C. Malone, 'The Female Genital Mutilation Trial that has put girls at a higher risk', (2015, 7 Feb) *The Mirror*, <http://www.mirror.co.uk/news/uk-news/female-genital-mutilation-trial-put-5122952>, accessed 12.5.15.

⁴ S. Bufton, 'Child abuse: female genital mutilation acts of violence done to young girls for sexual control' (2009) *Criminal Lawyer* 5-6.

⁵ UNICEF, *Female Genital Mutilation/Cutting: A statistical overview and exploration of the dynamics of change*, (2013) http://www.childinfo.org/files/FGCM_Lo_res.pdf, accessed 17.5.15.

⁶ Notably, in the United Nations Declaration on the Elimination of Violence Against Women, as detailed by the End FGM European Network, at: <http://www.endfgm.eu/en/female-genital-mutilation/a-human-rights-violation/fgm-violates-womens-rights/>, accessed 12.5.15.

⁷ *Ibid.*

⁸ Ed. 'Female Genital Mutilation: Woman arrested at Heathrow Airport', (2015, 6 Feb) *BBC News*, <http://www.bbc.co.uk/news/uk-england-london-31171844>, accessed 12.5.15.

⁹ As *Daughters of Eve*, a not-for-profit group explain at: <http://www.dofeve.org/about-fgm.html>, accessed 12.5.15.

¹⁰ UNICEF, above at note 5.

¹¹ H. Moore, 'Female Genital Mutilation/cutting' editorial, (2013) *BMJ* 347.

¹² *Ibid.*

¹³ J. Hayes, 'Protecting child victims of Female Genital Mutilation' (2015) 45 *Family Law Journal* 3. On Scotland: J. Muneer and K. Macfarlane, 'Female genital mutilation - be FGM aware' (2014) *Family Law Bulletin*, July, 3-4.

¹⁴ The NHS has useful information pages, here: <http://www.nhs.uk/conditions/female-genital-mutilation/pages/introduction.aspx>, accessed 12.5.15. Also outlined in UNICEF, above at note 5, p.7.

¹⁵ *Ibid.*

¹⁶ UNICEF, above at note 5, Chapter 5.

¹⁷ UNHCR 'Too much pain: Female Genital Mutilation and Asylum in the European Union, a statistical overview, Feb 2013, UNHCR. Available at: <http://www.unhcr.org/531880249.pdf>, accessed 12.6.2015, p.9.

¹⁸ *Ibid.*

¹⁹ Which is not to say that the circumcision of male babies is necessarily positive, it is not however within the scope of this article. Hayes, above at note 13 considers this comparison in more depth in light of the judgment in the care case *Re B and G (Children)* (No 2) [2015] EWFC 3.

²⁰ UNICEF, above at note 5, p.7.

²¹ UNICEF, above at note 5, p.7.

²² UNICEF, above at note 5.

²³ UNICEF, above at note 5, p.8. In fact the number of countries is growing. Nigeria is now reported to have a new law against FGM: S. Mukasa, 'Nigeria's bill targeting FGM is a positive step, but must be backed by investment', (2015, 20 May) The Guardian, <http://www.theguardian.com/global-development/2015/may/20/nigeria-fgm-gender-violence-bill-investment>, accessed 26.5.15.

²⁴ Above at note 5, pp.63-73.

²⁵ A. Macfarlane & E. Dorkenoo, 'Female Genital Mutilation in England and Wales: Updated statistical estimates of the numbers of affected women living in England and Wales and girls at risk Interim report on provisional estimates', (City University, London, 2014) 7. S. Long, 'Multiculturalism and female genital mutilation' (2004) UCL Jurisprudence Review 169.

²⁶ UNICEF, above at note 5. The report explains that there are two key sources of data on the prevalence of FGM internationally, USAID Demographic and Health Surveys and UNICEF Multiple Indicator Cluster Surveys. Combining data from these sources produces the best estimates that are currently available (pp.1-4).

²⁷ *FB v SSHD* [2008] UKAIT 90.

²⁸ *Ibid.*

²⁹ A. Byrne, 'Supporting women after genital mutilation', (2014), Nursing Times, 110[18], 12-14. The author is a specialist midwife who works with women who have experienced FGM.

³⁰ Available at the Health and Social Care Information Centre website: <http://www.hscic.gov.uk/catalogue/PUB16773>, accessed 26.5.15.

³¹ UNHCR, above at note 17.

³² UNHCR, above at note 17, p.5.

³³ UNHCR, above at note 17, p.23.

³⁴ Macfarlane & Dorkenoo, above at note 25.

³⁵ A. Macfarlane & E. Dorkenoo, 'Prevalence of FGM in England and Wales: National and Local Estimates', (City University, London, 2015) 23.

³⁶ UNICEF, above at note 5, considers the measurement of prevalence in Chapter 4.

³⁷ Macfarlane & Dorkenoo, above at note 25.

³⁸ UNICEF, above at note 5, also discuss the problems of this method, p.23.

³⁹ Outlined on the Health and Social Care Information Centre website, <http://www.hscic.gov.uk/fgm>, accessed 26.5.15.

⁴⁰ Clinical Audit Support Unit, Health and Social Care Information Centre, 'Female Genital Mutilation (FGM) - March 2015, experimental statistics' (2015) available from: <http://www.hscic.gov.uk/catalogue/PUB17463/fgm-mar-2015-exp-rep.pdf>, accessed 26.5.15.

⁴¹ *Ibid.* At the time of publication a further 3,737 new cases of FGM have been identified in later reports covering April-December 2015, accessed 22.3.16.

⁴² In Scotland the equivalent legislation is the Prohibition of Female Genital Mutilation (Scotland) Act 2005.

⁴³ Muneer & Macfarlane, above at note 13.

⁴⁴ Explanatory Notes to the Serious Crime Act 2015, Section 72, available at <http://www.legislation.gov.uk/ukpga/2015/9/notes/division/3/5/2/7>, accessed 20.8.15.

⁴⁵ K. Rawlinson, 'Police obtain first FGM protection order', (2015, 17 July) The Guardian, <http://www.theguardian.com/society/2015/jul/17/police-obtain-first-fgm-protection-order>, accessed 20.8.15.

⁴⁶ This provision came into force on 31.10.2015.

⁴⁷ Email from the Department of Health, author Astrid Fairclough, FGM Programme Manager, 8th June 2015.

⁴⁸ UNICEF, above at note 5, pp.8-9.

⁴⁹ UNICEF, above at note 5, p. 117-118.

⁵⁰ There might, for example be some strong support in some of the cities, in the UK from groups such as FORWARD <http://www.forwarduk.org.uk/> in London and NESTAC in Manchester <http://www.nestac.org/>, both accessed 13.6.2015.